Care Quality Commission

York and Scarborough Teaching Hospitals NHS Foundation Trust

Inspection report

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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Inadequate**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

York and Scarborough Teaching Hospital NHS Foundation Trust provides a comprehensive range of acute hospital and specialist healthcare for approximately 800,000 people living in York, North Yorkshire, Northeast Yorkshire, and Ryedale.

The trust manages three acute hospital sites and five community hospitals. There are type 1 ED at York and Scarborough.

There is a workforce of over 10,000 staff working across the hospitals and in the community.

The York Hospital is the Trust's largest hospital. It has over 700 beds and offers a range of inpatient and outpatient services. It provides acute medical and surgical services, including trauma, intensive care, and cardiothoracic services.

Scarborough Hospital is the Trust's second largest hospital. It provides acute medical and surgical services, including trauma and intensive care services.

We carried out this unannounced inspection of York and Scarborough Teaching Hospitals NHS Foundation Trust as part of our continual checks on the safety and quality of healthcare services.

We inspected Emergency and Urgent Care, Medical care, and Maternity services. We also inspected the well-led key question for the trust overall. We did not inspect surgery, critical care, services for young people and children, end of life care, out-patients, or diagnostics at this inspection.

In March 2022 we carried out an unannounced focused inspection of Medical care of the York Hospital following significant safety concerns we had received. Following this inspection, we issued a warning notice Section 29A under the Health and Social Care Act 2008 in regard to the standards of care provided on the medical wards. We suspended the rating of good for this service.

Our findings

At this inspection the trust rating of requires improvement stayed the same. We did see improvements made as a result of our warning notice on the medical wards.

Following our core service inspections we sent the trust a letter of intent to take urgent enforcement action of serious concerns we found in maternity services and the emergency department at York.

Risks included identification and management of deteriorating patients, management of patients waiting within the departments and medicines management, including controlled drugs in both core services. We also found that the mental health room in the emergency department was unsuitable, and the service did not control infection and prevention well. We also raised concerns regarding assessing and responding to risk within the maternity services, for example the lack of available CTG machines to monitor fetal well-being.

We returned to reinspect these core services during the well led inspection. We found some improvement in the emergency department. However, we did not find similar improvements in maternity services and therefore imposed urgent conditions upon the service. These included:

- implementing an effective system for managing and responding to patient risk to ensure all mothers and babies were cared for in a safe and effective manner and in line with national guidance
- Operating an effective clinical escalation system to ensure every woman attending the hospital is triaged, assessed, and streamlined by appropriately skilled and qualified staff.
- Implementing an effective risk and governance system which ensures that:
- There was oversight at service, division, and board level in the management of the maternity services.
- There were effective quality assurance systems in place to support the delivery of safe and quality care.
- Risk and occurrence of incidents were properly identified and managed, to include an effective system of recording actions taken and ensuring learning from any incidents.
- Serious incidents were reflected and reported correctly in line with national guidance and adequately investigated.
- Ensuring learning was shared from the investigation.
- Incident grading was reviewed to ensure it was accurate and in line with national guidance.

Following our inspection in November, CQC received concerns in relation to staff behaviours, bullying, harassment, and discrimination. As such we extended our well-led inspection to include further staff interviews including board level managers, staff focus groups for staff who belonged to an equality network or staff who felt they had a protected characteristic and a trust wide CQC staff survey. We received a total of 1028 responses to our staff survey.

Our rating of services stayed the same. We rated them as requires improvement because:

- We rated safe, effective, and responsive as requires improvement, caring as good and well-led as inadequate.
- We rated 3 of the trust's 9 services as inadequate and 3 as requires improvement. In rating the trust, we took into account the current ratings of the 19 services not inspected this time.
- Staff did not always meet the trust target for mandatory, role specific and safeguarding training. Services did not control infection risk well. The maintenance, use of facilities, premises and equipment did not always keep people safe. Staff did not always manage clinical waste well. Staff did not complete risk assessments for each patient promptly. Staff did not identify and quickly act upon patients at risk of deterioration. Services did not always have

Our findings

enough nursing and medical staff with the right qualifications, skills, training, and experience to keep patients safe. Staff did not keep detailed records of patients' care and treatment. Records were not always clear, up-to-date, or stored securely. Services did not manage medicines well. Managers did not always investigate incidents and share lessons learnt promptly.

- The trust did not always provide good care and treatment, use the findings to make improvements and achieve good outcomes for women. Policies were not always updated with national guidance and evidence-based practice in a timely manner**.** The trust did not always make sure staff were competent for their roles. Senior leaders did not always appraise staff's work performance and did not always hold supervision meetings with them to provide support and development.
- Staff did not always treat patients with compassion and kindness in the emergency department at York. They could not always respect their privacy and dignity and take account of their individual needs.
- The maternity service did not always plan and provide care in a way that met the needs of local people. It was not inclusive and did not always take account of patients' individual needs and preferences. People could not access the service when they needed it to receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.
- Senior leaders were not always visible and did not always support staff to develop their skills. The vision and strategy had not yet been embedded. They did not always use systems to manage performance effectively or make decisions and improvements. They did not have clear oversight of the key risks and had not always mitigated immediate risks. Staff did not always feel respected, valued, and supported. They were not always clear about their roles, responsibilities, and accountabilities. The trust did not have a culture where staff could raise concerns without fear as they were not always managed appropriately. Leaders and staff did not always engage with patients, staff, equality groups, the public and local organisations to plan and manage services.

However:

- Staff provided good care and treatment and gave patients enough to eat and drink. They advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week and staff worked well together.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.

How we carried out the inspection

The team that carried out the well led inspection included two inspection managers, 10 inspectors, one assistant inspector and an inspection planner. In addition, there was an executive reviewer plus three specialist advisors experienced in executive leadership of NHS trusts. The inspection team was overseen by Sarah Dronsfield, Deputy Director of Operations.

During the core service inspection we spoke with 72 members of staff including nursing, medical, healthcare assistants, porters, and domestics.We received feedback from 72 patients who had accessed treatment in maternity, medicine, and urgent and emergency service. We reviewed 84 patient records and a range of policies, procedures and other documents relating to the running of the service. We observed various handovers and MDT safety huddle meetings. We also looked at a range of performance data and documents including meeting minutes, audits, and action plans.

Our findings

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with 11 legal requirements. This action related to 6 services.

Trust wide

The trust must seek and act on feedback from relevant persons on the services provided, for the purposes of continually evaluating and improving such services. **Regulation 17 (2) (e).**

The trust must ensure the organisation supports all staff, including those with particular equality characteristics, to feel respected and valued and supports an environment where staff are encouraged to speak up and raise concerns without fear of blame or reprisal. **Regulation 18 (2) (a).**

The trust must ensure that the guidance within all policies is up to date, accurate and relevant to the service. This includes, but is not limited to, the guidance within the workforce and equality, diversity, and inclusion (EDI), freedom to speak up, policies for transgender and non-binary people and unacceptable behaviours from patients. **Regulation 18 (2) (a).**

The trust must demonstrate it supports its staff by challenging unacceptable behaviours and language. This includes, but is not limited to, racism and discrimination. **Regulation 18 (2) (a).**

The trust must ensure it takes account of the Workforce Race Equality Standard, Workforce Disability Equality Standard and NHS staff survey data to ensure both staff from ethnic minority groups and disabled staff are not disproportionately disadvantaged by working in the organisation. **Regulation 18 (2) (a).**

The trust must ensure that structured case reviews are focussed on the implementation of recommended actions and the actions are monitored, completed, and recorded. **Regulation 17 (2) (f).**

The trust must fullyinvestigate and seek to learn from the death of a person with a learning disability or autistic people including seeking LeDeR reviews. **Regulation 17 (2) (e).**

The trust must gain assurance that learning from incidents and risks are shared within the organisation to prevent the risk of reoccurrence. **Regulation 17 (2) (f).**

The trust must ensure that risks recorded at corporate level and in the board assurance framework are current, not duplicated and have clear actions for mitigation which can be monitored and measured. **Regulation 17 (2) (b).**

Our findings

The trust must ensure that high level risks, particularly in relation to estates are fully assessed and mitigated to the lowest level of risk. **Regulation 17 (2) (b).**

The trust must ensure there is an accountability framework for care groups to monitor performance on action plans or mitigating risk. **Regulation 17 (2) (b).**

The trust must ensure there is full clinical engagement to support operational performance and that challenges are resolved with a focus upon patient safety across the organisation. **Regulation 17 (2) (a).**

The trust must ensure that there is adequate oversight of the harms caused by delays to assessment and treatment. **Regulation 17 (2) (a) (f).**

The trust must ensure ongoing patient safety concerns such as falls, pressure ulcers and healthcare care acquired infections are addressed in a timely way and all possible actions are taken to address concerns. **Regulation 17 (2) (a) (f).**

The trust must ensure adequate action is taken following audits which identify medication storage issues. **Regulation 12 (2) (g).**

The trust must ensure they are delivering fundamental standards of care and patients receive safe and effective care that meets their needs. **Regulation 12 (1) (2) (a) (b) (c) (g).**

The trust must ensure that complaints are responded to in a timely way, result in further investigation if indicated and where possible involve family in the investigation. **Regulation 16 (1) (2).**

In York:

Urgent and emergency care

The service must ensure their new ED has sufficient side rooms for medical staff to see and treat patients, barriered isolation rooms for infectious patients, handwash basins and storage areas for equipment. **Regulation 15 (1) (c).**

The service must ensure their new ED environment does not compromise the fundamental standards of care staff can provide to patients, protects their privacy and dignity, and ensures staff can offer them emotional support. **Regulation 10 (1)(2) (a).**

The service must review processes for ED staff completing full resuscitation trolley checklists to ensure all specialist live-saving equipment is stocked and in date in the event of an emergency. **Regulation 15 (1) (e).**

The service must ensure ED staff accurately and consistently complete risk assessments for each patient on admission or arrival and review this regularly using appropriate screening tools (in which they are trained and familiar). **Regulation 17 (1)(2) (c).**

The service must ensure all patients in ED are wearing wristbands at all times for improved safeguarding, security and easier identification when prescribing and administering medications. **Regulation 12 (1)(2) (a)(g).**

Our findings

The service must ensure the service improves compliance in sepsis screening, especially for patients receiving antibiotics within an hour. They must also ensure ED medical staff improve their overall training compliance rate in sepsis screening and all ED staff complete screening for patients at risk of sepsis (to better recognise and respond to warning signs of deterioration). **Regulation 12 (2) (a)(g)(h).**

The service must ensure staff do not place patients at higher risk such as those with IV access or allergies in inappropriate environments for their needs and observe them accordingly. **Regulation 12 (1)(2) (a)(d).**

The service must ensure ED staff maintain detailed records of patient's care and treatment, so they are clear, up to date and stored securely. **Regulation 17 (1)(2) (c).**

The service must ensure ED staff fully and accurately complete patients' fluid and nutrition charts and offer patients drinks, especially long waiters, and those in recovery. **Regulation 17 (1)(2) (c).**

The service must ensure ED nursing and medical staff training compliance in the mental capacity act (MCA) and deprivation of liberty safeguard (DoLS) meets trust target. **Regulation 18 (2) (a).**

The service must ensure executive, care group and operational leads and managers are responsive, supportive and take action when ED staff need help. **Regulation 18 (2) (a).**

Maternity Services

The service must ensure there are sufficient quantities of cardiotocography (CTGs), central monitoring and telemetry equipment. This was to ensure women and babies are continually assessed and monitored. **Regulation 12 (2) (f).**

The service must implement an effective system to assess and monitor compliance to ensure the baby tagging process is adhered to in line with trust policy. **Regulation 12 (1) (2) (e).**

The service must ensure that mandatory training compliance, including core and role specific training meets the trust target. They must improve the compliance rates for theatre recovery training, practical obstetric multi-professional training and saving babies lives version 2. **Regulation 12(1)(2)(c).**

The service must ensure they assess the risks during the triage process to ensure the health and safety of service users. **Regulation 12 (2) (a).**

The service must ensure all staff are aware of and consistently follow the trust policy to safely store medicines including controlled drugs. **Regulation 12 (1)(2) (g).**

The service must ensure that the assessment of risk, preventing, detecting, and controlling the spread of, infections, including those that are health care associated is managed in line with trust and national guidance. **Regulation 12 (2) (h).**

The service must ensure storeroom doors are not left open or unlocked and accessible to patients or members of the public. **Regulation 12 (2) (b).**

Our findings

The service must ensure both theatres are serviced, maintained, and fit for purpose in line with best practice guidance. **Regulation 12 (2) (b).**

The service must ensure the maintenance of the theatre environment meets the national standards. They must ensure they are both fit for purpose, inspected yearly and actions instigated. **Regulation 15 (1) (a) (b) (c) (e)**

The service must implement an effective system to assess, monitor, and drive improvement in the quality and safety of the services provided. They must demonstrate improvements in patient outcomes to be in line with national guidance and benchmark against a similar sized service. **Regulation 17 (1)(2)(a).**

The service must ensure fire risk assessments are up to date, thoroughly assessed and documented to meet best practice guidance. For example, they must ensure fire exits are clearly marked and have safe exit routes. They must ensure fire drills are completed regularly and audited. **Regulation 17 (1) (2) (a)(b).**

The service must implement an effective system to identify and report incidents including the severity of harm. The system must ensure incidents are appropriately reported to internal and external systems within appropriate timescales. The system must ensure incidents are effectively reviewed, lessons and actions are identified and shared with staff. Regulation **17(1)(2) (a)(b).**

The service must implement a robust governance process and risk management strategy. For example, they must ensure they instigate a process to effectively triage women in a safe environment. They must ensure they have effective risk management processes in place to manage and mitigate all risks. **Regulation 17 (1)(2)(a).**

The service must ensure key environmental and clinical audits are completed and monitored with action plans. For example, audits on fresh eyes assessments and WHO safety checklists. Regulation **17(1)(2)(a)(b).**

The service must ensure that there are enough midwifery and medical doctors to meet minimum staffing levels and they should mitigate against the risks of short staffing. **Regulation 18(1).**

The service must ensure that persons employed receive such appropriate support, training, professional development, supervision, and appraisal as is necessary to enable them to carry out the duties they are employed to perform and be enabled where appropriate to obtain further qualifications appropriate to the work they perform. **Regulation 18(2) (a).**

Medicine

The trust must ensure that that care meets the needs of service users by improving referral to treatment times. **Regulation 9 (1) (a) (b) (c)**

The trust must ensure that effective systems are in place to ensure staff adhered to the Mental Capacity Act. **Regulation 13 (1)(2)(3)**

The trust must ensure that all staff groups complete designated mandatory training sessions. **Regulation 12 (2) (c)**

The trust must ensure that medical staff and additional clinical staff complete safeguarding training and PREVENT Awareness training sessions. **Regulation 12 (2) (c)**

Our findings

The trust must ensure that all medical staff have completed Mental Capacity Act and Deprivation of Liberty Safeguards training sessions. **Regulation 12 (2) (c)**

The trust must ensure that all nursing and medical staff complete and are maintain adult life support and adult advanced life support training skills. **Regulation 12 (2) (c)**

The trust must ensure that all staff receive annual appraisals. **Regulation 12 (2) (c)**

The trust must ensure that all bank and agency staff had a full induction and competencies assessed prior to them working in the medical service. **Regulation 12 (2) (c)**

The trust must ensure that controlled substances hazardous to health (COSHH) are always locked away. **Regulation 12 (2) (g)**

The trust must ensure that mixed sex breaches where men and women share the same area did not occur. **Regulation 12 (1) (2) (a) (b)**

The trust must ensure that where necessary patients have risk assessments completed and reviewed as per guidance employed. **Regulation 12 (1) (2) (a) (b)**

The trust must ensure that time critical medicines are given when prescribed. **Regulation 12 (1) (2) (f) (g)**

The trust must ensure that the patient's own medicines book is completed on admission and when the medicines are returned to them on discharge. **Regulation 12 (2) (g)**

The trust must continue to ensure patients nutritional and hydration needs are met and this is confirmed through the Malnutrition universal screening tool (MUST) auditing process. **Regulation 14(1)(2)(3)(4)**

The trust must ensure that the Freedom to speech up policy guidance (v11) which was passed its review date of February 2022 is updated. **Regulation 17 (1)**

The trust must implement effective systems and processes to assess, monitor and improve quality and safety. **Regulation 17 (1) (2) (a)**

The trust must ensure that all incidents are reported through the trust incident reporting system. **Regulation 17 (2) (a) (b)**

The trust must ensure that patients records are maintained securely, are accurate, complete, and contemporaneous records maintained in respect of each service user. **Regulation 17 (2) (c)**

The trust must ensure that there are sufficient allied healthcare professional, nursing, and medical staff to keep people safe. **Regulation 18 (1)**

In Scarborough:

Urgent and emergency care

Our findings

The service must still ensure all ED medical staff comply with all aspects of their mandatory training and core specific training modules to meet trust target. **Regulation 18 (2) (a).**

The service must ensure their new ED environment does not compromise the fundamental standards of care staff can provide to patients and protects their privacy and dignity. **Regulation 10 (1)(2) (a).**

The trust must review processes for ED staff completing full resuscitation trolley checklists to ensure all specialist live-saving equipment is stocked and in date in the event of an emergency. **Regulation 15 (1) (e).**

The service must ensure ED staff know about and deal with any specific risk issues such as patients at risk of sepsis. They must complete patient's sepsis 6 care bundle paperwork including medication administration times, patient details and follow up actions. **Regulation 12 (2) (a)(g)(h).**

The service must ensure ED staff review national patient safety alerts for relevant learning and ensure measures taken around historic alerts are maintained. **Regulation 12 (1)(2) (b).**

The service must ensure service leads take action to improve their performance in the royal college of emergency medicine (RCEM) standards and develop a robust action plan from the 2020-21 results. **Regulation 12 (1)(2) (i).**

The service must ensure ED medical staff's additional learning compliance in dementia and learning disabilities (LD) awareness meets trust target. **Regulation 18 (2) (b).**

The service must ensure managers monitor the service's use of Deprivation of Liberty Safeguards and ensure staff know how to complete them. Managers must also monitor how well the service follows the Mental Capacity Act and how they would make changes to practice when necessary. **Regulation 11 (1).**

The service must ensure the service continues to work to improve the following performance standards at Scarborough hospital;

the median time from arrival to treatment.

the percentage of patients admitted, transferred, or discharged within four hours.

the monthly percentage of patients that left before being seen. **Regulation 12 (1)(2) (i).**

Maternity Services

The service must ensure that mandatory training compliance, including core and role specific training meets the trust target. They must improve the compliance rates for theatre recovery training, practical obstetric multi-professional training and saving babies lives version 2. **Regulation 12(1)(2)(c).**

The service must ensure all staff are aware of and consistently follow the trust policy to safely store medicines including controlled drugs. **Regulation 12 (1)(2) (g).**

The service must ensure clean utility doors are not left open or unlocked and accessible to patients or members of the public. **Regulation 12 (2) (b).**

Our findings

The service must implement an effective system to assess, monitor, and drive improvement in the quality and safety of the services provided. They must demonstrate improvements in patient outcomes to be in line with national guidance and benchmark against a similar sized service. **Regulation 17 (1)(2)(a).**

The service must ensure fire risk assessments are up to date, thoroughly assessed and documented to meet best practice guidance. For example, they must ensure fire exits are clearly marked and have safe exit routes. They must ensure fire drills are completed regularly and audited. **Regulation 17 (1) (2) (a)(b).**

The service must implement an effective system to identify and report incidents including the severity of harm. The system must ensure incidents are appropriately reported to internal and external systems within appropriate timescales. The system must ensure incidents are effectively reviewed, lessons and actions are identified and shared with staff. **Regulation 17(1)(2) (a)(b).**

The service must implement a robust governance process and risk management strategy. They must ensure they have effective risk management processes in place to manage and mitigate all risks. **Regulation 17 (1)(2)(a).**

The care group must ensure key environmental and clinical audits are completed and monitored with action plans. For example, audits on fresh eyes assessments and WHO safety checklists. Regulation **17(1)(2)(a)(b).**

The service must ensure that there are enough midwifery and medical doctors to meet minimum staffing levels and they should mitigate against the risks of short staffing. **Regulation 18(1).**

The service must ensure staff receive an annual appraisal. **Regulation 18(2) (a).**

Medicine

The trust must ensure that that care meets the needs of service users by improving referral to treatment times. **Regulation 9 (1) (a) (b) (c)**

The trust must ensure that attendance to patient 'fundamental care needs' are met, including getting enough help to wash or keep clean and to eat meals, as well as being able to get help from staff when needed. **Regulation 9 (1) (a) (b) (c)**

The trust must ensure that medical staff complete safeguarding training, PREVENTAwareness, Mental Capacity Act and Deprivation of Liberty Safeguards training sessions. **Regulation 12 (2) (c)**

The trust must ensure that medical staff complete annual adult life support training. **Regulation 12 (2) (c)**

The trust must ensure that all staff complete the mandatory training sessions relevant to their roles. **Regulation 12 (2) (c)**

The trust must ensure that effective systems are in place to ensure staff adhered to the Mental Capacity Act. **Regulation 13 (1)(2)(3)**

The trust must ensure that all bank and agency staff had a full induction and competencies assessed prior to them working in the medical service. **Regulation 12 (2) (c)**

Our findings

The trust must ensure that controlled substances hazardous to health (COSHH) are always locked away. **Regulation 12 (2) (g)**

The trust must ensure that where necessary patients have risk assessments completed and reviewed as per guidance employed. **Regulation 12 (1) (2) (a) (b)**

The trust must ensure that there is sufficient space around patient beds, with oxygen and suction placed by every bed. **Regulation 15 (1) (c)**

The trust must ensure that patients records are maintained securely, are accurate, complete, and contemporaneous records maintained in respect of each service user. **Regulation 17 (2) (c)**

The trust must ensure the Care Group 2 risk register identifies all the current risks including none compliance to referral to treatment targets, consultant, and nursing staffing shortfalls. **Regulation 17 (1) (2) (a) (b)**

The trust must ensure that there are sufficient allied healthcare professional, nursing, and medical staff to keep people safe. **Regulation 18 (1)**

Action the trust SHOULD take to improve:

Trust wide

The trust should ensure that it follows the recommended period for repeating and recording Disclosure and Barring Service checks for directors. **Regulation 5.**

The trust should consider ensuring all recording and timelines for grievances and disciplinary processes are a complete and contemporaneous record.

The trust should ensure clear levels of responsibility and accountability for management of staff not employed by the trust for example York Teaching Hospital Facilities Management (YTHFM) staff. **Regulation 19.**

The trust should consider increasing the frequency of safeguarding reporting to board to improve oversight.

The trust should consider recruiting looked after children specialist nurses to support capacity for initial health reviews.

The trust should ensure it meets the criteria for accessible information standard (AIS), **Regulation 9.**

The trust should ensure disabled staff are protected in line with the Equality Act 2010 and have meaningful personal adaptation plans to ensure they are treated fairly; with dignity and respect they deserve. **Regulation 18.**

In York:

Urgent and emergency care

The service should ensure all ED staff's mandatory training modules are complete and compliance meets trust target, especially medical staff. **Regulation 18.**

Our findings

The service should ensure ED medical staff complete their required level of safeguarding training, especially for safeguarding children. **Regulation 18.**

The service should ensure the IPC team and sepsis leads are better embedded and visible in the department to support staff with potentially infectious patients, assessments, or audits. **Regulation 12.**

The service should review pharmacy CD inspection policy to ensure it is clear how often inspection should take place. **Regulation 17.**

The service should review departmental processes for recording of controlled drugs to ensure all documents are completed in line with NICE guidance. **Regulation 17.**

The service should ensure ED and SDEC staff offer patients in waiting areas enough to drink and eat. They should also ensure staff fully and accurately complete fluid balance and nutritional charts for patients. **Regulation 14.**

Maternity services

The service should ensure midwifery staff complete their mentorship training to provide them the skills to facilitate preceptorship programmes to new students and newly qualified midwifes. **Regulation 18**

The service should ensure all version-controlled documents are reviewed and in date. **Regulation 17**

The service should ensure they can evidence the decision making and governance processes surrounding the use of balloon catheters. **Regulation 17**

Medicine

The trust should ensure that cleaning records are completed in all clinical areas. **Regulation 12**

The trust should ensure that monitoring and action plans are in place should water checks and legionella checks fail. **Regulation 12**

The trust should ensure that equipment such as drip stands, and ceiling hoists were available on ward 23. **Regulation 12**

The trust should ensure that patients had venous thromboembolism (VTE) checks and risk assessments are completed and documented within the current trust protocol within 14 hours. **Regulation 12**

The trust should ensure that patients on the acute stroke ward 23 received their daily 45 minutes of rehabilitation. **Regulation 9**

The trust should ensure that psychology services are made available for patients. **Regulation 9**

The trust should ensure they achieve joint advisory group on gastrointestinal endoscopy (JAG) accreditation throughout the trust. **Regulation 17**

Our findings

The trust should ensure that consultants lead daily ward rounds on the emergency assessment unit to ensure patients are discharged and improve patient flow. **Regulation 9**

The trust should ensure that patients discharge plans are commenced on admission to the service so that support is in place where needed on the patients discharge. **Regulation 9**

The trust should consider introducing patient records and consent audits. **Regulation 17**

The trust should consider introducing pain audits to gain assurance that pain services are improving patients' outcomes. **Regulation 17**

The trust should consider identifying dedicated rehabilitation and kitchen areas for use when undertaking patient assessments on the acute stroke ward. **Regulation 15**

The trust should consider that doors to rooms where medicines are stored are lockable and kept locked when not in use. **Regulation 12**

"The trust should ensure that patient information on white boards remains confidential throughout the service and is not located in areas where the general public can see it. Regulation 10".

In Scarborough:

Urgent and emergency care

The service should ensure care group one compliance with closing complaints meets the trust target. **Regulation 16.**

The service should ensure staff responsible complete legionella water testing daily as per their required schedule. **Regulation 17.**

The service should ensure service staff are trained in sufficient numbers to recognise or respond to the warning signs of sepsis in patients. **Regulation 18.**

The service should ensure ED staff keep records for patients on trolleys waiting in the ambulance arrival corridor secure. **Regulation 17.**

The service should ensure ED staff complete all sections of risk assessments for patients who show signs of mental ill health. They should consider revising this documentation's length to improve staff compliance. **Regulation 17.**

The service should ensure the service does not contravene their SOP for the care and treatment of patients whilst in an ambulance. **Regulation 12.**

The service should ensure ED staff recognise or make reasonable adjustments to meet patient needs such as those with mental health issues or anxiety. **Regulation 9.**

Maternity services

Our findings

The service should ensure midwifery staff complete their mentorship training to provide them the skills to facilitate preceptorship programmes to new students and newly qualified midwifes. **Regulation 18**

The service should ensure resuscitation trollies are checked in line with trust policy and records are available to evidence completion. **Regulation 12**

The service should ensure they can evidence the decision making and governance processes surrounding the use of balloon catheters. **Regulation 17**

Medicine

The trust should ensure that safety huddle documentation is formalised across the service. **Regulation 17**

The trust should ensure that staff receive feedback from incidents. **Regulation 17**

The trust should consider introducing auditing of consent and patient records. **Regulation 17**

The trust should ensure that monitoring and action plans are in place should water checks and legionella checks fail. **Regulation 12**

The trust should consider that doors to rooms where medicines are stored are lockable and kept locked when not in use. **Regulation 12**

Is this organisation well-led?

Our rating of well-led went down. We rated it as inadequate.

Leadership

Although leaders had the skills and abilities to run the service, they did not always understand or effectively manage all of the priorities and issues the service faced. There were limited succession plans to support staff to develop their skills and take on more senior roles.

At the time of inspection, there were 6 permanent executive and 7 non-executive directors in post, plus the chair of the board and 1 associate non-executive director. The chief operating officer (COO) post was vacant with an interim deputy in post who was also the chief allied health professional (AHP). During our inspection the medical director was stepping down from this role and the trust was awaiting a new medical director from an external recruitment. There was also 1 director of communications who was not an executive. Most of the executive directors had been in post for 3 years or less, and for the majority, they had joined the trust either just prior to or during the COVID-19 pandemic.

Executive leaders described a situation where they had come into the trust with the intention of improving clinical engagement and leadership through the introduction of a new care group structure in 2019. This new structure was not embedded before the 2020 COVID-19 pandemic and much of the organisational leadership reverted to command-and-control style as a part of the response to the pandemic. Now the trust had emerged from the pandemic, with gaps in both governance processes and cultural development. This had led to the implementation of a behavioural framework in 2022, but this was not yet fully operational or embedded at all levels within the organisation.

Our findings

We heard from staff at all levels, that board members were not always visible within the organisation. This was recognised by the non-executive and executive directors, and they were aware that work needed to be done in this area. The board did not always function as a unitary board. We heard examples where the non-executive teams were not fully informed on issues, were not meaningfully involved in decision making or were discouraged from engaging with frontline staff. We were also told that engagement with clinicians was not always addressed by executive directors, which could impact upon overall confidence and performance of the trust. The executive team did not always respond well or quickly to feedback and staff raising concerns and we heard of occasions where leaders displayed defensiveness or appeared to tolerate poor behaviours from staff. Governors were also not always encouraged to actively engage with issues or visit frontline areas.

Executive leaders had identified key roles which were essential to supporting improvement, such as an equality and diversity lead, leads for clinical quality improvement and patient experience facilitators. Also, more clinically focussed roles such as a falls lead and learning disability leads were newly created roles. These were identified in 2020, but due to pandemic were still be recruited to, or the roles were not fully embedded to have effect. There were other clinical support teams such as the infection prevention and control (IPC) team that had been identified as being under resourced and were either newly recruited or in progress for recruitment.

The absence of a chief operating officer impacted upon the operational oversight of performance in the trust and senior leaders told us that key performance metrics were not fully explored, monitored and challenges mitigated where performance was poor.

There was a skills review board, which through appraisals mapped skills and gaps at the board level. To develop succession planning with the trust there was a shadow board, and the trust planned to use the 2023 strategy refresh to identify what skills were needed at board. The trust board approved and implemented a board development programme in 2019 which was planned to be re-evaluated in 2022/23. Senior leaders told us there need to be a stronger strategic focus which could bring the operational performance and strategy into line.

The executive director of workforce was a new post in 2019 and it was recognised that workforce and wellbeing had not been a priority for the trust prior to 2019. Senior leaders described a legacy of historical issues which impacted on current culture, governance, and leadership within the organisation, for example previous workforce establishment reviews had not been fully recruited to particularly at the York site. When establishments were reviewed after the pandemic, the staffing levels were already at a shortfall which increased pressure on services provided by the trust.

The trust had provided leadership and development training for managers at various levels in the organisation. However, the leadership framework had only just been introduced. We heard examples where managers did not uphold the trust's values and behaviours, take action responsively or take accountability for performance. It was recognised leadership development was a priority for the trust.

During our inspection, we raised our concerns formally with the trust about maternity and the emergency department. When we returned to complete our inspection, we found that in some areas, the pace of responding and the thoroughness in reviewing our concerns was inconsistent, particularly in maternity services.

At care group level, leadership had been expanded to included allied health professional (AHP) leads within the triumvirate structure. However, there was discrepancy in banding for AHP leads with other leaders, with AHPs being on lower pay bands in all but one care group. We were not assured this supported the AHP lead role and gave them sufficient responsibility to have a full impact.

Our findings

There is a requirement for providers to ensure that directors are fit and proper to carry out their role. This included checks on their character, health, qualifications, skills, and experience. During the inspection we carried out checks to determine if the trust was compliant with the requirements of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).

We found the FPPR Procedure was fit for purpose and the files complied with the requirements of the regulation. We reviewed 9 director (including executive) files and nine non-executive director files in total. Our review included checks for the newest executive and non-executive appointments. There was an annual process in place to continuously monitor fitness to practice, however some Disclosure and Barring Service checks recorded were not within the recommended 3 to 4 year period. All directors' appraisals were in date and completed within the last year.

Estates and facilities were provided to the trust by a wholly owned subsidiary of the trust, York Teaching Hospital Facilities Management (YTHFM). They deliver a range of services to the trust which were governed by a master services agreement which detailed a set of agreements for the running of day to day business activities between both parties. The governance structure for the management of the processes within YTHFM was led by a separate management group with its own chair and representatives. In 2018 the estates and facilities staff's employment was taken over by YTHFM.

The trust director of finance had been in post for 13 years and the organisation had a good track record of financial delivery. There were no concerns about the capability and capacity of the finance team within the Trust or in relation to financial governance.

The integration of committees that focus on medicines optimisation was well established. The chief pharmacist was a member of the executive committee.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. There were limited enabling strategies in place to support the delivery of the strategy and the strategy did not align with high level risk within the organisation.

The trust had a strategy known as 'Building better care together'. The strategy was aligned to the Integrated care system (ICS) ambition and recognised the changes in delivery of care following the Covid pandemic. It had been refreshed in 2021 and was due for review in 2023. The refreshed strategy had been informed through listening exercises with senior clinical and non-clinical leadership teams across all trust sites and engagement sessions with the care group teams as well as at trust board workshops.

There were 6 priorities.

- clinically led, excellent hospital and integrated community services.
- safe, open, and empowering culture and working environment.
- keeping people well, reducing health inequalities.
- improving end of life care.
- contributing to delivering a net zero NHS.
- research, innovation, and education to drive quality improvement and optimal use of our resources.

Our findings

These priorities were underpinned by workstreams and plans. Clinical priorities were described in each clinical service. Aspirations for the quality of clinical care were high, but they did not link to the current risk levels within the trust or the current levels of trust performance. It was not clear how the trust would move from its current performance to the high level of aspiration described in the strategy. Senior leaders told us there was a need to strengthen the leadership of strategy within the trust to turn it into achievable action.

Staff were aware of the strategy, and we heard during our core service inspection how it was impacting developments at frontline level in some areas. This was not consistent however, and there was not always a clear path between the strategies' aspirations and learning from incidents at ward level.

Strengths identified within the strategy were research and net zero aims. Senior leaders recognised there was need to engage care groups to achieve operational delivery of the strategy. However, each care group had a plan which related to the strategy and there was also an allied health professionals (AHP) strategy. There was a workforce and organisational development strategy launched in 2019 and for review in 2024. This did acknowledge the impact of the pandemic and had strategic aims which included recruitment and retention, health, and wellbeing (HWB), talent management, leadership development, culture and equality, diversity, and inclusion (EDI). The trust had also launched a behavioural framework to support delivery of the strategy.

A quality strategy was currently in draft format and due to go out for further external consultation. A public meeting was held with members to co-produce the quality priorities. However, attendees did not represent fully a diverse cross section of the community served by the trust, despite the desire to address health inequalities within the strategy.

There was a mental health strategy at draft stage; developed with relevant partners and stakeholders. The trust was engaging with a range of groups in the community to ensure they met the needs of diverse groups. The priorities of the strategy included:

- ensuring that the mental health needs of all patients were met with compassion and kindness.
- that people with mental health needs continue to have their needs met and rights protected while receiving care for their physical condition and are signposted to appropriate and timely mental health support.

There was also a single comprehensive infection prevention and control (IPC) strategy being developed and was due in September 2022.

The trust had a good financial track record, consistently delivering a position that was at least as good as the approved revenue plan each year since 2019/20. The Trust had a good pre-pandemic record of delivering recurrent cost improvements and in some years overachieving against the efficiency requirement. The Trust's cost improvement target for 2022/23 was £32.4m with 43% (£13.8m) identified as being non-recurrent in nature. The Trust was forecasting that it would deliver this target.

The pharmacy department had a clear strategy and key priorities for the next three years, aligned with the 'Building Better Care Together' programme. The strategy seeks to embed medicine optimisation principles throughout the Trust and enable staff to use medicines safely and effectively. The Trust benchmarked its performance in handling medicines against nationally recognised standards.

Culture

Our findings

Although staff were focused on the needs of patients receiving care, they did not always feel respected, supported, and valued. Some staff told us they did not feel they could raise concerns without fear of blame or reprisal. The trust did have systems to seek and act upon feedback from staff and other relevant persons. The service did not promote equality and diversity in daily work.

Executive leaders had recognised there was work to do to invest in staff welfare, behaviour and equality, diversity, and inclusion (EDI). Care groups which had been formed in 2019, were meant to increase clinical engagement and accountability. However, this had not come to fruition due to the 'command and control' approach adopted during the COVID-19 pandemic. Prior to 2019, the trust did not have an executive director of workforce and senior leaders told us there had been insufficient focus on support for staff.

Senior leaders told us that there were issues in staff retention, more than in recruitment. The trust had implemented a new people and culture committee to identify challenges. Senior leaders told us there was a need to put in place basic support mechanisms for staff, such as celebrating achievements and providing regular support from managers. This had not been embedded at the time of our inspection. It was also widely recognised that low staffing levels and redeployment of staff to cover areas with staffing pressures impacted upon staff morale. This was also reflected in staff exit interviews on leaving employment.

The trust had also implemented a fairness forum in 2015. The forum had only been chaired by the chief executive from January 2022. There were new staff networks, with the race equality group formed in 2022, a network for LGBTQ+ staff which was more established, and a veterans, carers, and woman's network. The networks had begun to move forward on issues for staff and patient experience, but they were very much in their infancy. Senior leaders did not act as champions for these networks.

The trust had introduced and new behavioural framework in response to the feedback that behaviour of some clinical staff was not always adequately challenged. However, we heard examples from staff experiences where behaviour had not been challenged appropriately and poor behaviour had been normalised. Staff also told us that managers could often display poor behaviours, particularly when challenged and suggested that management training was not in place to support them dealing with negative challenge. Staff described that when concerns about other staff behaviour had been escalated to senior leaders these were not always addressed with the individuals concerned.

During our inspection, our inspectors witnessed and experienced poor staff behaviours including inappropriate challenge when concerns were raised. We found staff did not always respond promptly to our concerns about patients' health, care or experience which led to us escalating patient concerns repeatedly. We observed this during both onsite visits, and this was escalated to senior executive staff in the trust including the Chief Executive to ensure actions were taken.

Senior leaders commenced reverse mentoring, where they receive mentorship from lower grade staff from ethnic minority groups within the wider organisation to explore their experiences of working for the trust and addressing potential bias.

Not all workforce or EDI related policies and processes were in place, for example there was no policy on supporting transgender or non-binary staff or patients. There was no policy for dealing with patients who used discriminatory language. Other policies were still being ratified such as policies relating to workforce and equality, diversity, and inclusion (EDI) and freedom to speak up.

Our findings

Staff told us they did not always raise issues, either due to experience of retribution or blame; or more commonly as no action was taken as a result so they no longer engaged with the process. Staff described that due to feeling unheard it was difficult to feel pride about the organisation.

Results from the 2022 NHS staff survey indicated the trust was significantly below the benchmarking score and worse than the 2021 results for staff:

- who would recommend the organisation as a place to work
- who would recommend the organisation to friends or relatives who needed treatment for the standards of care being delivered
- who had personally experienced discrimination at work from patients
- who felt the organisation acted fairly with regard to career progression or promotion.

Results from the 2022 NHS staff survey indicated the trust was just below the benchmarking score and these scores were slightly worse than the 2021 results for staff in relation to:

- compassionate culture
- inclusion
- engagement
- morale
- feeling secure about raising issues about unsafe clinical practice
- feeling confidence that the organisation would address the concerns.

However, the trust had improved and scored better than the benchmarking average for staff:

- from an ethnic minority background who experienced discrimination
- from an ethnic minority background who experienced harassment, bullying or abuse from patients, relatives, or the public in the last 12 months
- who experienced gender discrimination
- who felt valued by their team and their manager
- who felt the colleagues were understanding and kind and treated each other with respect and showed appreciation.

We did not find evidence that staff believed the results of the staff survey had been widely discussed or actions had been taken. The trust had an action plan following the results of the 2021 staff survey, but timescales for action were long, with many not due until the late 2022 or the first quarter of 2023.

A range of incentives had been implemented, including financial remuneration for bank staff and staff moving wards; and provision of food and drink for staff who were working night shifts. Several wards had commenced wellbeing initiatives to support staff.

Results for the CQC staff survey

Our findings

During this inspection, we invited clinical and non-clinical staff from all services to complete a survey and we received 1028 responses. The trust were unable to send this out to only trust staff, as staff from YTHFM were included in all staff communications. We therefore removed 32 responses from our analysis from staff who identified as facilities and estates staff.

Emerging themes were:

• Poor leadership and culture

• Reluctance to speak up

• Insufficient staffing leading to pressures on services and poor care

• Staff experience of bullying, harassment, and discrimination

• Unfair recruitment practices and progression opportunities.

In total, 53% of respondents disagreed (disagreed or strongly disagreed) that communication between senior management and staff was effective. We heard from staff who had experienced or witnessed bullying, harassment, and discrimination. There was evidence to suggest that such practices were prevalent, with staff referring to a 'bullying culture' and using words such as 'rife' and 'commonplace.' Perpetrators included managers, colleagues and people using services.

Gender pay gap

The trust's gender pay gap report and action plan was published in 2022. The mean hourly rate of pay represented a gender pay gap of 31% and the median, a gap of 22%. This was a significant increase from when reporting began in 2017 from mean gap of 29% and median gap 10%. Data over each year showed that the gap had only been improved in the first year and then deteriorating year on year. The greatest gender pay gap was within the medical and dental workforce. On average, females earned more in most pay bands than males, however this was in the lower pay bands. The bands where males earned more than females are in band 8a, band 8b, band 8c and the very senior manager grades,

Action planned to address the gap was to promote the work of the carers network, training on EDI and reviewing recruitment processes, job planning, flexible working and leave policies. However, many of these actions had commenced in 2021 and had not impacted upon the results in 2022.

Freedom to speak up

The trust had a substantive Freedom to Speak up Guardian (FTSUG) since August 2020; who was employed 30 hours per week, this had been increased in April 2022 from 18.5 hours. There were also new fairness champions recruited from staff across the organisation. The trust had followed guidance from the national guardian's office when determining how freedom to speak up had been operationalised within the organisation.

The FTSUG reported to the national guardian office in line with guidance, as well as producing an annual report to present at the trust's board meeting. Both the chief executive and chair were key sources of advice and support for the FTSUG and met with them regularly. There was both an executive and non-executive lead for FTSU with clearly articulated roles. The non-executive would take the lead on an FTSU issues regarding executive members of the board.

Our findings

Between September 2021 and August 2022, 123 cases had been raised to the FTSUG which was similar to the previous year. This number was not dissimilar to other trusts of a similar size within the region, however the capacity of FTSUG and champions varies between providers so the comparison is difficult. There had been a slight reduction in the numbers of cases relating to inappropriate behaviours and relationships, but these still accounted for nearly half of all cases, with 23% related to bullying and harassment. The FTSUG received concerns from a range of professional groups. There had been an increase in concerns from nursing, midwifery and AHP staff over the year, with a reduction in concerns being raised by administration and clerical staff.

We heard that staff did not feel supported or safe raising concerns to their local management or HR teams. Staff felt that it was futile to raise concerns as there was a general feeling that nothing would change. We heard there were delayed responses to concerns raised which compounded the opinion that staff were not listened to. Staff also questioned the independence of the FTSUG role as they reported to the CEO. We also heard reports that staff had been labelled as "troublemakers" or reprimanded by managers for raising issues either as an incident or to the FTSUG. HR teams were not seen as impartial but as supporting managers.

The FTSUG had focussed upon increased visibility within the organisation, attending the different hospital sites, attending, or providing information given at induction, and attending staff benefit fairs. There had also been a roadshow carried out in October 2022 to increase awareness of their role. There were also promotional communications within the trust, including screen saver messages, flyers, posters, publications via staff bulletins and social media. The FTSUG also supported the staff networks as well as attending quality groups, staff forums and staff side representative meetings. However, there was no mandatory training for staff around the FTSUG role and the Freedom to speak up policy was out of date.

Equality and diversity

The trust had equality objectives that ran from 2020-2024. These objectives covered three areas: patients, building environment and workforce. This was following a review of the trust's performance in June 2022 by an external EDI consultant. The trust's EDI lead had only been in post since August 2022 and had begun to create an action plan. However, there wasn't sufficient understanding of, and commitment to equality and diversity reflected across the organisation, particularly by senior leaders of the trust. We were not assured that the action plan would be effectively implemented across the trust.

Following our inspection, we were made aware of serious allegations of racism and discriminatory behaviour including poor behaviours from managers within YTHFM. Leaders within the trust were aware of these concerns due to cross over arrangements in managing HR. We extended the inspection to complete a survey of trust staff, carry out focus groups and re-interview key leaders at the trust.

The trust had commissioned the advisory, conciliation and arbitration service (ACAS) to conduct an external review into serious cultural concerns including alleged bullying and harassment by the management tiers within the York Teaching Hospital Facilities Management (YTHFM).

The published report in June 2020, confirmed a poor culture and breakdown of trust between employees and management at YTHFM. It found many examples of longstanding poor cultural behaviours. This report and 18 recommendations were shared with the trust and YTHFM board.

A previous report in 2017 (the Bridlington report) also confirmed a longstanding historical culture of bullying, particularly by middle and lower tier management dating back several years to previous estates & facilities department.

Our findings

Human resources (HR) functions from the trust provided HR support to YTHFM, which blurred the lines between the two organisations in terms of line manager responsibilities and accountability. It was unclear in some staffing data how to differentiate trust staff and YTHFM staff. For example, YTHFM staff were included in mandatory training data at care group level alongside trust staff, yet they were not part of the national staff survey. The trust had also sent the CQC staff survey to staff at YTHFM as they were included on the all staff distribution lists.

We heard from trust staff, that they had raised concerns about the use of offensive language in meetings and this appeared to be normalised in some parts of the trust. Staff reported that the language used had been deemed as unacceptable, but this had not been followed up by meaningful action by the trust.

The Workforce Disability Equality Standard (WDES) was introduced in 2019 and is mandated for all NHS trusts in England with the aim of furthering equality and inclusion for disabled staff in the NHS. There are 10 metrics calculated from data collected directly from trusts and the NHS staff survey. According to the latest WDES data, the trust was performing worse than the national benchmark in terms of harassment, bullying or abuse from managers or colleagues, as well as the percentage of staff who reported this harassment, bullying or abuse the latest time it happened. In addition, the trust were also performing worse than the benchmarking average in terms of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work, and overall engagement of disabled staff compared to non-disabled staff. The latest WDES action plan had identified the areas of improvement in the data but some of the actions lacked some detail of how they might be effectively implemented.

We heard about delays for staff who needed reasonable adjustments. Staff reported that managers did not support flexible working arrangements or reasonable adjustments required to keep staff in work and support their individual needs.

The Workforce Race Equality Standard (WRES) became mandatory for all NHS trusts in 2015/16 and trusts are required to show progress against 9 workforce indicators. The trust performed worse than the national benchmark across most of the indicators. The latest WRES data identified the trust was worse than the benchmarking average for representation of staff from ethnic minority groups at band 8a and above (non-clinical roles) and band 6 and above (clinical roles). The trust also performed worse than 90% of trusts nationally in terms of the likelihood of appointment from shortlisting for staff from ethnic minority groups, with only 10% of candidates from ethnic minority groups being appointed (compared to 26% of white candidates). The percentage of staff who believed that the trust provided equal opportunities for career progression or promotion was significantly lower for staff from ethnic minority groups (42%), than for white staff (57%).

Experience of discrimination from a manager or other colleague at the trust was worse than the benchmarking average, with 20% of staff from ethnic minority groups reporting discrimination, compared to 6% of white staff. The percentage of staff from ethnic minority groups experiencing harassment, bullying or abuse from other staff (31%, compared to 25% of white staff) was also worse than the benchmarking average. This is reflected in other feedback we received from staff throughout our inspection.

The latest WRES action plan did not focus strongly enough on concrete actions that needed to be taken to improve race equality within the trust, with only limited exploration of how processes could be adapted, or learning could be applied to improve the experience of staff from ethnic minority groups.

Staff spoke of bullying, harassment and discrimination related to a range of protected characteristics, including age, sex, race, sexuality, and disability. This also included factors such as role and time in post. Examples given included unfair treatment and bias from managers, offensive language, a lack of support for staff with mental health issues and older employees not having the same access to training opportunities as others. The results of the survey matched our

findings from speaking to staff that behaviours were normalised and not challenged appropriately. Almost two thirds of staff who witnessed discrimination did not report it. Staff from ethnic minority groups, non-clinical/administrative staff, and newer staff were less likely to report discrimination. More than half of staff who reported harassment, bullying or abuse did not believe that the organisation took appropriate action. Staff spoke of not having a voice and not feeling listened to when speaking up, for example there were multiple reports of issues raised being 'ignored,' dismissed and 'swept under the carpet.'

International recruitment

We were not assured that adequate support was in place for internationally recruited staff once in the UK. The trust had recruited a number of internationally recruited nurses, with 400 joining since 2019 and another 100 due to join in the near future. The trust was increasing the support to staff prior to recruitment by providing English language teaching, but there was insufficient consideration of their accommodation needs or supporting their wider integration into either the trust or local community.

Executive leaders recognised that they needed to be more aware of the experience of staff joining the trust from overseas and a member of staff had brought their story to board to share. It was recognised that even very experienced internationally recruited staff did not normally apply for senior roles and the trust was looking to address this although it was unclear how this would be achieved.

Disciplinary and grievance processes

From board papers, there were 11 open disciplinary cases with one exceeding the 6-week target. There were 7 open grievance open cases, with two exceeding the 1-month target.

We reviewed 7 disciplinary records, of which 4 had been completed and 3 were open. In these records, we found that the trust followed their own processes in terms of timescales for investigation, hearings, and outcomes. The decisions made were appropriate and in line with trust policy. However, not all meetings were adequately recorded and not all records were easy to find.

We reviewed 6 grievance records, of which 4 had been completed and 2 were open. In these records, we found that the trust followed their own processes both in terms of timescales for investigation and outcomes. The decisions made were appropriate and in line with trust policy. However, not all meetings were adequately recorded and not all records were easy to find.

The trust had recruited a new head of employee relations to oversee timescales and improve the recording of disciplinary and grievance records. This lead was also looking at themes and trends with disciplinary and grievance processes and was working alongside the freedom to speak up guardian (FTSUG) and EDI lead to pick up cultural issues which needed to be addressed. In the week preceding the inspection the trust had started to monitor themes and trends.

Governance

Governance processes did not operate effectively across the organisation to ensure risk and performance issues were identified, escalated appropriately, managed, and addressed promptly.

Our findings

The trust's governance structure included 3 committees reporting to the board: quality and safety; digital, performance and finance and people and culture. Each committee was chaired by a non-executive director however, the membership of each committee varied.

There was also an executive committee which reported into board, where the executive team met and reported to board. There were seven committees or groups reporting to the executive committee:

- Quality and patient safety group (QPAS) (which also reported directly to the quality and safety committee).
- Risk committee.
- Transformation committee.
- IPC strategic assurance group.
- Health and strategy group.
- Sustainability committee.
- Workforce working group.

Corporate functions including the YTHFM reported into executive board as well as care group oversight and assurance and care group boards.

Reports to board and committees were being developed to highlight specific areas of focus. However, not all leaders felt assured they had received all available information and oversight of risks to the organisation although there was some improvement in data which allowed triangulation of performance.

Also reporting into QPAS were 16 working groups, including falls improvement, pressure ulcer improvement, deteriorating patient risk groups amongst others. Each care group had their own quality and safety, people and culture and finance and performance meetings. We were not assured that this structure facilitated a good flow on ward to board information. For example, concerns raised by staff in maternity were not appropriately escalated or known at board level.

The trust was developing much of its governance processes to close loops which had previously been absent. This work had begun in 2019 but had been delayed due to the COVID-19 pandemic. This meant many committees had only been newly formed, for example the people and culture committee had been in place since June 2022. Structures were newly implemented to reflect the trust objectives; people (workforce committee), quality (quality committee), flow and elective recovery (performance committee). All boards and committees met monthly, but we were not assured time between meetings allowed for meaningful action.

Governance teams at care group level had been managed and recruited to within the groups with no standardisation. There was variability in the composition of teams, skills, and the grades of staff within them leading to an inconsistent approach to governance at care group.

We were not assured how the trust managed oversight and assurance from the YTHFM. We found concerns on inspection that risk assessments had not been carried out and it was not clear what the trust's process was for assuring itself service level agreement (SLA)'s were being met and risks were being mitigated to the lowest level. Policies such as water testing policies where responsibility sat with the YTHFM were out of date expiring in June 2021.

Our findings

IPC and estates issues in theatres were not always adequately addressed, work was under way to improve governance in infection prevention and control. A new infection prevent strategy and assurance group was established in June 2022. The focus was upon strengthening governance and joint working with the YTHFMand capital planning. It had been identified for example, that the backlog in maintenance works by the YTHFM was impacting upon the control of clostridium difficile within the estate.

Learning from deaths

The trust had a policy and procedure in relation to learning from deaths and a monthly group to ensure that mortality is monitored, reviewed and, where necessary, investigated. A monthly and quarterly assurance report was presented to the QPAS for oversight and assurance.

Where an investigation into a death was required, the trust used a structured case review (SCR). The reviewer would decide if further investigation such as declaring a serious incident (SI) was required. The process to escalate an SCR to an SI was complicated with the case going to a patient safety investigation meeting, learning from deaths group, then quality and safety group for agreement and finally the case going to an SI group for sign off.

If no SI was declared, the SCR resulted in an action plan being developed, which was presented at learning from deaths group and may be escalated to QPAS or if relevant the deteriorating patient group. There was a backlog of SCR action plans with 24 with ongoing open actions, 17 of these deaths occurred in the last 2 months, the oldest date of death was Jan 2022. The trust was improving in its performance of SCR completion. The number to be completed outstanding was reducing but there was a rise in the numbers of action plans which were required. We reviewed 4 SCRs, in all there was a lack of focus upon delivery of improvements identified by SCRs. Action plans were absent from reviews, some were not signed off. Actions were out of date and had not been reviewed in a timely way. It was not always clear if actions had been completed.

We were not assured the trust was taking appropriate action to learning from the deaths of people with a learning disability or autistic people. The National Learning from lives and deaths of people with a learning disability and autistic people (LeDeR) reviews care received by a person with a learning disability or autistic person following their death. The LeDeR last report to the trust from 2020 showed out of 11 LeDeR reviews, 4 had findings which highlighted different outcomes of the trust's SCR process.

No final LEDER reports had been received by the Trust since Dec 2020, although the trust told us they would carry out an SCR as a minimum for all deaths of a person with a learning disability. The trust had not followed up the lack of LeDeR reports received by them until November 2022. The trust had 8 deaths alone in 2022/23 period so far that required a LeDeR review.

Themes from SCRs were reviewed and reported to the learning from deaths group as were reviews which indicated the patient had received poor care. The number of deaths being reviewed by medical examiners (ME) was improving but still below the 100% target at 90%.

Incidents and incident reporting

The trust investigated all reported incidents in line with the local and national policies and procedures. Serious incidents (SI)'s were reported through to the corporate SI group who scrutinised investigations and sought assurances

that all learning and improvement actions had been identified, were measurable and had been shared accordingly. Actions were then tracked for completion within the care groups. Where action plans were not completed this was escalated back to the SI Group. The SI group reported into QPAS. This was a newly implemented process due to the previous lack of rapid learning reports and undelivered action plans.

In response to emerging themes from SI's and incidents a number of improvement groups had been established around specific themes (e.g., deteriorating patient & sepsis, MDT process, nutritional improvement, upper GI bleed) to develop work programmes and raise awareness of key learning and issues with staff groups. Some of these groups were still in their infancy and needed develop further over the coming months. Also in its infancy was the sharing of learning from incidents, SI's and deaths across the trust. New initiatives included newsletters to share key learning, weekly nursing lead meetings within care groups to disseminate and share learning, themes and trends, monthly matron meetings to share learning from SI action plans, patient experience, and incidents.

The trust followed guidance for the reporting and investigating of incidents reportable to HSIB. However, they were slow in implementing recommendations when made. Following a recent HSIB review from May 2022 there were recommendations which had still not been implemented. The action plan included written guidance to support the telephone triage process, however there was still no robust process and procedure in place at the time of our inspection.

Clinical audit

Until 2020 the trust had no clinical audit processes in place, and we heard that at the time of our inspection audits at care group level were limited. Senior leaders were unable to describe how audits were having any positive impact upon patient care, for example there had been no demonstratable reduction in falls or pressure ulcers.

Risk appetite

The trust did not have a process for regular review of risk appetite. We were not assured this, and other governance processes, were embedded at senior level within the trust. There was a risk that the risk appetite within the trust had already been exceeded. An annual plan was being implemented which would incorporate risk appetite being considered at board, but this was not yet in place.

Financial governance

There were no current concerns about the board's capability in relation to financial governance. The board received information on finance, performance, and quality from a range of sources that were both internal and external to the trust. It was supported by committees that scrutinise and review assurance on internal control. No issues or concerns had been escalated to NHS England by the trust or its auditors in relation to financial governance.

Management of risk, issues, and performance

Leaders and teams did not always use systems to manage performance effectively. We were not assured the board had sufficient oversight and focus on the operational risks or had effective systems to ensure learning from incidents were shared with actions implemented. The trust did not always identify or escalate relevant risks and issues or identify actions to reduce their impact. The trust had plans to cope with unexpected events.

Risk

Our findings

The trust had a risk management strategy and was in the process of reviewing its risk management framework. The framework was due for sign off in November 2022. The board assurance frameworks (BAF) was developed from risks to the organisation, was not linked to the trust strategic objectives. The risks listed were being unable to deliver care to the required standards, access to diagnostics, constitutional standards, vacancies, finance, patient safety, acute collaboration, and net zero. The mitigating actions for each risk were not clear and actions were not tracked.

The BAF linked with the corporate risk register (CRR) which escalated the highest level of risk from care group level upwards and reflected and repeated some of the risk identified within the BAF. Leaders we spoke with were well sited on the high level risks which were identified at this level. The BAF and CRR were reviewed at each committee.

The corporate risk register had actions, but they were high level, not clearly articulated or easy to measure or track. There were 12 significant risks on the corporate risk register, 5 of which dated back to 2018. These 5 related to IPC, cyber security, insufficient knowledge of bank staff, deteriorating patients and insufficient staff.

Six risks had been added this year and included the maternity transformation programme, delivering activity as per national plan, staff shortages, pressure on ED workforce and failure to deliver the financial plan. There was obvious duplication in risk and actions around staffing levels with a risk from 2018 and 2022 that did not consolidate risks or mitigations. Senior leaders recognised there was further work to do to align common risk management themes across the organisation and interdependencies and to align to place risk management.

YTHFM also held a risk register and actions were shared responsibility with the Trust. High level risks on this register included: general risk to air handling units in theatres, staffing for renal technicians and health technical memorandum (HTM) 03 compliance. Some of these risks had been on the register for a prolonged period of time, for example HTM03 compliance was submitted in 2015 and had a risk scoring of 12 without any recent updates on mitigations other than awaiting funding. The risk to air handling units was scored at 15 but no actions had been addressed and the risk was also awaiting funding.

The trust had a Master Service Agreement (MSA) which has associated key performance indicators that are reported through to EPAM monthly as part of the governance arrangements., however it was not clear how the trust held YTHFM to account on multifactorial its performance. For example, whilst the policy stated that departmental heads were responsible for fire risk safety in their departments, there was a reliance on fire safety officers employed by YTHFM to complete the annual reviews and risk assessments departments. Senior leaders admitted they could not be assured all relevant checks had been completed, as issues that had been longstanding with fire doors had been found to be unresolved during our inspection.

Within care groups, risk registers were co-ordinated by the associate chief operating officer (ACOO). Each speciality held their own risk register with risks being owned and mitigated at the lowest level. Risk registers were discussed at directorate assurance meetings and included in governance reports for each care group. Any risk with a score of 16 or above had to have a risk application template submitted for the monthly risk assurance meeting. The trust was in the process of updating this process so that any risks of 10 or above would also need a risk application.

However, there was no accountability framework for care groups to monitor performance on action plans or mitigating risk. We found there was a lack of robust governance systems and processes to assess, monitor and manage risks within maternity services and the emergency department in York. Staff, including senior leaders, could not clearly articulate how risks were being managed, the actions put in place to mitigate risks and reduce the reoccurrence of incidents. For

example, the impact of the closure of beds within the emergency department at York in combination with pressures to flow throughout the hospital were not highlighted at board level. Risks with the maternity department were not escalated above care group level, actions were not progressed for long periods of time and some high-level risks did not appear on the risk register at all.

However, we did see some improvement on the medical wards in relation to our previous warning notice issued following our last inspection. Improvements were seen in nutrition and hydration and fundamental standard of care. Mental capacity assessments however were still incomplete in many cases.

We were not assured of the trust's own process to assess and manage risk. We identified issues with fire safety and the security of babies on the maternity unit which had not been identified through the trust's own processes. During the inspection we were provided with verbal feedback that the risks we had raised had been mitigated. However, we were not assured that this was the case, for example when we returned there were ongoing fire and security risks.

Following our core service inspection, we sent the trust a letter of intent to inform them of serious concerns we found in maternity services and the emergency department at York and our intent to take urgent enforcement action. Risks included identification and management of deteriorating patients, management of patients waiting within the departments and medicines management, including controlled drugs in both core services. We also found that the mental health room in the emergency department was unsuitable, and the service did not control infection and prevention well. We also raised concerns regarding assessing and responding to risk within the maternity services, for example the lack of available CTG machines to monitor fetal well-being.

We returned to reinspect the core services during the well led inspection. We found some improvement in the emergency department. However, we did not find similar improvements in maternity services and therefore imposed urgent conditions upon the service.

Risks we had raised at the core service inspection were not shared with key staff in a timely way. Key staff we spoke with were either unaware of the issue or had been made aware but not received adequate support from senior leaders to address concerns raised.

Senior leaders told us they were not confident that managers throughout the trust had adequate risk management training which impacted upon the consistency with which risk was recorded. This was an area that leads were planning to address. The trust were on system operation framework (SOF) level 3 and were subject to a system wide quality improvement board jointly chaired the integrated care board (ICB) and NHS England.

Incident reporting and oversight of incidents

We reviewed 6 serious incidents and tracked the investigation and learning from these. Incident reports varied in the amount of detail supplied, and some lacked key information. There was evidence in half of the reports that patients and their families had been consulted and feedback sought around the incident investigation process. All files indicated that Duty of Candour (a legal requirement for trusts to say sorry when things have gone wrong) had been discussed with the patient or their family. None of the reports were clearly written or easy to read and some went into extensive, unrequired clinical guidance.

Our findings

Senior leaders were aware of themes and trends within their incident and SI reporting, for example the increased moderate harm incidents and number of cases referred to HSIB with maternity had noted. We were not assured that action to address this increasing harm was effective or managed at pace. We also found that incidents such as post-partum haemorrhage were not graded correctly and this was not picked up as a theme, neither was the high incidence of babies born before arrival. We were not assured there was adequate scrutiny into these incidents to identify themes.

It was also noted in trust meeting minutes that SI's within the emergency department highlighted delayed diagnosis as a main theme, with the main delay around the misdiagnosis or delayed diagnosis of sepsis and delayed diagnosis of ovarian or testicular cancer. We did not see evidence that this was being addressed in a co-ordinated way. Our findings at York ED were that sepsis documentation continued to be incomplete.

Operational performance

The trust's digital, operational and finance committee was new and had only met a few times. In terms of acute flow, the trust had been escalating at operational pressures escalation level (OPEL) 4 for 12 months. The number of ambulance handovers taking more than 60 minutes had been deteriorating since October 2021 and the target had not been hit since August 2021. For type 1 attendances waiting over 12 hours in the ED, the trust's performance had been deteriorating since September 2021 and the target had not been reached since November 2021. The median time for patients to be assessed was showing a trend above the mean in recent months. Discharges before 5pm was only at 63% which did not meet the target of 70%.

The trust was seeing a high acuity of patients attending and being admitted. The performance for post admission reviews by a consultant was consistently below the expected level as was daily reviews by a senior clinician. There were challenges in maintaining consistent recording of reviews, medical engagement, and medical capacity across the 7-day period. The numbers of patients with no right to reside was a continued challenge for the trust.

The trust had implemented some actions to ease pressure of acute flow such as the same day emergency care (SDEC) units and they were looking at pathway 0 patients and timely discharge. Support from the wider system was being implemented but all this was having a limited effect at the time of our inspection. We were not assured that there was full clinical and operational management engagement to address flow within the organisation. For example, the Bristol model had been considered but dismissed due to estates restraints in terms of accommodation additional capacity. Senior leaders told us not all clinical areas were proactive in supporting flow at pace through the system, they hoped the new quality improvement (QI) methodology would help staff to work through the current blockages to flow and create bottom up designed solutions.

The trust was behind target on its elective recovery programme. Data provided by the trust showed a trajectory by March 2023, that there will still be 397 patients waiting over 78 weeks for treatment and 121 patients waiting for cancer treatment for longer than 63 days. The trust was not hitting performance targets before the COVID-19 pandemic. The trust was receiving tier 1 support from NHS England due to its recovery performance. However, by the time our inspection concluded in March 2023, the trust had made some gains in operational performance and were ahead of the trajectory with only 193 patients waiting more than 78 weeks.

Senior leads were unable to state the volume and trajectory for patients waiting 52 weeks for treatment and the chief operating officer at executive level was vacant. Performance management at care group level was not embedded and the trust was planning to implement a 'star chamber' approach with challenged specialties. Theatre utilisation was only at 78%, meaning capacity was lost to progress on surgical lists.

Our findings

Senior leaders told us they did not always have clinical support for proposed recovery trajectories. They were not always sighted on areas of poorest performance and challenged specialities. We were not assured that the trust had adequate oversight of the harms caused by delays to pathways. All waiting lists were stratified according to Royal College guidance and elective surgery waiting lists over 78 weeks are monitored through 3-monthly admin calls to patients to determine whether any clinical symptom deterioration has occurred. Where any deterioration of symptoms is reported this prompted a clinical review, to determine next appropriate step and prioritisation. However, a SOP had been developed to record harms, particularly low harms which may indicate an emerging risk, for tracking and monitoring purposes had not been agreed at QPAS. Senior leaders were therefore not receiving assurance about high risk areas or emerging risk.

The trust had not begun any work to look at high risk groups of patients who were waiting or to consider health inequalities. Some proposals had been made to look at 'waiting well', maximising physical function and addressing deconditioning of patients on waiting lists, but this did not have comprehensive clinical backing. The only target which was being met was the target for out-patient follow ups, despite the national guidance to de-prioritise this work.

There were some initiatives to address backlogs, such as the implementation of an elective hub off site for trauma and orthopaedic patients, but this was having limited impact. Senior leaders had identified that there was a need for stronger leadership in transformation and strategy to address the ongoing performance issues. The trust had a business continuity working group which ensured business continuity plans were up to date and fit for purpose.

Falls, pressure ulcers and Healthcare acquired infections (HCAI)

The trust had been slow to address ongoing patient safety concerns. The incidence of falls continued to be a concern for the organisation and was monitored by the falls improvement group. The trust was waiting for a falls prevention lead to commence in post. Falls required e-learning had only just been rolled out within the trust. Thematic work showed a higher incidence of falls with harm in patients deemed medically fit and who were waiting in hospital for either care home placement of a care package. One care group had also experienced an increase in violence and aggression incidents resulting in patient falls associated with the inability to implement required levels of enhanced supervision. The trust had only implemented a multifactorial falls assessment in June 2020.

Pressure ulcers (PU) continued to demonstrate 'special cause for concern' based upon trust wide data. There were high numbers of category 2 PU being reported which was linked to staffing levels which in turn led to patients not being repositioned, skin checked, and risk assessed with adequate frequency. Harm meetings were held with key members of the multidisciplinary team to consider if the PU incident should be recorded as an SI, and to review outstanding action plans.

The newly implemented electronic risk assessment and care planning software was having some impact through releasing staff from time consuming paperwork and improving recording of both falls and PU's. This was rolled out in all adult inpatient areas at the time of our inspection. It was not being used in maternity due to the imminent go-live of the regional system and it was not used in ED as further work needed to be developed to enable the scheduling of assessments in ED.

Performance of the trust for health care-associated infections (HCAI)'s, such as clostridium difficile infection (CDI) and methicillin sensitive Staphylococcus aureus (MSSA) were among the worst in the region and was not showing signs of improvement. The IPC team had developed, with relevant stakeholders, a CDI action plan and annual plan.

Deteriorating patient

Our findings

National Early Warning Score (NEWS2) recording compliance had been below target since October 2021. This had been reviewed within the trust and their opinion was that the prescribed observations was incorrect and too frequent. We were not assured this was being addressed in a timely or robust way, as the parameters for frequency of observations were set by NEWS2 and are widely used elsewhere.

The trust had a commissioning for quality and innovation (CQUIN) to achieve 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation, and time of clinical response recorded. This was being met with the trust achieving 74% in quarter two of 2022/23.

Safeguarding

The safeguarding report only went to board annually with an exception report for safeguarding going to the board quarterly via the quality committee. This gave limited assurance of the boards oversight of safeguarding. As a result of concerns raised at our last inspection 2 mental capacity act (MCA) leads have been recruited, however we still found multiple gaps in MCA processes particularly on the medical wards.

The trust had no looked after children specialist nurse in post, which left the named doctor to do initial health assessments with limited capacity for reviews.' Named doctors were not always attending executive meetings. The recording of injuries in non-mobile baby at York was 100% compliant, but not at Scarborough due to arrangements with an external provider in Scarborough ED. This was being addressed

A learning disability nurse lead was new in post at the time of our inspection. The trust had recognised they needed more support within the learning disability team and had increased the capacity within the team.

Duty of Candour

We found evidence of some long delays in the implementation of duty of candour. For example, in 1 case, an apology in writing to a family was not issued until several months after the first opportunity to do so. We reviewed duty of candour letters to families and found multiple occasions that the correspondence was dismissive of concerns raised by families.

Medicines management

Risks and medicines management issues were reviewed by the medicines safety group and escalated to the medicines management group. The medicines management risk register was regularly up dated and mitigating action was taken. An audit programme was in place and included recent audits of

- Safe and secure handling of medicines
- Controlled drugs
- Prescribing standards and documentation of administration on electronic Prescribing and Medicines Administration (ePMA)
- Gentamicin prescribing and monitoring
- Epidural review, compliance with 2007 National Patient Safety Agency (NPSA) alert.
- Medicines reconciliation

Our findings

The pharmacy department has developed a system to target patients prescribed medicines where harm was more likely if doses are missed (critical medicines) and prioritise those patients for medicines reconciliation.

However, we found repeated issues with medicines storage particularly in maternity services. This had been highlighted as an issue on numerous audits of the clinical environment and also was found on our inspection. We were not therefore assured that adequate action had been taken following audit results. We also found issues with medicines storage within the emergency department (ED) and the maternity department which had not been picked up by internal process within the trust. The audit section on safe and secure handling of medicines was removed when questions were reviewed, and this was being investigated by the trust.

Finance

The trust had a good track record of achieving its financial targets albeit the underlying financial position was identified as £38.3m within the breakeven plan for 2022/23. Currently (October 2022/23) the forecast of financial performance is for the Trust to deliver against the breakeven 2022/23 financial plan.

Information Management

Staff could find the data they needed, but not always in easily accessible formats that helped them understand performance, make decisions and improvements. The information systems were not all integrated and security was a risk.

The trust had a digital strategy up until 2022 that built upon its predecessor. This proceeding strategy focused the merger of York and Scarborough hospitals and had resulted in a bespoke patient electronic record, designed, and maintained by the trust. As the trust was using this bespoke record there were difficulties in maintaining the system, managing interoperability with other systems, and upgrading the system based upon clinical developments.

Following on from our previous inspection, where we had found issues with maintaining contemporaneous records, the trust had reverted in some instances back to paper records rather than progressing with electronic solutions. The trust did not meet NHS digital target of being paperless by 2020. The new electronic observation system was also bespoke and developed in house and had not yet been rolled out to all clinical areas.

Therefore, a new strategy was being developed to look at the sustainability of the bespoke solutions including the newly implemented electronic observations system and the possibility of 'off the shelf' solutions which would be more sustainable and provide better integration and interoperability and the introduction of electronic prescribing.

Electronic observations had been used in the Trust for 10 years using computers on wheels. Since October 2022 these had been completed using handheld devices. Electronic prescribing and administration have been used in adult inpatient areas since 2017. A new digital strategy and options appraisal was in progress to look at the long-term sustainability of the bespoke in-house solution. Options include the possibility of an "off the shelf" solution which may be more sustainable and would allow for electronic fluid prescribing and paediatric prescribing.

Leaders told us that not all clinicians were engaged with the digital agenda and there were fears systems would not be robust enough. Not all services were paper light and not all paper records had been scanned in each specialty.

The chief digital information officer had only been at the trust for a couple of months at the time of our inspection. The trust also had a chief clinical information officer and chief clinical nursing information officer in post.

Our findings

Due to the slow pace in IT solutions within the trust there had been little progress made on virtual wards. This was also hampered due to the limited clinical space within the estate. IT solutions for community services were not well developed and no patient and public involvement in the development of IT had been implemented.

The trust had a suite of reports covering performance, operational activity, quality and safety and staff absence. The trust's key priority indicators formed part of the reports to board and extended further with supporting metrics for sub-committees to the board. There were also a number of dashboards which provided greater detail to support management and monitoring of various performance, operational and quality indicators. The trust performance report (TPR) was very new and still in development. Managers at all levels told us that there were issues with accessing relevant data in a timely way. Prior to the developing TPR, there was very limited data the trust could provide as assurance to either non-executive directors or governors.

Informatics at care group level was still being developed. There was a lot of data at care group level, but this was not pulled into coherent care group level data. A data quality improvement group had been developed but there was still need for improved analysis of data and data literacy. Not all managers at care group level were trained in the use of the dashboards available to them.

The business intelligence and insight team had fully documented procedures and instructions for production and submission of national returns within stipulated timescales and following validation checks and were compliant with daily submissions to secondary use service maintained by NHS Digital.

Cyber security was not strong, as the trust was running on an older operating version and was not yet on the more secure NHS mail system. There had been 7 incidents reportable to the guardian's office so far this year, however, 6 resulted in no action. NHS Digital fire walls were in place and software that protected systems were in place. The trust also had issues with connectivity which impacted upon efficiency of patient care. The trust was in the process of migrating to this system.

To support the senior information risk owner (SIRO) there was data protection officer, this was a new post in 2021. The relevant policy and processes for working with the Data Information Office had been refreshed. The trust was compliant the submission of death notifications to NHS digital, currently between the trust and primary care the target of 100% reported within 72 hours was met.

Engagement

Leaders were beginning to actively engage with patients, the public and local organisations to plan and manage services. Engagement with staff and the public was not yet robust. They collaborated with partner organisations to help improve services for patients, in response to pressures.

The trust did not have a patient and public engagement strategy. However, leaders described how their involvement was threaded through the quality strategy. The trust had recognised they needed to strengthen patient and public involvement (PPI) and so had created new posts which were all recently recruited to, or out to recruitment. One of these new posts was the head of patient experience. They would lead on strategy, initiatives and research, patient experience, use of champions and develop external engagement. This post was still vacant.

PPI was new within the trust and the new leads were starting work from a low level of engagement. Leads described resistance to improvements throughout the organisation. However, they saw the impact of the new QI methodology as a positive development which could aid their improvement work.

Our findings

One of the new PPI leads and the patient EDI lead had made some rapid improvements. This included involving members of the public in recruitment days for Patient Service Operatives (PSO). The trust were developing new patient safety partner roles who would act as patient representatives joining and participating in key conversations and meetings focusing on various patient safety amongst other initiatives.

All the initiatives were newly commenced and needed further embedding and evaluation of their impact. The PPI leads had also initiated regular patient stories at board which board members had welcomed and spoke of the impact that this had upon their understanding of patient experience.

Other examples of initiatives within the trust were prompted by individual experiences of people using services. For example, a person with an access dog had been the catalyst for revision of the accessible dog's policy, education for staff about patients with access dogs and the scoping for a 'dog spending area'; and the experience of a patient who had a hearing impairment, had prompted the development of deaf awareness posters to raise awareness for staff with the patient concerned being involved in the drafting of the posters.

Preliminary results of the CQC 2021 inpatient survey showed the Trust's average score fell from 76% (2020) to 72% (2021). In terms of indicative national comparisons, 34 of services were in the middle 60% and 33 were in the bottom 20%. There were no services in the top 20%. Results which were worse in 2021 compared with 2020 included length of time on waiting lists, time to get to a bed, and the number of nursing staff.

The top issues identified by respondents to the friends and family test (FFT) in November 2021 were waiting times, communication (including attitude of staff), the low number of staff on duty. The top three reasons cited in informal and formal complaints in November 2021 were: staff attitude, care needs not being met, and communication.

The trust was slow to implement the accessible information standard (AIS), from information supplied by the trust little work had been done prior to September 2022. A report from the fairness committee was going to board in November 2022 describing the impact of the lack of accessibility support for patients. There had been an increase in complaints and concerns about accessible communication during the pandemic.

The trust did not always communicate in the most accessible format for staff. For example, staff in maternity told us that they had received communications about urgent updates following our inspection, only by email, even when their working practices meant they often did not have time to access their emails prior to starting clinical shifts.

The trust had a strong volunteer system with good processes for recruitment and a healthy number of applicants for volunteer roles.

The trust was beginning to develop its partnership role within the integrated care system (ICS). Most of the work had been in relation to how the system could support the trust in improving flow through the trust's services. This had led to closer working with the local authority to discuss particularly complex discharge cases. This work was slow moving due to the complexity and was not yet having an impact upon flow. The trust was beginning to look at options for sharing workforce and support to social care.

Mutual aid for elective work was both offered and requested, and the trust had just agreed to extend the use of the elective hub at Hull. The trust was working with partners in independent health to support mutual aid. Virtual wards were planned with support from a mental health trust to support patients with a mental health need, this was in its infancy.

Our findings

In July 2021 the trust launched a single point of access for external partners to report concerns relating to discharge. This has resulted in some planned work to implement a trust wide discharge improvement group, monitor discharge performance, and agree upon discharge documentation, communication, and design training.

Leaders identified there was much more work to do around integration, in particular for workforce and engagement with local communities. Identified areas were health inequalities and EDI within local communities and working with partners. For staff, work was still needed to map skills across the ICS, utilise AHPs better across the patch and there had been discussions about supporting staff to move between organisations with the region to support development.

Learning, continuous improvement and innovation

Systems and processes for continually learning and improving services were not embedded. Learning from complaints and incidents was not consistent across the trust and the pace of delivering improvement was slow.

The trust had adopted a quality improvement (QI) methodology, but this was in its infancy.A QI strategy group had been established in January 2021 to develop a trust-wide systematic approach for QI. This had been approved at board in August 2021, at the time of our inspection, only 30 people had been trained as QI leaders / champions. There was work to do to embed QI throughout the organisation and make it more business as usual.

We saw other examples through our core service inspection where action to be taken on improvements was slow and staff often told us that changes had only been implemented due to external scrutiny rather than generated through internal channels. For example, one QI work stream related to nutrition, which was the focus of improvement work following our last inspection. We also saw the lack of sharing learning across hospital sites, for examples processes we saw implemented in the Scarborough emergency department had not been replicated at York.

Care groups had carried out self-assessments on the QI work and there was a QI delivery group in place. Care groups owned their own improvement plans and one care group had developed a QI council of staff interested in improvement work. Senior leaders were optimistic about the impact the QI approach would have but were in agreement this was the very beginning of QI development within the trust.

There were some other examples where QI had begun to have an impact, but only in response to incidents. For example, incidents around diabetic ketoacidosis had triggered a stakeholder group being established to identify the issues and a driver diagram developed to address the problems. This led to a diabetes continuous improvement group, which was established with wider stakeholder engagement. There were plans to feed themes from diabetic patient incidents into this expert continuous improvement group.

In response to poor performance in the average time to attending ED and going to theatre, a development group was established for fractured neck of femur on the York site. Following work with stakeholders, performance for this metric was better than the national average. This work had been shared with the Scarborough site who were adopting some of the learning and beginning to look at cross site working.

One care group had begun some smaller ‘ground up’ projects such as providing ear defenders for children having casts removed, purchasing a children’s wheelchair, and providing a breast feeding space for visitors/staff. Whilst these were having impact at ward and department level there was a lot more work required to initiate ground up large scale projects across the trust.

Our findings

The Trust had a 'Green Plan' with a target was to deliver a net zero estate by 2040 on all buildings and an 80% reduction by 2032. The trust started a project in March 2022, largely funded by grants to improve energy use and sustainability at Bridlington and York hospitals, following board approval for a business case on 4th November 2021.

Performance on complaints was variable across care groups, with an average performance of 56% of all responses being sent within 30 days. Some care groups performance was as low as 20%. Complaints responses we reviewed did not always result in further investigation such as a root cause analysis when this was indicated and routinely did not involve family. Informal complaints managed through the patient liaison service (PALS) were closed within 10 days in 67% of cases which was below target. Complaints about ED remained high with the main issue being waiting times. The longest length of open complaint was over 100 working days, but none have gone over 160 days.

The trust had in place counter fraud arrangements through Audit Yorkshire from the NHS Counter Fraud Authority and has a named local counter fraud specialist. To ensure that counter fraud resources were effective there was a counter fraud plan and annual report.

The trust was participating and had performed in the National Audit of Care at the End of Life (NACEL). The survey asks staff to provide their views on confidence levels for caring for patients at end of life. The trust was still working to replace DNACPR forms with Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms.

Key to tables					
Ratings	**Not rated**	**Inadequate**	**Requires improvement**	**Good**	**Outstanding**
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔🡐	🡅	🡅🡅	🡇	🡇🡇
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔🡐 Jun 2023	Requires Improvement 🡇 Jun 2023	Good ➔🡐 Jun 2023	Requires Improvement 🡇 Jun 2023	Inadequate 🡇 Jun 2023	Requires Improvement ➔🡐 Jun 2023

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Requires Improvement	Requires Improvement	Good	Requires Improvement	Inadequate	Requires Improvement
Community	Requires Improvement	Good	Good	Good	Good	Good
Overall trust	Requires Improvement ➔🡐 Jun 2023	Requires Improvement 🡻 Jun 2023	Good ➔🡐 Jun 2023	Requires Improvement 🡻 Jun 2023	Inadequate 🡻 Jun 2023	Requires Improvement ➔🡐 Jun 2023

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
The York Hospital	Inadequate 🡻 Jun 2023	Requires Improvement 🡻 Jun 2023	Good ➔🡐 Jun 2023	Requires Improvement 🡻 Jun 2023	Inadequate 🡻🡻 Jun 2023	Inadequate 🡻🡻 Jun 2023
Scarborough Hospital	Requires Improvement 🡹 Jun 2023	Requires Improvement ➔🡐 Jun 2023	Good ➔🡐 Jun 2023	Requires Improvement ➔🡐 Jun 2023	Requires Improvement ➔🡐 Jun 2023	Requires Improvement ➔🡐 Jun 2023
Bridlington Hospital	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Requires improvement Oct 2019	Good Oct 2019
Overall trust	Requires Improvement ➔🡐 Jun 2023	Requires Improvement 🡻 Jun 2023	Good ➔🡐 Jun 2023	Requires Improvement 🡻 Jun 2023	Inadequate 🡻 Jun 2023	Requires Improvement ➔🡐 Jun 2023

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for The York Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↓ Jun 2023	Requires Improvement →← Jun 2023	Good →← Jun 2023	Requires Improvement ↓ Jun 2023	Requires Improvement ↓ Jun 2023	Requires Improvement ↓ Jun 2023
Services for children & young people	Requires improvement Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015
Critical care	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
End of life care	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015
Maternity and gynaecology	Good Oct 2015	Requires improvement Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015
Outpatients and diagnostic imaging	Good Oct 2015	Not rated	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015
Surgery	Good Feb 2018	Good Feb 2018	Good Feb 2018	Requires improvement Feb 2018	Good Feb 2018	Good Feb 2018
Urgent and emergency services	Inadequate →← Jun 2023	Requires Improvement ↓ Jun 2023	Requires Improvement ↓ Jun 2023	Inadequate →← Jun 2023	Inadequate →← Jun 2023	Inadequate →← Jun 2023
Maternity	Inadequate Jun 2023	Requires Improvement Jun 2023	Good Jun 2023	Requires Improvement Jun 2023	Inadequate Jun 2023	Inadequate Jun 2023
Overall	Inadequate ↓ Jun 2023	Requires Improvement ↓ Jun 2023	Good →← Jun 2023	Requires Improvement ↓ Jun 2023	Inadequate ↓↓ Jun 2023	Inadequate ↓↓ Jun 2023

Rating for Scarborough Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↑ Jun 2023	Requires Improvement →← Jun 2023	Good →← Jun 2023	Requires Improvement →← Jun 2023	Requires Improvement →← Jun 2023	Requires Improvement →← Jun 2023
Services for children & young people	Requires improvement Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015
Critical care	Good Feb 2018	Requires improvement Feb 2018	Good Feb 2018	Requires improvement Feb 2018	Requires improvement Feb 2018	Requires improvement Feb 2018
End of life care	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015
Surgery	Good Oct 2019	Good Oct 2019	Good Oct 2019	Requires improvement Oct 2019	Requires improvement Oct 2019	Requires improvement Oct 2019
Urgent and emergency services	Requires Improvement ↑ Jun 2023	Requires Improvement →← Jun 2023	Good →← Jun 2023	Requires Improvement ↑ Jun 2023	Requires Improvement ↑ Jun 2023	Requires Improvement ↑ Jun 2023
Maternity	Inadequate ↓↓ Jun 2023	Requires Improvement ↓ Jun 2023	Good →← Jun 2023	Requires Improvement ↓ Jun 2023	Inadequate ↓↓ Jun 2023	Inadequate ↓↓ Jun 2023
Outpatients	Requires improvement Oct 2019	Not rated	Good Oct 2019	Requires improvement Oct 2019	Requires improvement Oct 2019	Requires improvement Oct 2019
Overall	Requires Improvement ↑ Jun 2023	Requires Improvement →← Jun 2023	Good →← Jun 2023	Requires Improvement →← Jun 2023	Requires Improvement →← Jun 2023	Requires Improvement →← Jun 2023

Rating for Bridlington Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Requires improvement Oct 2019	Good Oct 2019
End of life care	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015
Surgery	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019
Outpatients	Requires improvement Oct 2019	Not rated	Good Oct 2019	Requires improvement Oct 2019	Requires improvement Oct 2019	Requires improvement Oct 2019
Overall	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Requires improvement Oct 2019	Good Oct 2019

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires improvement Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015
Community health services for children and young people	Requires improvement Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015
Community health inpatient services	Requires improvement Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015
Community end of life care	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015
Overall	Requires Improvement	Good	Good	Good	Good	Good

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Care Quality Commission

The York Hospital

Wigginton Road
York
YO31 8HE
Tel: 01904725610
www.yorkhospitals.nhs.uk

Description of this hospital

York and Scarborough Teaching Hospital NHS Foundation Trust provides a comprehensive range of acute hospital and specialist healthcare for approximately 800,000 people living in York, North Yorkshire, Northeast Yorkshire, and Ryedale.

The York Hospital is the Trust's largest hospital. It has over 700 beds and offers a range of inpatient and outpatient services. It provides acute medical and surgical services, including trauma, intensive care, and cardiothoracic services.

Medical care (including older people's care)

Requires Improvement ↓

Is the service safe?

Requires Improvement ↓

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff, however, not all staff completed it.

Mandatory training was comprehensive and met the needs of patients and staff. However, we observed shortfalls in training completion for all staff groups.

Staff said the learning hub contained the mandatory training information and staff would be emailed when they were due to update their mandatory training topics. Some staff said they often did not have time to complete the mandatory training sessions, other staff if able completed this training during quieter periods such as weekends. Completion of mandatory training subjects was monitored monthly by both the ward sister and matron.

At York hospital medical and dental staff overall training completion rate was 53.3%. This was lower than the trust target of 85%. Of the 17 statutory training courses, only two had a completion rate of more than 85%, and one of them required just one person to complete it. None of the additional learning or required learning modules achieved the 85% target. Training statistics confirmed that 35.6% of medical staff had completed sepsis awareness training.

Nursing and midwifery staff overall completion rate was 84.4%. Of the 22 statutory training courses, only four were not meeting the trust target of 85% completion. Completion rate for sepsis awareness was 75.9%. Of the role specific courses, only one of the seven modules had a completion rate higher than 85%.

Additional clinical staff had an overall completion rate of 73.0%. Of the 20 statutory training courses, five had completion rates of over 85%. Sepsis training had 60.6% completion rate and none of the seven required training modules achieved the 85% trust target.

Corporate led sepsis audits were paused in April 2022 to focus resource to the re-launch of the sepsis screening tool. A re-launch of the sepsis pathway took place on World Sepsis Day (13 September) which included additions based on learning from incidents and serious incidents. The associated policy remained to be updated.

Dementia awareness and learning disabilities awareness online training sessions were completed by staff; however, we noted some completion rates did not meet the trust baseline of 85%. For dementia awareness training medical and dental staff overall training completion rate was 46%; nursing and midwifery staff and allied health professionals overall training completion rates were 81% and 82% respectively.

Learning disabilities training compliance for medical and dental staff was 45%. Nursing and midwifery staff and allied health professionals overall training completion rates were 87% and 75% respectively.

Renal staff were supported by a clinical educator. Staff completed core competencies and received face to face training sessions on the care of fistulas and central venous catheters including minimising risk of needle dislodgement and line disconnection. York staff were 83% (19/23) compliant and non-compliant staff were working towards their competencies under supervision.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Safeguarding policies which included female genital mutilation guidance and procedures were in place. The current guidance was due for review in April 2022. This has been completed and the updated guidance was currently out for comment and scheduled for ratification 10 November 2022. The short delay in updating the guidance has been due to City of York and North Yorkshire Safeguarding Partnerships updating there multi agency guidance, to ensure the trust guidance aligned with that of the Safeguarding Partnerships. The original guidance remained fit for purpose.

Safeguarding training and PREVENT Awareness training sessions were completed by all staff groups. However, we observed some shortfalls in completion of these training sessions for medical staff and additional clinical service staff. We observed that 60.4% of medical staff had completed safeguarding adult's training – level 2 and 51.3% completion of PREVENT awareness level 3 training.

Staff could approach safeguarding support through the hospital and local safeguarding authority safeguarding team.

The hospital safeguarding teams contact details including contact details for the local safeguarding authority was located on each clinical area.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff confirmed that should there be a safeguarding incident these incidents were reported on the trust incident reporting system and the safeguarding team alerted.

Nursing staff training module statistics confirmed compliance ranged from 88% (Prevent awareness level 3) to 100% compliance for safeguarding adults' level 1 and safeguarding children level 1 and level 3 training.

The trust confirmed that disclosure and baring checks statistics had been completed for all staff prior to working at the trust.

Cancer patients had alert cards which meant they were kept safe and isolated during their stay.

Cleanliness, infection control and hygiene

Staff used equipment and control measures to protect patients, themselves and others from infection. However, cleaning records were not always complete. Equipment and the premises were kept visibly clean.

The Infection prevention and control (IPC) team complete a fortnightly walk round of wards with a senior member of the Care Group team highlighting areas for learning and environmental issues.

Medical care (including older people's care)

In response to Covid-19, the service had followed NHS guidance. Staff completed twice weekly lateral flow tests and continued to wear personal protective equipment (PPE). Staff wore PPE, which included gloves, masks and apron's when treating patients. Staff cleaned the local environment and equipment, after patient contact.

Anti-bacterial hand gel was available for the use of staff and patients. We observed different staff members frequently applying gel to their hands. Clinical staff's arms were also bare beneath the elbows. Hand wash guidance was displayed above sinks.

There were gaps in compliance for staff groups in attendance at infection, prevention and control (IPC) training (level 2). Compliance for all groups ranged from 56.5% (medical and dental) to 90.7% (nursing and midwifery).

The service confirmed zero reported cases of MRSA and one case of MSSA over the last three months at York Hospital. The Care Group 2 excerpts from Quality committee minutes for infection control 2022 confirmed infection rates were monitored and action plans in place where needed. A focussed IPC week and relaunch of champions took place earlier in the year. Additional support included site visits and additional training.

In endoscopy settings when people were seen with suspected communicable diseases, elective patients had an alert on their electronic record. For inpatient bookings, the ward informed the endoscopy team when they called them to confirm a date and time for procedure. Endoscopy staff also checked to see if an alert was identified and noted this information in the recovery area diary.

In radiology settings guidance was in place to support staff when people were seen with suspected communicable diseases.

Each ward had a designated domestic whose responsibility was to ensure the cleanliness of the ward. Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. Random checks of curtains around patient beds confirmed they were clean and in-date. Staff said side rooms were used for end of life and neutropenic patients.

The trust has accreditation to provide decontamination, packing and moist heat sterilisation services. The date of accreditation expiry was 18 May 2023.

Clinical equipment cleaning schedules were displayed along with the ward cleaning frequencies in accordance with NHS cleaning standards. We were told that senior staff audited the cleaning.

Not all cleaning records were complete; records from the emergency assessment unit had not been completed for three weeks.

Cleaning audits from 26 September 2022 to the 30 October 2022 throughout medicine at York Hospital compliance levels over a five-week period ranged from a red rating 86.16% for ward 37 to amber and green ratings for the remaining clinical areas.

Water checks and legionella checks were completed throughout the year. We saw most checks had passed, where a failure was identified on the 2 November 2022 there was not a supporting action plan confirming what actions the trust should take to ensure safety.

Medical care (including older people's care)

September to November 2022 weekly tendable hand hygiene audit data for performing hand hygiene confirmed compliance ranged from 85.7 (ward 21) to 100% compliance across eight medical specialities.

September to November 2022 weekly tendable hand hygiene audit data for donning gloves confirmed compliance ranged from 22.2% (ward 22), six medical wards were rated amber to 100% compliance across medical specialities.

Environment and equipment

The maintenance and use of facilities, premises and equipment kept people safe. However, we observed on the acute stroke ward there were no rehabilitation or kitchen areas for use when undertaking patients risk assessments. Staff were trained to use equipment. Staff managed clinical waste well.

Entry to each clinical area was secure, patients and visitors had to identify themselves before gaining entry to clinical areas.

Over two days we visited eight clinical areas. In ward 21 we saw black bags and equipment stored in corridors. The remaining clinical areas we visited were well maintained; some had been redecorated. During the inspection we observed that patients could reach call bells and staff responded quickly when called.

Ward 23 the acute stroke ward had no dedicated rehabilitation or kitchen areas for use when undertaking patient assessments. Space allocated on ward 24 was used for storage. This meant that all patients who required this type of assessment were being assessed at their home. On ward 23 staff said equipment such as drip stands were in short supply and no ceiling hoists were available.

All reusable medical devices were assessed and recorded on the trust Backtraq database. They were maintained in accordance with MHRA Managing Medical Devices (2021) and we saw some examples of the records of planned and reactive maintenance recorded.

Electrical safety testing was performed to standard IEC 62353 standard for the in-service and post repair testing of electromedical devices. All calibrated test devices were recorded when used in the test and verification of a device. We saw that portable appliance testing checks took place and equipment passed these checks when we undertook random checks of equipment which confirmed they were checked in 2022 by the presence of dated stickers.

The trust had equipment service schedules in place which were monitored to ensure services were completed, for example at York we saw that 96.41% where no more than one month overdue their service date.

Staff were trained on devices in accordance with their band, area of responsibility, and what they were expected maintain.

On some wards we visited we undertook random checks of medicines and equipment in the resuscitation trolley and found all to be in-date. The resuscitation trolley was tamper evident. Resuscitation equipment records check lists confirmed weekly checks took place.

Controlled substances hazardous to health (COSHH) were not always locked away. On the Emergency Assessment Unit, the COSHH substances were not locked away, although, the door to the room had a lock on it.

Completed radiation risk assessments (RRAs) approved by the Trust's Medical Physics provider were embedded for Nuclear Medicine and x-ray room 7 at York. Risk assessments for each room were recognised as a gap and action plans

were in place to address this. Risk mitigation processes included Medical Physics input into room design, dose reference level (DRL) monitoring by Medical Physics and regular equipment quality assurance. Completed risk assessments included the workplace, Ionising Radiation Regulations 2017, radiation risk assessment, (Regulation 8) x-ray for room 7, injection rooms and patient areas. Risk assessments for mammography rooms 2 and 4 and mobile units were planned for December 2022.

Staff disposed of clinical waste safely and protocols were in place for the safe disposal and spillages of cytotoxic waste.

Business continuity plans were in place.

Assessing and responding to patient risk

Staff completed and updated risk assessments for patients to remove or minimise risks. However, we found that some risk assessments were not completed within 24 hours of admission. Compliance for both the adult life support and adult advanced life support training for nursing and medical staff was below the Trust training target of 85%. Staff identified and quickly acted upon patients at risk of deterioration.

Following the March 2022 inspection, CQC issued the trust with a warning notice in response to its ineffective systems for managing patient risk assessments, pressure area care and falls prevention. Systems to ensure that patient risk assessments and care provided in relation to pressure damage and falls prevention had improved.

Staff completed risk assessments for most patients, using a recognised tool, and reviewed this regularly. The trust confirmed all patients admitted to the trust over the age of 65 were required to have a falls assessment as per national guidance and trust policy. We found one falls assessment not completed had not resulted in impact to the patient and falls equipment was in place.

Therapy staff were available but the environment on Stroke unit did not allow for regular rehabilitation to take place; however, this had not impacted on people's skin integrity.

Patients had venous thromboembolism (VTE) checks completed. The current protocol was to document the patients risk assessment within 14 hours. Reassessment within 24 hours was not captured electronically. In October the VTE audit across medicine in York confirmed 82.5% of patients received a VTE assessment, 59.8% within 24 hours of admission. The week commencing 14 November 2022 VTE compliance was 76.5% across site; from 40.9% for cardiology to 100% for acute medicine.

Compliance for both the adult life support and adult advanced life support training for nursing and medical staff was below the Trust training target of 85%. Adult life support training compliance for medical and nursing staff was 54.1% (79 of 146 staff) and 83.2% (263 of 316 staff) respectively. Adult advanced life support four-year training statistics for medical and nursing staff were 71.4% (five of seven medical staff) and 82.4% (14 of 17 staff)

In October 2022 88.2% of urgent or unplanned medical admissions were seen and assessed by a consultant within 12 hours of admission and an average of 88% over the previous 12 months for post take complete within 14 hours.

Protocols were in place for sepsis and cancer patients.

The deteriorating adult patients monitoring and escalation policy (v5) included clear direction on patient monitoring, what to do should a patient deteriorate, staff duties and responsibilities, completion of training and competency assessments and the escalation pathways for each hospital location.

Medical care (including older people's care)

National early warning score (NEWS) tools monitored patients at risk of deterioration. Immediate contact with the critical care outreach nurse took place should the patient score seven and above. Nursing staff also contacted the critical care outreach doctor to confirm the patient had flagged so that appropriate intervention could occur. Observation of the electronic NEWS tool in practice confirmed calculations were made against the Glasgow Coma scale which were part of the NEWS. The electronic NEWS process was used correctly, and staff were responsive to the outcome of the news scores.

The 'NEWS2 Observation Frequency' report dated 29 September 2022 confirmed that average NEWS2 compliance for York Teaching Hospitals NHS Foundation Trust was between 80-85% month on month. The audit included the review of 178 patients over several wards.

The service had 24-hour access to mental health liaison and specialist mental health support.

Shift changes and handovers included all necessary key information to keep patients safe. Staff shared key information to keep patients safe when handing over their care to others through safety briefs, board rounds and huddles and at the operational meetings attended by members of the multi-disciplinary teams across the trust. Huddles did not take place in the critical care unit, acute admissions medicine unit or ward 29.

Local safety standard for invasive procedures (LocSSIPs) endoscopy audits (undated) were shared by the trust and confirmed approximately 97% were correctly completed.

LocSSIPs meetings were monthly on the third Friday which involved departmental representatives. Findings were discussed to promote and share good practice and address any learning points or areas of improvement arising.

Staffing

The service did not have enough allied health professional staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The trust confirmed shortfalls in allied health professional (AHP) staff. The information provided confirmed that three of the four Care Group 2 (CG2) speciality groups actual staffing levels were below the planned staffing rates. The staffing shortfalls were from 1.01 to 6.16 whole time equivalent (wte) staff for acute medicine, care of the elderly and refer and treat specialities within CG2. The stroke speciality group actual staffing was above its planned staffing level by 1.09 wte.

Conversations with staff confirmed staffing shortfalls, for example, three physiotherapy staff were based on ward 23 not the allocated seven.

The last AHP staffing paper was discussed at the trust executive committee on the 21 September 2022 confirmed that AHPs were assigned operationally to care groups but not assigned to a ward rota. They were managed as speciality teams to cover across wards to support annual leave, sickness, vacancies, and gaps in establishment. The staffing report also confirmed as of August 2022 there were 14.87 AHP vacancies within the acute elderly emergency general medicine and community services in York.

The trust confirmed they had not met the AHP staffing recommendations for intensive care unit and stroke services which had impacted on their ability to deliver high quality care.

The trust confirmed AHP professional leads had undertaken a review of recruitment and retention work programs such as attending the universities and recruitment events. Engagement with regional workstreams through the AHP faculty ensured the trust benefited from regional programs of support, and new roles.

In addition, the following initiatives were and will be introduced:

- Apprenticeship routes
- International registered AHP recruitment
- Changes to the preceptorship programme to commence November 2022 to offer further support to the newly qualified AHPs and international recruits.
- Return to practice

We asked the trust to confirm whether all bank and agency staff had a full induction and competencies assessed prior to them working in the medical service but did not receive information these processes were in place.

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service used the Safer Nursing Care Tool (SNCT) – adult inpatient design 2013 version and Safe Care patient acuity tool to plan staff need and skill mix requirements for clinical areas. The first establishment review was completed in the summer (2022). Senior staff and some staff from wards we visited confirmed that staffing had improved since the March 2022 CQC inspection.

SafeCare is an accredited tool used within the trust to review patient acuity against real-time staffing levels, enabling staff to raise 'red flags' to identify areas of concern and identify any potential risk to matrons within the Care Group. Matrons contacted the wards each morning to confirm the real-time staffing levels and redeploy staff to areas that were unable to meet the fundamental care needs of their patients. Wards were red, amber and green (RAG) rated based on staffing levels and acuity and escalations taken to morning and afternoon staffing meetings with assistant chief nurse of the day. Staff said areas where red flag risks were not mitigated and closed were recorded monthly and triangulation data including datix reports collated to identify any harm that occurred as a result of reduced staffing levels and high patient acuity.

The trust confirmed the standard operating procedure entitled 'Daily Nursing and AHP Workforce and Escalation Meetings. Adult Inpatients Wards' was embedded across both sites. This identified where wards required additional support through a RAG rated system and the impact of this on the fundamental basic cares for patients and where support could be deployed from other areas.

The safer staffing reports from July to November 2022 confirmed the average nursing day and night fill rates for Care Group 1. The statistics showed the percentage of staffing shortfalls for qualified and unqualified staff were mostly observed during the day when compliance levels ranged from 68% to 84%. Some qualified staff shortfalls were also observed over night with compliance levels from 82% to 95%.

Staff said staffing had been really challenging and skill mix was not achieved. They told us staff were often moved, and staffing was not a reflection of the usual staffing numbers. Staff said where shifts were not fully staffed the clinical area

would occasional close to admissions. Should bed closures occur staff were redeployed from all areas to support especially if bank and / or agency staff could not be sourced. Other staff groups expressed some concerns about the replacement of staff with newly qualified staff. There was ongoing recruitment which included international recruitment.

The nursing workforce report dated 20 October 2022 was presented to the trust resource committee. Current workforce pressures and concerns were identified one of which related to the fill rates since July 2021. Fill rates above 80% were achieved for the night shifts since June 2021 but there continued to be a concern in relation to the day shift for the registered workforce.

The nursing workforce report confirmed that the trust continued to report a significant number of unmet shifts in relation to temporary staffing requests for registered and unregistered nurses. In August 2022, 39% of all shift requests were unfilled a deterioration of 1% which equated to 403 shifts.

Staffing shortfalls were reported via the trust incident reporting system; were discussed in safety huddles and at the larger operational meetings. The trust confirmed that any unmitigated staffing actions highlighted at the end of each month were reviewed and discussed at the Care Group quality committee, alongside any reported nurse sensitive indicators to establish if harm came to patients or staff due to unmitigated staffing concerns. The results were triangulated to include ward to board feedback to reduce incidence and promote safer staffing.

We looked at random staffing rotas to ascertain planned against actual nurse staffing levels. For example, the emergency assessment unit (EAU) rota for the 1 September to 30 September 2022 confirmed shortfalls of registered nurses and health care assistants across the month. These staffing shortfalls were not always replaced by bank or agency staff due to a lack of availability. It should also be noted that the shift coordinator also covered the new non right to reside ward 29. Staff said that there had been no staffing incidents recorded since the Covid staff joined the unit as staffing levels had increased.

Staff said there were 20-30% vacancy rates across the medical service. The trust July to September 2022 vacancy total was 63.24 vacancies for Care Group 1.

Forty newly qualified staff were due to start work at the trust. We were told there were no band 6 or band 7 vacancies.

Service sickness rates ranged from 2.26% to 16.52% from November 2021 to the end of October 2022.

We asked the trust to confirm whether all bank and agency staff had a full induction and competencies assessed prior to them working in the medical service but did not receive information these processes were in place.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service did not have enough medical staff to keep patients safe. Staff told us the service remained short of acute physicians. The service had an identified lead physician.

The trust confirmed compliance had been maintained with regards to staffing skill mixes and distribution of staff grades in accordance with the standards set in the ‘Society for Acute Medicine and West Midlands Quality Review Service

publication, Quality Standards in the acute medical unit'. This was reviewed annually as part of consultant job planning reviews and on annual rotation of junior staff to ensure compliance with Royal College of Physician guidelines. They were currently compliant in the 2022 guidelines. Should non-compliance be noted this was discussed at a weekly meeting with the trust rota team, junior doctors and senior clinicians and plans agreed to address shortcomings reviewed. The trust said they had employed roughly 30 trust grade doctors in the past year to ensure the trust had safe staffing levels of junior doctors.

Currently, the medical service was supported by three acute physicians supported by two from renal, respiratory and gastroenterology and eight whole time equivalent elderly care consultants. Two registrars worked within elderly medicine and funding was received from associate specialists for registrar positions. A dedicated frailty consultant was in post.

The renal ward 33, acute elderly ward 21 and stroke ward 23 had lead consultants allocated.

Staff confirmed the acute medical unit which was a GP referral and direct admission ward had no consultant lead which meant they had no responsibility for the ward organisation or running of the ward. A consultant of the day rota was introduced eight weeks ago. Different speciality consultants were allocated to work on the ward for one week from 0800 to 1700. Another consultant provided on call support for the ward until 10pm. Consultant staff were supported by general medicine and speciality doctors daily.

The trust confirmed there were geriatric medicine (GIM) or an acute consultant on-call resident between the hours of 9am-10pm seven days per week. Between 10pm and 9am there was a non-resident GIM or acute consultant on-call. There is also an additional on-call Renal, Respiratory, Cardiololgy, Gastro, Geriatric and Stroke Consultant on call. Most consultants working on the no-resident rota lived within 30 minutes of the hospital site, although due to the size of the cross-site patch, some consultants lived outside of the 30-minute trust standard. There were always resident intensive care clinicians on-site in an emergency.

The Emergency Assessment Unit (EAU) was supported by designated consultant staff. A consultant lead was identified for the five-bed frailty unit based on the EAU. One consultant and registrar and five junior doctors were allocated to work during the day. Staff said four Advanced Clinical Practitioners who were nurses also worked on the EAU. At night out of hours cover was provided by a named consultant and registrar. The consultant rota for October confirmed allocation of consultant staff throughout the 24-hour period. Staff confirmed when the unit first opened six-weeks ago there were occasions when there was no senior medical cover at night; support was provided by the on call medical register.

From January 2023 weekend consultant cover would move to a three-person rota consisting of: one GIM consultant; one acute physician on call and one cardiologist on call. They all held responsibility for post-taking, reviewing and being available for escalation of patients. The GIM consultant will be based in the emergency department and downstream wards; the acute physician will be based on AMU and Medical SDEC. The cardiologist will be based in coronary care unit and attend cardiology patients across the site.

We asked the trust to confirm whether all bank and agency staff had a full induction and competencies assessed prior to them working in the medical service but did not receive information these processes were in place.

Records

Staff kept records of patients' care and treatment. Records contained some documentation shortfalls and were not always seen to be stored securely. Records were easily available to all staff providing care.

Medical care (including older people's care)

The service currently used a mixture of paper and electronic records. The new electronic patients' records system was being introduced across the medical wards. This new system was in use on ward 21 identified patients' personal details, risk assessments and safeguarding information pertinent to the patient. We saw that staff entries into patient records were dated and timed. Staff said that 70% of patient's records were now recorded within the new patient's records system, however, clinical medical records remained paper based. Staff said to-date no documentation audits had been completed on clinical medical records.

Risk assessments were not always completed, for example, one person had not had a falls assessment completed; however, this had not influenced the care they received. They were recognised as a falls risk and cohorted for observation.

We saw a selection of risk assessments or in the process of completion for individual patients. These risk assessments included venous thromboembolism risk, falls, bed rail and Purpose T (the skin care tool).

We reviewed eight patients records on ward 21 and 33 and saw that the nursing section which included electronic risk assessments and care plans was completed. Documentation shortfalls were seen in the section completed by the medical staff and included:

- Smoking, alcohol use and drug use sections were not completed
- Medical staff signatures, bleep numbers and dates were missing
- The consultants post ward round information contained no doctors' signatures, General Medical Council numbers and dates were missing
- MRSA risks and Cognitive screens were not recorded
- Sentinel Stroke National Audit Pathway (SSNAP) pathway paperwork incomplete
- Deprivation of Liberty form not completed

Patients paper records were stored in records trolleys which were lockable, although, when checked we found these trolleys were mainly unlocked across the medical wards.

The trust confirmed there was no formalised medical records audit and that they would add this to the Care Group audit plan. Informal review of records and feedback had occurred during other processes such as incidents or complaints however this cannot be formally evidenced.

Medicines

The service used systems and processes to safely prescribe, record and store medicines. However, we found that time critical medicines were not always given on time.

Medicines policies and procedures were in place for staff to access.

Staff said there had been occasions when time critical medicines were not given due to the medicines either having not been prescribed or needed to be ordered from pharmacy. There were also delays in administering time-critical medication between the emergency department and frailty unit due to availability of medication and medicines being sent to the wrong wards.

Medical care (including older people's care)

On two clinical areas staff wedged open doors to the rooms where medicines were stored. We questioned this practice and staff from one area said the door was left open because this was what the doctors wanted.

The clean utility room door on ward 21 where the medicines were stored had no lock. We did not see the trusts medicines storage guidance to confirm the Trusts stance on storage of medicines in lockable rooms. Clean utility room doors within other wards visited were closed and locked when not in use.

The cupboard where the controlled drugs were kept was locked. We saw that CD storage policy had been followed as there was nothing displayed on the outside of the cabinet to indicate CDs were in the cupboard.

The trust multi-disciplinary antimicrobial stewardship team led the antimicrobial agenda to promote safe and effective antimicrobial prescribing and administration. A trust antimicrobial strategy and workplan was in place.

Pharmacists and pharmacy technicians' completed medicines reconciliation between Monday and Friday (8am to 5:30pm) and at weekends on medical admissions wards between 10am and 4pm.

Staff followed systems and processes to prescribe and administer medicines safely. Electronic prescribing and medicines administration (EPMA) records were updated by medical staff. The existing medicines systems for the administration and recording of medicines were slow and staff found these difficult to navigate. Medicines seen were appropriately prescribed.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff completed medicines records accurately and kept them up to date.

Pharmacy support was on every ward. Staff from the frailty unit on the admissions assessment unit confirmed they were well supported by pharmacy.

Medicines including medical gases, controlled drugs and prescribing documents were stored securely.

Monitoring records provided assurance that medicines were kept within the recommended temperature ranges. We checked some CDs on one ward with the nurse present and saw that all were in date. The CD book was complete with no information gaps. Staff said the CD stock levels in the book were checked weekly with monthly checks by the pharmacist.

A patients own medicine book was completed where patients own medicines are recorded when admitted to the ward. Staff said on occasion staff had forgotten to record when patients own medicines were returned to them on discharge.

Incidents

Staff had not always reported incidents. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Medical care (including older people's care)

The incident management policy with the associated governance processes at Care Group and corporate level were used to ensure effective incident management. The trust was preparing to introduce 'Patient Safety Incident Response Frameworks (PSIRF)'. An outline project plan was established, and an interim patient safety specialist ensured additional capacity and expertise to the implementation of PSIRF.

The Care Group and trust governance and assurance committees received reports on incident management, themes, trends and lessons learned to inform action plans and service developments. This information was reported into a corporate assurance group for oversight and scrutiny.

All staff knew what incidents to report and how to report them, however, staff said they did not always have time to report incidents, therefore, the trust could not be assured they had a complete oversight of incidents. Staff said senior management were aware not all incidents were reported. Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Some staff we spoke with confirmed completion of duty of candour training. The trust when asked did not confirm whether there had been any duty of candour incidents at the York Hospital site.

Following the inspection, the Trust confirmed that all care groups monitored and recorded all stages of Duty of Candour compliance on Datix. The August 2022 quality and safety report was provided as evidence which confirmed the findings of the Duty of Candour Quarter 3 audit. Twenty incidents were audited against the three stages 1,2 and 3. Seven of the 20 incidents related to Care Group 1 all of which had the three stages identified as completed.

Overall, the audit outcome confirmed an improvement in compliance with Duty of Candour evidence from the last audit for the care groups. Stage 1 and Stage 2 were both above 90% compliance. However, Stage 3 was at 85% (17 of 20 incidents), which was below the threshold but an improvement on the previous audit. One recommendation was identified for the patient safety team to review the notes and confirm if there was written evidence in the notes of a verbal Duty of Candour for the six incidents identified.

National Patient Safety Alerts were shared with the appropriate alert lead who coordinated the actions required to implement the recommendations. Updates were provided to the Quality and Safety Group. All alerts will be discussed by the Quality & Safety Group to seek alert closure.

Is the service effective?

Requires Improvement ➔🡐

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Mitigation was in place to ensure guidance was current and this was monitored through the trust quality and patient safety group and at monthly directorate assurance meetings.

Medical care (including older people's care)

Monthly outstanding actions which related to National Institute for Health and Care Excellence (NICE) guidance was escalated via the Care Group 1 quality assurance meeting.

NHS York and Scarborough Hospitals Foundation trust currently worked to the most recent NICE Guidance NG89 last updated in August 2019, Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism.

The trust followed NICE pathways for prostate, lung and breast cancer in older patient. Participation in national audits had taken place and data from associated trust audits was reviewed. For example, the prostate cancer data was reviewed quarterly. Action plans were in place for the 2021 breast audit and a urology action plan was in development following the 2022 urology audit.

Patients admitted to the trust over the age of 65 had a falls assessment as national guidance and per trust policy. Currently the 12 longest stays in the department were monitored. These patients were monitored to assess if harm had occurred due to a long wait. Bitesize training was taken as part of the improvement work from this audit and reported to the Falls Improvement group (FIG) and Quality and safety meeting every Monday.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

On the acute medical unit (AMU) all patients were reviewed daily and an additional review was undertaken at 12pm at the consultant led board round. Any patient requiring a review outside of this time is reviewed by the doctor resident on AMU.

The hospital anxiety and depression scale (HADS) was used by doctors to determine the levels of anxiety and depression the patient experienced. Although, staff said no psychology input was provided if indicated.

The trust had applied the 'Dementia Friendly Charter' within the medical service. A dementia ward was onsite. Wards on the York site used the Dementia 'forget me not' symbol in clinical setting; it was present on the bed board and the electronic whiteboard, so all staff saw which patients had a diagnosis of dementia. The 'What matters to me 'document was in use and John's campaign formed part of clinical practice which aimed to involve the family carer from admission to hospital until discharge. The trust was participating in the National Dementia Audit 2022. Dementia care was audited through weekly and monthly audits, the compliance level of these audits was not shared.

Nutrition and hydration

Following the March 2022 inspection, we issued the trust with a warning notice in response to its ineffective systems for managing nutrition and hydration and at this inspection we found:

Following the inspection in October 2022 we received an enquiry that raised patient safety concerns about ward 35 in the period of time we inspected. The concerns related to assistance for patients at mealtimes, staff having not responded to calls for help from patients and relatives and patients' privacy and dignity having not been maintained.

During the inspection we found on the whole that there were systems in place to ensure patients nutrition and hydration requirements were assessed and provided in line with care needs had improved.

Medical care (including older people's care)

The trust recognised that improvements were required in this area following the previous inspection and had started to implement additional measures to ensure patients received sufficient nutrition and hydration, for example, red trays were provided to all ward areas, designed to identify patients who require assistance at mealtimes and those who had food charts in place. The traffic light jug lid scheme was in place on the medical wards to assess the volume of fluid that patients drank over a time period.

Monthly monitoring of progress was reported to the Nutrition Steering Group where in September, 44 incidents were reported that had selected yes to is there a food, nutrition, hydration or fluid element to this incident. Of the 44 incidents reported the themes identified were: clinical (9), pressure ulcers (16), staffing shortages (10), Staff incidents (2), Falls (4) and medication error (3).

We observed a positive experience for a patient on stroke unit. Food and fluids were received in line with their dietary requirements. Additional nutritional supplements were provided where needed. A patient told us the fundamental standards of their care were being met.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

There was a comprehensive menu where patients could 'mix and match' their preferences for meals. We saw staff involve patients in decisions about what drinks they wanted. Three patients said food choices were excellent and could access drinks and biscuits in-between meals.

We saw weights being appropriately taken for people at risk of malnutrition.

Food charts were implemented in a timely way for those at risk of weight loss.

Fluid charts implemented were completed contemporaneously for people at risk of dehydration.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

We saw appropriate use of thickener and nutritional supplements. Thickener was stored in the kitchen as opposed to the medicine cupboard and therefore thickener was not being marked as administered on medication recording.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Malnutrition universal screening tool (MUST) auditing took place. The fundamentals of care quarterly audit results from April to August results showed improvements were required across the 13 wards identified on the audit. For example, the question, has all appropriate action taken in line with MUST scores identified that wards 23 (10.7%) and 34 (0%) were rated red and the ambulatory medical unit was rated amber (83.3%) for MUST scores completion within 24 hours of admission. The remaining 10 wards rating status was green with scores from 86.4% to 100%.

Medical care (including older people's care)

The majority MUST audit data for five of the six areas audited were red rated scores with compliance scores rated from 0% to 84.2% which showed low levels of compliance against the areas assessed. The worst scoring question was 'If required is a food chart fully completed and current as all area's compliance scores were identified as 0%. It was evident from the fundamentals of care quarterly audit results from April to August 2022 that the trust needed to ensure ongoing staff training and monitoring continued in this area.

The June and July 2022 tendable audits identified some scores of 100% for fluid balance charts being in place, updated and evaluated daily. We also observed 100% scores for food charts being in place and updated contemporaneously for September 2022. There was no scoring against the other six questions included within this audit.

Since the inspection the trust has implemented a live dashboard to support staff with continuous monitoring of their areas and to drive improvements with MUST. The live dashboard data for November 2022 for direct admissions from the emergency department to the ward areas identified the number of assessments by ward, where we observed higher completion of these assessments on some ward areas.

Two additional areas were monitored which confirmed the lowest and highest level of compliance across the identified ward areas. These areas were: assessment compliance within 24 hours of admission by ward (3% on ward 24 to 100% on the surgical assessment unit) and reassessment compliance within seven days of previous assessment by ward (20% on ward 23 to 100% on the acute medical unit.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

The trust had a dedicated pain team which staff could call for advice and support which patients can access through a referral route.

The trust had implemented most of the 'Faculty of Pain Management's Core Standards for Pain Management'. Work was ongoing to achieve the remaining standards. The service confirmed they met waiting times recommendations for acute pain only.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately.

The trust was asked to provide two pain audits for the York Hospital site; no audits were received.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment.

Medical care (including older people's care)

The trust provided data which confirmed how patients' outcomes at York Hospital compared to similar sized hospitals in Yorkshire and Humber. The four audits included the fractured neck of femur in older people, acute stroke, renal and cystic fibrosis.

Acute length of stay (LOS) for hip fracture presentations was less that other trusts in the region and England as a whole. Overall, LOS was in the 3rd quartile, higher than Hull and England average. York Hospital sat in the top quartile for all other outcome measures except for pressure ulcers which was in the 2nd quartile and slightly above the other Trusts.

30-day mortality as published on the National Hip fracture database at August 2022 for York Hospital was 5.3%. In comparison, Leeds General Infirmary were 5.7%, Harrogate at 5.4% and Hull at 6.8%.

Hyper Acute Stroke services were provided at York Hospital. Monitoring of stroke performance and outcomes was managed locally and through participation in the Sentinel Stroke National Audit Programme (SSNAP). York Hospital was currently rated by SSNAP as a level C rated service based on data from April to June 2022. The performance metrics for eight comparable trusts confirmed red, amber and green ratings for each of the 10-performance metrics. We saw three trusts of which York Hospital was one of them all scored red for speech and language therapy. The SSNAP 'Post-acute Organisational Audit Report December 2021' confirmed seven recommendations all of which were due to complete from July to December 2022.

Staff confirmed patients on the acute stroke ward, ward 23 had not received their daily 45 minutes of rehabilitation.

Psychology services were not available for patients.

Cystic Fibrosis audit outcomes showed the York Hospital outcomes against all centres in the UK. York Hospital site was 171 on the report. The data showed:

- York Hospital centre was above the mean for age (showing good life expectancy compared with peers)
- York Hospital was on the mean for lung function and BMI (showing comparability with peers)

York Hospital was above the mean for pseudomonas colonisation. The trust confirmed that this comparability was difficult to interpret as it may mean they had better sputum sampling for the group compared to peers or may represent more people acquiring pseudomonas. The reports showed high inhaled antibiotic use compared with peers which indicated good treatment of pseudomonas.

In 2019, York Hospital did not achieve joint advisory group on gastrointestinal endoscopy (JAG) accreditation as a result of being unable to provide evidence against some core mandatory standards and due to the size of backlog with insufficient plans to resolve this. The Scarborough and Bridlington service were to have a full accreditation visit in November 2023 and it was proposed the trust submitted a request to have a full accreditation review to include all three sites, York, Scarborough and Bridlington. This was discussed at the endoscopy operational meeting and agreed at board level by the chief executive committee. The service created an endoscopy clinical quality improvement lead role, the key part of this job plan was JAG project lead.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance to provide support and development but not all staff had received an appraisal within the timescales set by the trust.

Medical care (including older people's care)

Staff were experienced, qualified and mostly had the skills and knowledge to meet the needs of patients.

Managers gave all new staff a formal induction with competency assessments around area specific skills and some generic skills, for example, medicines. The quality and professional practice team supported staff for up to 12 months alongside local mentors as part of the preceptorship programme.

Managers identified poor staff performance promptly and supported staff to improve.

Managers made sure staff received specialist training for their role. The staff training needs analysis provided the basic training requirements for each band required to function in the role. Ward sisters oversaw statutory and mandatory training which was recorded centrally on the learning hub.

There are designated clinical educators for ED and renal working alongside ward based and community clinical educators. This team comprised of three senior nurses and two band 4 clinical trainers. Each clinical educator focused on designated wards to develop clinical skills or work with the ward sisters to look at learning and skills required from after action reviews in relation to falls, root cause analysis outcomes for pressure ulcers and clinical serious incidents.

Staff completed objective structured clinical examination (OSCE) assessments, for example, venepuncture, so they and the trust were assured of their competencies in these areas.

Band 4 clinical trainers supported non-registered staff with development through the care certificate as well as pastoral support.

There were shared learning days for all departments and the quality calendar identified a rolling programme which concentrated on the fundamentals of care training sessions.

Clinical nurse specialists linked to cancer and palliative care had access to more formal supervisory sessions.

Some nursing staff said they had not received regular, constructive clinical supervision of their work. Medical staff confirmed they could access good on-line learning and had a designated supervisor to support them within their role.

The renal clinical educator was in post since July and currently updating training materials, standard operating procedures and writing material for new training sessions.

Renal staff had completed simulation training scenarios on dialysis related hypotension, venous needle dislodgment and air embolism on 10 November which 9 staff attended, plan to repeat these sessions again in January and February.

Staff confirmed they had completed annual appraisals. Appraisal statistics dated 18 October 2022 confirmed 74% of nursing and midwifery and 78% of allied health care professionals had received an appraisal.

Staff said they had received ‘SAGE & THYME’ training which was designed to train them how to listen and respond to patients, clients or carers, who are distressed or concerned.

Staff received end of life and delivery of difficult news training.

Medical care (including older people's care)

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked across health care disciplines and with other agencies to care for patients. One example was the 9am multi-disciplinary meeting (MDT) meeting with the community stroke team to discuss patients on the acute stroke unit, ward 23.

New medical examiner (ME) referrals were discussed, and actions decided at the daily safety huddle with the head of nursing and associate chief nurse. Weekly meetings took place with governance lead physicians who appointed a structured judgement review reviewer to discuss new ME referrals. Learning and actions from deaths were discussed at the monthly directorate assurance, clinical governance and full Care Group meetings.

Patients mostly had their care pathways reviewed by relevant consultants or senior doctors.

Contact details of the multi-disciplinary team were displayed on ward areas.

The trust met monthly and quarterly with other providers as part of the range of meetings hosted by the Humber and North Yorkshire Cancer Alliance. In July 2022 the extraordinary lung clinical delivery group meeting was arranged to discuss the roll out of lung health check programme across the Cancer Alliance and the expectations for the next 5 years. We also noted that further discussion in this area took place at the quarterly meeting on the 8 August 2022 whose discussions also included targeted lung health checks (LHC) – next steps. Cancer Alliances have been tasked with rolling out LHCs to 100% of eligible population by 2027\28 a 5-year modelling had been done and completed this was on a place-based deprivation basis and validated by Public Health England

Seven-day services

Key services were mostly available seven days a week to support timely patient care.

Discussions at the trust executive committee on the 19 October 2022 confirmed the trust had reviewed the seven-day hospital services clinical standards in 2021. In summary, there was assurance of partial compliance with the four priority standards, with some further detailed audit work required to inform a comprehensive action plan. The work stream was led through the urgent and emergency programme board; accountable to the executive transformation committee.

The trust confirmed that there was a resident consultant allocated to acute medical unit (AMU) between the hours of 9am-10pm seven days per week. Short-term gaps created due to sickness or unexpected absence were covered by the consultant contract which states prospective cover in times of need. The rota was circulated a week in advance to all medical staff who worked on the AMU. Cover for anticipated gaps was negotiated by the acute operational team in conjunction with the acute medicine clinical director and acute physicians.

Hyper acute stroke, respiratory and cardiac patients were seen twice daily by a consultant until a clear care pathway was established.

Staff said consultants had not led daily ward rounds on the emergency assessment unit.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Medical care (including older people's care)

Therapy staff services for ward 23 the acute stroke ward took place from Sunday to Friday with no services on Saturdays. There was a reduced service on Sunday. Staff said a business case had been put forward to increase this service to seven days a week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Patient information leaflets were available on clinical areas which patients, relatives and carers could access.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Following the March 2022 inspection, CQC issued the trust with a warning notice stating that the trust did not have effective systems to ensure staff adhere to the Mental Capacity Act. The trust continued to not have effective systems in place to ensure staff adhered to the Mental Capacity Act.

We found a mixture of practices in relation to the completion of capacity assessments at York Hospital. On the acute stroke unit, ward 23, it was not clear who took undertook capacity assessments.

On ward 21, one patient record confirmed they had Deprivation of Liberty Safeguards (DoLS) and Do Not Attempt Resuscitation forms fully completed.

On the emergency assessment unit, a capacity assessment was not in place for a patient with cognitive impairment assessed as requiring bed rails.

On ward 33, there were three patients whose illness meant staff should have considered and assessed their capacity to make decisions, however this had not been done.

A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order was in place for one patient on Ward 24 deemed as not having capacity with no capacity assessment completed. In addition, no capacity assessments were completed for two patients described as confused.

However, we found that capacity assessments, Deprivation of Liberty Safeguards (DoLs) applications and DNACPR's were completed correctly for the records looked at on Ward 21.

DoLs applications and presence or reference to a capacity assessment having taken place were audited from April to September. Compliance ranged from 0% to 100% for different parts of the process. The clinical areas rated red for completed capacity assessments or having capacity referenced in the patients notes included the acute medical unit and ash ward. The AMU and ash ward were also rated red for 'is there evidence of a DoLs application.

Staff clearly recorded consent in the patients' records and ensured that patients consented to treatment based on all the information available. This was confirmed by one patient who said, 'nothing was done without reason'.

Medical care (including older people's care)

The trust did not currently audit consent processes at York Hospital and was going to review this as part of their work plan.

We found shortfalls in staff training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Nursing staff training statistics confirmed 86.2% had completed training in the Mental Capacity Act and 84.9% Deprivation of Liberty Safeguards.

Medical staff training statistics confirmed 48% (74 of 154) had completed training in the Mental Capacity Act and 39% (60 of 154) Deprivation of Liberty Safeguards.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We spoke with 17 patients across the medical service. Patients said staff treated them well and with kindness, were lovely and helpful. Patients mostly described good care experiences, although, said it could be noisy at night.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way, for example, we say that curtains were drawn around the patient to protect their dignity.

We observed staff assigned to the bay were aware of people's needs and spoke to them with respect. Staff attended to personal care needs and oral hygiene, dignified care and interactions.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

One patient told us that they observed an incident where a dementia patient had been upset and the staff member had managed this situation well and was supportive of the patient.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them.

Staff had received 'SAGE & THYME' training which was designed to train them how to listen and respond to patients, clients or carers, who are distressed or concerned.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff mostly ensured patients and those close to them understood their care and treatment. Staff supported patients to make informed decisions about their care.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

We observed how a nurse involved a patient and ensured the patients understanding when giving them prescribed medication. The nurse checked the electronic prescription chart, asked the patient what drink they would like to take their medicines with. The nurse was respectful and explained the process and assisted the patient to take the tablets.

Staff said patients' feedback from the acute stroke unit (ward 23) had not been collected, listened to or evaluated when collected. Following the inspection, the Trust said that feedback was collected through the friends and family test, although did not provide any further evidence to confirm this for ward 23. Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Patients gave positive feedback about the service.

Is the service responsive?

Requires Improvement ● ↓

Our rating of responsive went down. We rated it as requires improvement.

Service planning and delivery to meet the needs of the local people.

The service planned but did not always provide care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Further detail about the mixed sex breaches we found can be found in the 'access and flow' section of this report.

The service relieved pressure on other departments when they could treat patients in a day.

The standard operating procedure for the emergency assessment unit (v1) detailed the role of the unit in providing patient centred emergency care services for people who would expect to be in hospital between four to 24 hours. The guidance within this policy was clear and informed staff of responsibilities and how the service should operate.

Medical care (including older people's care)

The trust had a system to identify people with cognitive problems or those living with dementia.

The trust also used a booklet titled "What matters to me" to assess specific requirements of the patient with dementia to enable personalised care to be given. This was updated from the previous version and relaunched on the 1 September 2021.

The 'MacMillan Recovery Package' was used in cancer services. This package was referred to as the personalised care agenda within the trust and formed a key part of the trust cancer strategy. The trust implemented risk stratified follow up in the breast, colorectal, lung surgical, early endometrial, low risk melanoma pathways with plans to roll out to prostate. The trust monitored performance via a personalised care dashboard.

The completion of Equality Impact Assessments (EIA) and the process of embedding EIAs into processes for change in terms of policies and services, including transformation was an area of identified development for the Care Group and the trust. The equality impact assessment register showed three EIAs related to medical services; Nutrition, Falls and Self-administration of medicine. The medical service does not have a specific Equality impact assessment currently.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The trust achieved compliance with the Accessible Information Standard (AIS) as one of three agreed equality objectives 2020-2024. The trust had undertaken several initiatives to ensure compliance against the AIS, for example, an on-demand British Sign Language video interpreting was introduced during the pandemic, to support the trusts work on accessible communication in 2021. The roll-out of this facility had been progressed to other trust sites.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had access to communication aids to help patients become partners in their care and treatment.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had information leaflets available in languages spoken by the patients and local community.

Planning meetings took place with medical staff on the acute stroke unit, ward 23.

The trust's baseline assessment for the National Institute for Health and Care Excellence clinical health guideline NG27 was completed as "partial compliant" in July 2016. The Care Group had worked on an outstanding action in relation to NG27 for shared care agreements with patients' carers. It was envisaged that agreements could be personalised to the patient's needs. The clinical educator for community services is working on a proposal for the form the agreement will take. Stakeholder engagement is ongoing.

A "red bag" system was used for patients admitted from a care facility when they bought their passport with them to ensure continuity of care. The passport was completed by trust staff when the patient was ready for discharge.

Medical care (including older people's care)

The trust had created a “what matters to me” document which was completed on admission to the wards; sent home with the patients for use in their home or care facility and with Yorkshire Ambulance Service to enable an effective transition of care. Patients also received a copy of the electronic discharge notification which included details of medication prescribed or stopped and follow up information.

The learning disabilities nurse and specialist therapist supported learning disability and dementia patients. Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports.

Nursing staff identified the patient groups who required enhanced care to maintain their safety or care needs. These patient groups included patients with dementia, confusion, high falls risk and aggressive patients. We saw individual patients’ frequencies of care requirements noted in their enhanced care records, for example, one patient required care checks every 15 to 30 minutes.

On the acute medical unit, a white board which was located in a corridor identified specific patient’s needs, for example, the headings included: jugs (fluids), diet, stool charts, falls, nil by mouth, samples, checks per bed. Staff said they saw this as a good way to see immediately what the patients’ needs were. This information was available to the multi-disciplinary team.

Access and flow

People could not access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

The trust said their access policy followed best practice recommendations and was embedded across the organisation.

Staff described two streams of admission to the acute medical unit (AMU), either through GP referrals each afternoon or from the emergency department. Patients who came straight to the AMU waited in the relative’s room prior to being seen or admission to the ward.

The emergency assessment unit (EAU) opened in August 2022. Admissions activity to the EAU was 849 patients in August and 1010 patients in September 2022. The EAU took referrals from the emergency department, GPs and the wards. Patients returned to the EAU daily for antibiotic therapy, speciality reviews or blood transfusions.

The rapid assessment frailty unit began operating as part of the emergency admissions unit in August 2022 which meant the service operated 24 hours per day, seven days per week. Median length of stay (LOS) for patients treated in the unit until August 2022 remained at five hours, however, this stay increased to as much as 21 hours in August once the unit opened overnight.

The trust had not achieved the referral to treatment (RTT) targets and was currently a Tier 2 trust for elective recovery. This involved fortnightly meetings with the Integrated Care System and regional team to monitor progress on the 78-week target and number of patients over 63 days on the cancer pathway. The trust resubmitted the operational plan trajectory to the region for these targets with an anticipated position of 397 78-week waits by March 2023.

Medical care (including older people's care)

To address the current performance position the trust had implemented an improvement programme to support the trust strategy delivery 'Building Better Care'. This programme had projects which targeted elective care (Maximising elective recovery), outpatients' transformation and cancer and the early diagnosis and staging was part of the programme. The trust had accessed elective recovery monies to establish the programme team, run a full validation of the RTT waiting list and accessed capital funds to establish an elective hub off the main site at York.

The September 2022 performance dashboard for Care Group One (CG1) downloaded on the 14 November 2022 confirmed CG1 had achieved the 78+ week wait with a focus on the elimination of the 52 week waiters. The trust confirmed they had fallen short by 11 patients.

The September 2022 report against referral to treatment (RTT) positions for CG1 included figures over a 14 month period from September 2021 to November 2022. The 18-week performance was 66.5% against a target of 90%. The 52+ week waiters identified 43 waiters. The specialities included in the RTT figures included: acute internal medicine, cardiology, gastroenterology, general medicine, elderly medicine and respiratory medicine. An improvement was noted for the 18-week performance although, it was identified the main worry remained around gastroenterology waiters.

Risks pertaining to the cardio/respiratory service were identified due to the increase in demand and lack of space at the trust. In particular, stress echo was identified as a big risk and this area was a focus of the Integrated Care System.

The September 2022 trust performance report identified ongoing monitoring for lung cancer patients to bring performance into alignment with standards. An improvement was seen against the lung cancer faster diagnosis standard from September 2021 (45.5%) to August 2022 (73.3%). The 31 day treatment standard was between 88.9% to 100%, whilst the 62 day treatment metric over the same period ranged from zero to 64.3%. Performance in December 2021, April, June and August 2022 was between 60% to 64.3%.

A team of seven RTT pathway trackers (five WTE) worked with the trust's Care Groups to validate and track patient pathways and held meetings fortnightly at specialty level. Earlier in the year the majority of RTT treatment waiting lists were reviewed by an external company with less than 2% of reviewed pathways having their clocks stopped.

Over the last 12-months York Hospital met report turnaround times for medical staff requesting diagnostic imaging and endoscopy. The referring clinician referred to reports from live systems immediately after the scans are taken.

The trust retained high levels of patients with no right to reside. These included local authority patients, domiciliary care, nursing and care home challenges. The service met weekly with the chief executive officer, local council, integrated care system, director of nursing and local place director. On the 11 October 2022, 88 patients with no right to reside remained in the hospital. The trust opened residential capacity to just over 100. Fifteen patients were moved to ward 29 and a spread in elderly medicine areas. Approximately 90% of delays were in medical and elderly specialities. Minutes from the Digital, performance and finance committee dated the 19 October 2022 confirmed discharges by 5pm had remained relatively static in September, at 63.3% against a target for 70%. The trust continued to work with the York system rapid quality review action plan to reduce system delays. The trust had increased the capacity of the York Care Unit and supported trust wide recruitment days.

The trust opened ward 29 as a delayed transfers of care ward. This ward accommodated medically fit to discharge patients. The 15 bedded ward opened two months previously now accommodated 19 patients with low care needs. We were told that the delays in discharge were usually due to patient care packages being agreed and/or care home beds not being available. Staff confirmed these patients discharge plans were not always fully in place which meant discharge plans needed to be completed prior to discharge.

Medical care (including older people's care)

On the 11 October 2022 12 medical outliers which included Covid patients occupied surgical beds.

We observed mixed sex breaches on the Emergency Assessment Unit (EAU) Frailty unit on the 13 October 2022 where men and women were sharing the same area. Staff said there were often mixed sex breaches in the frailty unit for days. The mixed sex breach was raised with senior staff later that day. Staff said they had been discouraged from reporting the mixed sex breaches through the trust incident reporting system.

The mixed sex audit report dated 26 September 2022 confirmed 32 patients were reviewed over a two-week period, of which 24 patients had waited for a bed for more than four hours after the decision to admit. Three recommendations resulted from this report which included correct patient selection, a definition of the area was to take place and a walk round was to be arranged. The outcome of these recommendations is not known.

On the EAU staff said daily consultant ward rounds did not occur which in turn impacted patient flow as patients could not be discharged. This also resulted in patients being held in the emergency department due to no spaces being available on the EAU.

Staff said patients were not seen on time in the EAU due to lack of medical support, especially overnight as there were no doctors to assess the patients. Staff said they would contact an on-call doctor for support.

Over the last three months York hospital statistics confirmed a total of 666 patients were moved between wards at night; 303 patients originated from the acute medical unit (AMU).

A trust discharge policy was in place and was undergoing review.

The trust implemented pathways to support the management of complex patients and discharge across the York locality, in collaboration with both the Local Authority and Integrated care system and local Place based commissioners. A discharge command centre was implemented to centrally manage all patient referrals who were medically optimised, ready for discharge and required health or social care support, using a single trusted assessment document for pathways 1-3. The York command centre operated seven days a week 8-6 Monday to Friday and 8-4 Saturday and Sunday. The command centre was staffed by a range of specialist discharge liaison nurses and support staff who triage referrals and allocated a lead agency for that patient who took responsibility for coordinating the discharge with the ward.

Care Group 1 completed a weekly programme of scrutiny on discharges to promote flow and reduce length of stay. External partners attended the cross-site discharge improvement group for CG1 and CG2 where discharges, complaints, incidents data and improvement plans were shared and discussed. Ten discharge related incidents from July to September 2022 were documented in the discharge improvement group minutes at York Hospital. The main themes for this quarter were discharge with no medication, the incorrect medication or no drug chart so medications are unknown. This was followed by no care support where care package was not in place.

The discharge lounge operated from 8am to 8pm five days a week and on a weekend between 9-5pm. A nurse was present from 10am to 6pm, otherwise, a healthcare assistant was present. Staff described staffing as safe, there was always one staff member in the discharge lounge. The discharge liaison officer contacted the discharge lounge and informed them of potential patient discharges. Patients were identified by which chair they sat in and whether they had a do not attempt resuscitation order. Pharmacy was contacted if patients needed discharge medicines. If patients became poorly, staff asked the ward sister to check the patient. Patients were given drinks and food if required. Three patients confirmed positive experiences whilst waiting in the discharge lounge.

Medical care (including older people's care)

Discharge planning started immediately and happened in a timely way, obstacles in the system postponed discharge. We saw examples of people medically fit for discharge that remained residing on wards.

Virtual frailty sessions take place at the patient's home as a means of monitoring and supporting them rather than admitting them to hospital.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The service clearly displayed information about how to raise a concern in patient areas.

Patients, relatives and carers knew how to complain or raise concerns. Staff said patients' feedback from the acute stroke unit, ward 23 related to the lack of rehabilitation as part of their care pathway.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

The top three reasons cited in PALS and complaints in November 2021 were: staff attitude, care needs not being met, and communication. The themes of hygiene needs, nutrition and hydration, staff numbers and discharge are already identified as areas for improvement at local level from the combined patient experience data sources.

Is the service well-led?

Requires Improvement ● ↓

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced however, actions to mitigate risks were not always timely or effective. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The Care Group 1(CG1) organogram confirmed leadership within CG1. The director associate chief nurse and associate chief operating officer were supported by matron's, heads of nursing, operational managers and clinical directors.

Matron's (Band 8) were responsible for a cohort of acute / chronic medical wards and visited their areas every morning to be updated to what is happening with bed status and staffing.

Medical care (including older people's care)

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, however, not all staff were aware of what the strategy involved. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood and knew how to apply them and monitor progress.

The Care Group one (CG1) strategy identified their key challenges and how with partnership working these challenges would be resolved. In year one (2021-22) the areas of focus were identified along with individual speciality focus plans for urgent and emergency care, lung cancer and frailty and same day emergency care. The strategy also supported the delivery of clinical care models and integrated care.

Not all staff understood the service's vision and values, and how to apply them in their work, at ward level we were told each ward was to be asked to develop their own strategy with guidance from the trust. Some staff knew a strategy existed but could not describe it.

The trust strategy 'Building Better Care Together' set out the clinical care models for the organisation and identified several 'high impact interventions' to support the delivery of the strategy and drive the recovery of the trust following the impact of the COVID-19 pandemic. The scope of the programme was approved in June 2021, with the project team in place by the Autumn. The programme was resourced through a blended model of substantive staff contributing time to 'Building Better Care', external project professionals and fixed term project posts. Responsible owners were identified from Care Groups and corporate teams with Care Group directors as clinical leads. The responsible owners led the programme of work across all Care Groups.

'Our cancer strategy – 2020-2025' was developed by the trust and defines its mission, vision, themes, foundations, values and strategic partnerships.

A comprehensive implementation plan for year 2 of the Dementia Strategy (2021-2024) 2022-2023 was in place.

Culture

Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Team working was positive across the service. Positive cultural work to introduce new international recruits included having people make things from their home country, a beach party and Christmas tasting sessions from each person's country.

Through observation and discussion with different grades of staff on ward 21 and the frailty assessment unit we identified a mix of views where some staff said they felt supported by their peers and management, whilst other staff described low morale.

Staff could access a freedom to speak up guardian. Freedom to speak up policy guidance (v11) was in place and was past its review date of February 2022. The trust had received several whistle blowing concerns since September 2021; the trust confirmed no further concerns had been raised since August 2022. The information provided confirmed the outcomes of the investigations and what support had been put in place for staff.

Staff told us that they could self-refer for six psychology or counselling sessions.

Flexible working agreements could be agreed.

We were told that stress risk assessments were completed with the agreement of the staff member and actions put in place.

Governance

Leaders operated governance processes throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities. Staff had regular opportunities to meet, discuss and learn from the performance of the service.

Governance reporting structures reported into the board of directors. Decision making took place at the executive committee, corporate enablers (for example finance), care group boards, oversight and assurance committees. The trust had a wide governance membership which reported into the board of directors and care groups. These groups included the quality and patient safety group, sustainability committee and quality and safety care group meetings.

Monthly audit reports with information broken down by speciality were shared. We saw evidence that clinical audits and tendable auditing had taken place. Quality Committee meeting minutes from September to November 2022 confirmed updates were given to summarise the key information, assurances and escalations from national mandated audit. These reports also confirmed that overdue actions were shared with Care Group Governance mailboxes for action.

Local nursing themes and trends were highlighted through weekly, monthly and quarterly tendable audits. The tendable audit outcomes were shared by matrons as part of the monthly assurance process.

The Quality committee had a standing agenda item for infection prevention and control updates and discussion with attendance from one of the team. Monthly updates were given.

The deteriorating patient group was a sub-group of Quality and Patient Safety Group (QPAS) and represented a trust wide approach to sepsis, deteriorating patient and resuscitation.

Monthly and bimonthly medical speciality meetings took place throughout the service, for example, the renal and gastroenterology specialities held bi-monthly clinical governance meetings.

The trust dementia improvement group met six weekly and medical care groups were represented by the relevant matron.

Board assurance around cancer waiting times was identified through the chief operating officer’s report on the 2 November 2022 and was presented to the board of director’s meeting. The report confirmed the trust remained off plan for the 78 week and cancer trajectories and had resubmitted updated trajectories as requested by NHS England regional team.

Management of risk, issues and performance

Systems to manage performance were not always seen to be effective as some of the areas identified in the previous CQC inspection had not been fully implemented. Risks were identified in other areas; actions identified to reduce their impact and plans were in place to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Medical care (including older people's care)

Managers did not act to improve all the areas of concern identified by the previous inspection. This was because effective systems were not in place to ensure staff adhered to the Mental Capacity Act. Patient risk assessments and care provided in relation to pressure damage and falls prevention had improved; however, we could not be assured that all patients who required these assessments had them completed on admission to the hospital.

Performance delivery was managed through Care Group operational teams, with regular discussion with the chief operating officer and the deputy director for performance and planning.

To address the current referral to treatment (RTT) performance position the trust implemented an improvement programme to support the trust strategy delivery 'Building Better Care'. This programme had specific projects which targeted elective care, outpatient's transformation and cancer; early diagnosis and staging as part of the programme. The trust had accessed elective recovery monies to establish the programme team, run a full validation of the RTT waiting list and accessed capital funds to establish an elective hub off the main site at York. A weekly performance update was sent to corporate directors, Care Group leaders and business managers, monthly reports were sent to the digital, finance and performance committee, and up to the trust board through the trust priorities report. However, at the time of inspection referral to treatment times were not achieved.

The trust had engaged with the Integrated Care System to access mutual aid from other Trusts and had commissioned insourcing for theatres and previously for endoscopy. An interim Improvement Director was appointed to support performance recovery. The trust had committed through the Executive Transformation Committee in October 2022 to explore further outsourcing options for additional capacity, a revised approach for pensions to support take up of extra contractual activity and a focus on increasing first outpatient capacity back to planned levels. The trust also agreed to increase administrative resource to support patient bookings and outpatients.

York medical specialities risk registers were discussed as part of the governance report at the Care Group assurance meetings. To ensure oversight and assurance for the care group risks of 16 or above submitted a risk application template for the risk assurance meeting monthly. Going forwards, risks of 10 or more would also require a risk application.

Staff confirmed some of the risks for medicine such as consultant staffing, delays in emergency department treatment and the hospital building being fit for acute care. The medicine risk register identified these areas and others as risks to the service.

Multi-disciplinary daily operational meetings captured risks, concerns and staffing issues. Discussions included intensive care admission capacity, operational pressure escalation levels, breaches and bed status, reparations, discharges/ delayed discharges and infection prevention and control status.

Monthly monitoring of Care Group 1's performance was presented to the trust board through performance reports. The October 2022, 'Our People Executive Committee Report' updated the executive board on key performance indicators and risks in areas such as vacancies and staffing.

Patient safety topics and updates which included incidents, falls and pressure ulcers were discussed at the Care Group 1 quality assurance committee and documented in the quality and safety assurance report dated 19 September 2022. All wards had individual improvement plans in place which related to the fundamentals of care. The creation of a fundamental of care dashboard through tendable was in progress.

The head of nursing attended the c-difficile cross-site Improvement group where themes from investigations were discussed along with pro-active planning to reduce the trust incidence of c-difficile. This was chaired by the assistant chief nurse and had representation from microbiology, infection, prevention and control, facilities and each Care Group. The Care Group medical director represented the Care Group from a medical perspective.

A trust-wide monthly local safety standard for invasive procedures (LocSSIPs) improvement group was established in October 2021 to oversee effective implementation of safety checklists and procedures for invasive procedures across the trust. The group reported to the quality and patient safety assurance committees to ensure corporate governance and oversight of its activity. The project plan had largely been delivered to ensure all invasive procedures had appropriate checklists and procedures in place and that these were audited regularly to ensure adherence and identify any gaps or omissions for further actions or learning and improvement.

The Trust 'Emergency Preparedness, Resilience and Response (EPRR) Policy' identified how the trust would prepare for, manage and maintain services during emergency situations.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The electronic patient record commenced within Care Group one (CG1) in September 2022, with a full roll-out of phase one completed in October 2022. On the York Hospital site staff had access to numerous computer terminals and this new information technology (IT) system was being introduced across the medical wards. New care planning and risk assessments which could be personalised formed part of this new IT system. This new IT system had not yet been introduced on the emergency assessment unit.

The new IT system was introduced to ward 21 six-weeks ago. Staff said they really enjoyed using the system. Patient care plans, admission information and risk assessments were completed on this system. When assessments were not completed these flagged on the patient's electronic record to alert staff to complete this assessment.

The system was currently being embedded within the Care Group and an information dashboard is in development to enable staff at ward level to audit the completion and reassessment of risk assessments for their patients. Currently, ward managers requested the information they required from the Nucleus information team at York Hospital in relation to the fundamentals of care and any individual patient data requests for investigations.

Phase one of Nucleus was able to generate reports for falls, purpose T and nutrition risk assessments. These reports were currently collated and disseminated to ward managers and matrons within CG1 at the end of a calendar month.

Nurses used iPads and phones to record and update patients' information, risk assessments and care plans.

Safeguards were in place to protect patient information using passwords and staff IT swipe cards.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups and the public to plan and manage services.

Medical care (including older people's care)

The service used the friends and family (F&F) test to capture patient feedback. Throughout the service we saw friends and family information posters displayed. The top issues identified by F&F respondents in November 2021 were waiting times, communication (including attitude of staff), and low number of staff on duty. The themes of hygiene needs, nutrition and hydration, staff numbers and discharge are already identified as areas for improvement at local level from the combined patient experience data sources.

The 2021 survey sample was taken from adult patients discharged from inpatient care in November 2021. The national response rate was 39%. The York hospital survey invited 1250 people to take part which gave a response rate of 39% compared with 47% in 2020. The largest number of responses came from people 66yrs and over (64%). Physical or mental health conditions, disabilities or illnesses were declared by 83% of people.

The trusts top five scores were in the areas of leaving hospital and food ratings.

The trust's bottom five scores were in the areas of care and treatment, hospital and ward, leaving hospital, and nurses. The trust confirmed that responses about support given by staff to meet 'fundamental care needs' had deteriorated, including getting enough help to wash or keep clean and to eat meals, as well as being able to get help from staff when needed. Hospital discharge remained a challenge for all. Actions were identified following this patient survey, for example: Questions asking patients about whether they were able to have a wash and clean their teeth were now included on Tendable. There were weekly and monthly question sets. Matrons also did daily checks regarding delivery of fundamentals of care and these were escalated at staffing meetings held twice daily. Results for the six months, April 2022 – October 2022 showed that both questions scored over 92% every month.

A recent internal snapshot patient experience survey of 254 patients showed that most patients had had their hygiene needs met that day.

The 2021 staff survey response rate was 40% (benchmark 46%). An improvement plan was developed by the trust which comprised of nine promise elements which identified the element score, actions, timescales, accountable team members, measures and other comments. The elements included: discrimination, bullying or violence, inclusion, recognition and reward, confident to speak up, safe and healthy. We observed that the trust scores mostly fell just below average scores, although, some areas scored average or just above. Timescales were identified, the majority being the 31 March 2023, although, we observed some areas had been completed in a shorter timescale, for example, the staff brief started in July 2022.

Staff said the Nursing Council started pre-Covid and was where the nursing voice was heard. The plan was to link nursing staff to different areas, for example, equipment so that the nursing voice can contribute to these areas.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The stroke pathway was an example of stakeholders working with the quality improvement (Qi) methodology to address quality issues identified by clinicians. The trust six stage QI methodology was based on the model for improvement and the team were working through the stages. There was evidence of using cause and effect methodology, staff discovery interviews, process mapping the pathway in-order to diagnose the problems which will then become part of a project aim and supported driver diagram. A project plan was owned and delivered by the Care Group.

Medical care (including older people's care)

A development group was established for fractured neck of femur on the York site to address the time from presentation at the emergency department (ED) to operation which was above average. Following work with stakeholders over the past 18 months and using Qi methodology, the trust position was now below the national average. There was now a clear process for managing the patients from presentation in ED and all were clear of their roles and responsibilities. This work had been shared with the Scarborough site who were now adopting some of the learning. It had also encouraged cross site working with clinicians and agreement of standardisation of processes.

Another example of continuous improvement was in diabetes. There was a response to incidents around diabetic ketoacidosis and a stakeholder group was established to identify the issues and a driver diagram developed to address the problems. This group had very recently recognised the benefits of this group and requested that a diabetes continuous improvement group, was established with wider stakeholder engagement. Themes from diabetic patient incidents will feed into this expert continuous improvement group.

The trust had planned to implement electronic remote monitoring when the Somerset Cancer Registry software was fully implemented which was expected to be completed by the end of March 2023; currently, site-specific teams kept individual spreadsheets to track patients on remote monitoring.

Maternity

Inadequate

Is the service safe?

Inadequate

We rated safe as inadequate.

Mandatory training

Midwifery and medical staff did not always meet the trust target for mandatory and role specific training.

The overall compliance for midwifery staff was 80% which did not reach the trust target of 85%. Of the 17 statutory training courses, only six had a completion rate of over 85%. Sepsis awareness training compliance was 83%. None of the required learning courses for midwifery staff achieved the 85% target.

The overall compliance for medical staff was 71% which did not reach the trust target of 85%. Only three of the 15 statutory training courses had more than 85% completion rate. Sepsis awareness training compliance was 37%. None of the additional learning or required learning modules achieved the 85% target.

Additional clinical staff which included healthcare assistants and midwifery support workers had an overall completion rate of 73.0%. This did not meet the trust target of 85%. Only five of the 20 statutory training courses had more than 85% completion rate. Sepsis awareness training compliance was 61% completion rate. None of the seven required training modules achieved the 85% trust target.

Staff we spoke with told us they did not have protected time to undertake mandatory training and staff were regularly requested to return to work clinically.

The mandatory training was comprehensive and met the needs of women and staff.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Midwifery and medical staff did not always meet the trust target for safeguarding training however they knew how to recognise, and report abuse and they knew how to apply it.

The overall compliance for midwifery staff was 86% for safeguarding adults' level 2 and 80% for safeguarding children level 3. They were 82% compliant for PREVENT awareness level 3. This is training designed to prevent radicalisation, extremism, and terrorism. This meant midwifery staff did not reach the trust training target of 85% in safeguarding level 3 and PREVENT training.

The overall compliance for medical staff was 75% for safeguarding adults' level 2, and 71% for safeguarding children level 2 and 60% for children level 3. They were 76% compliant for PREVENT awareness level 3. Medical staff did not reach the trust training target of 85% in all aspects of safeguard training.

The overall compliance for additional clinical staff which included healthcare assistants and midwifery support workers was 84% for safeguarding adults' level 2, and 81% for safeguarding children level 2 and 83% for children level 3. They were 87% compliant for PREVENT awareness level 3. This meant clinical support staff did not reach the trust training target of 85% in safeguarding level 2, safeguarding children level 2 and 3.

All staff we spoke with confirmed they had received, and mostly kept up to date, their safeguarding training.

We saw whiteboards in various managers offices which showed high levels of compliance with children and adult safeguarding training (levels 2 and 3) for triage and labour ward for April 2022.

Midwives undertook refresher safeguarding supervision training four times each year and compliance rate was 96%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a woman's mental health. We reviewed an individual crisis plan which was appropriate for a woman who had mental health concerns.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. However, they reported that the safeguarding team were not always responsive or supportive when there were safeguarding concerns and had rarely attended the units. This meant that staff were left to manage the safeguarding concern without their support.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect women, themselves, and others from infection. However, they kept equipment and the premises visibly clean.

We found several areas of concern in the theatre areas relating to infection control risks.

We observed ineffective skin preparation during a caesarean section which was not in line with manufacturer guidance. Staff told us one of the three birthing pools had been closed because of a positive test for e-coli which is a water-borne infection. However, the safety sign had been removed which was a risk as staff could have used this pool in error. We saw a visibly corroded trolley which was used to store theatre consumables and a tripod theatre stool which had ripped covers covered with tape. Staff were unsure of the policy or the process when asked how often theatres were deep cleaned.

We escalated some of these issues at the time of the inspection. Senior leaders provided assurance by completing a specific, measurable, attainable, relevant and time based (SMART) action plan to address concerns highlighted. These included a replacement trolley; handovers would include skin preparation and the commencement of skin preparation practice audits to ensure effective and safe practices.

Staff told us that theatre daily cleaning was the responsibility of the main theatres, however we heard this was not prioritised and staff had to escalate this on a regular basis.

Ward areas were mostly clean and had suitable furnishings which were clean and well-maintained. We observed cleaning being completed in clinical areas. The service performed well for cleanliness. We checked cleaning records which were up-to-date and demonstrated all areas were cleaned regularly. However, the national patient led assessments of the care environment (PLACE) inspections had not taken place since 2019.

Staff followed infection control principles including the use of personal protective equipment (PPE).

We received information from 17 women who said that the cleanliness of the units / ward was “extremely clean”, “exceptional” and staff constantly cleaned the wards.

We revisited the service six weeks following the original inspection and found additional concerns. The care groups smart action plan stated the theatre storage trolley had been replaced. However, when we re-inspected the theatres, we found the same corroded trolley in use. The tripod theatre stool was still in use and had not been replaced. We observed a room on the labour unit ready for use which had a soiled towel with blood stains stored in a dirty linen trolley. We also noted a cracked wall surface behind the hand sink in the same room which was an infection control risk.

The care group provided information to clarify actions taken to address concerns raised. Infection control champions (IPC) had recently been appointed across maternity. A matron was leading on this piece of work linking with IPC to understand specific training moving forwards.

Aseptic non-touch technique (ANNT) training had not been a focus but had now been added to core training with a plan being prepared to progress training in 2023.

Senior leaders confirmed that environmental audits were to be completed for all theatres commencing 2023.

Environment and equipment

The design and use of facilities and premises did not always keep women and staff safe. They did not always manage the safe storage of clinical waste.

We found several areas of concern in the maternity unit and theatres relating to environmental risks. The theatres were not large enough to accommodate the amount of staff required and also birthing partners during a procedure.

The theatres entrance doors did not have swipe card access. The theatres did not have signage to demonstrate they were in use when undertaking minor and or major cases including caesarean sections. This meant these areas were accessible to all staff, women, and their visitors. There was a potential risk of lack of privacy and dignity for women and an increased risk of infection.

We observed a storage room door left open on G2. The room did not have a digilock to ensure secure storage of items. The room contained consumables for the ward including, sharps, venflons and intravenous fluids (IV) etc. Staff told us storage was an issue in this area since the recent merge of the two wards (G2 and G3).

We observed a clean utility door left open on the labour unit. The room did not have a digilock to ensure secure storage of items. The room contained consumables for the ward including, sharps, venflons and intravenous fluids (IV) etc.

We saw sharps boxes not being stored in line with trust guidance. They were stacked on top of each other, were overfilled and being used to store a liquid. This meant staff did not always store clinical waste safely.

We revisited the service six weeks following the original inspection and found additional concerns. We observed the clean utility door left open on the labour unit, there was digilock in place. This room was used to store controlled drugs, emergency trollies containing drugs a drugs fridge plus general storage. We had escalated this with senior management at the time of the last inspection; however, no action had been taken to address the risk.

Maternity

We found a general storage room in use on the labour unit which contained general stores for midwifery community services. The room was unlocked and contained boxes of consumables and oxygen cylinders stored on the floor. We also noted the room contained large amounts of alcohol hand gel and chlorhexidine solution. We found an unlocked storage room for theatre stores with a full trolley of needles and boxes of blades and equipment was stored on the floor.

We had several areas of concern in the maternity unit and theatres relating to fire risk. There was a single fire exit which could only be accessed via the theatre two doors. However, this door was bolted during procedures as advised by the infection prevention control team.

This was a risk as the only other access to the theatre was via a scrub room side door which was not wide enough for beds or resuscitation equipment to be moved in the event of a fire or cardiac arrest.

We found both operating theatres to have limited space for the storage of theatre equipment. We observed a caesarean section in theatre two and observed a baby resuscitaire blocking the fire door exit.

Staff we spoke with confirmed there had been no recent fire safety drills. We escalated this at the time of the inspection. The care group provided immediate assurance by instigating fire drill training and an updated standard operating procedure (SOP) which was shared with staff

Following a review of the policy relating to modified early obstetric warning scores (MEOWS) we had significant concerns how staff would transfer women from the labour ward to intensive care or high dependency unit. The policy stated that "staff had to use the fire exit at the opposite end of the unit. The key for these doors were kept in the key cupboard behind the desk on labour ward. Staff were advised that the fire alarm would sound when these doors are opened and advised they would need to reset the alarm using the keypad next to the intercom once the doors are closed".

This was scored as significant on the care group's risk register and had a review date of 17 October 2022. It was unclear how long this had been a risk.

We escalated this at the time of the inspection. The trust provided information to say they had completed a fire risk assessment which confirmed the single fire exit door was a legacy door and was not part of the fire evacuation strategy. This was because there were three double exit routes from theatres. The fire exit signage had been removed and a push bar was planned to be fitted on the door if it was retained as a potential ambulant exit for any future evacuation plan. The care group clarified that the single fire exit in theatre two was to be removed and building work was planned to instigate this.

We observed large metal storage cages containing stock consumables directly opposite the labour unit's main entrance. There were differing stock items within the delivery; some consisting of sharps (needles & venflons). Staff told us the deliveries of stock were managed by the stock management team. Stores were distributed from the cages into the labour unit twice weekly.

This was a security and fire risk as the main corridor was accessible to all staff, women, and their visitors. This risk had been escalated by staff previously; however, stores deliveries continued to be managed in this way and was seen on our return visit.

Maternity

We revisited the service six weeks following the original inspection and found additional concerns. The trust provided a smart action plan following concerns raised at the first inspection which stated they had completed a full review of the departmental risk assessment and they were fully compliant with the fire evacuation plan. This confirmed there were three double exit routes from theatres.

We observed the fire door which led to the main corridor and was used for the transfer of women to HDU/ITU/ICU. This fire exit was blocked during our inspection with a baby resuscitaire and a ventouse machine. Staff told us that this fire exit was locked due to the risk of potential baby abduction.

Senior staff informed us that agency staff were not informed of the fire exits/key access and there was no evidence to support agency staff induction surrounding this.

We found that not all staff had swipe access to exit this fire door. This included the coordinator in charge of the day shift on the day of inspection and the labour unit manager. We escalated this to senior leaders and requested evidence to confirm all eligible staff had access. However, the information we received did not provide assurance. This meant we were not assured of the safe evacuation of women, their partners, babies, and staff in the event of a fire or transfer to HDU/ITU/ICU.

We also observed the corridor leading to G2/G3 was partially blocked with stores deliveries stored in metal cages. We had escalated these concerns following the first inspection; however, the risk had not been mitigated. We also observed trailing wires on the theatre one floor on the labour unit which was a slip and trip hazard. There was no dedicated rubber seal cover in place to mitigate the risk.

We escalated concerns with senior leaders and requested an immediate zoned fire test to be instigated to observe the release of the emergency exit leading to HDU. The fire test evidenced that the doors did not release during a zoned test. Senior leaders instigated an immediate review and escalated to board directors. Due to the immediate safety risk, we escalated this externally to the local fire service. Senior leaders told us they had commenced immediate review and repair of all fire doors within the trust. The review highlighted seven double fire exit doors at the York site were found to be faulty this included two of the fire exits on the maternity unit. The trust clarified an external review of all fire exits would be instigated. We saw staff relocated the metal cages to a storage space on G3 which mitigated the fire risk.

We had several areas of concern in the theatres in relation to reduced air ventilation. We observed the entrance door into theatre one propped open. This impacted on the reduction of air flow ventilation. We observed the doors within theatre two were bolted closed during procedures to improve air flow. Staff informed us this was a recommendation from the infection prevention control team following an increase in post-operative infections.

We escalated these concerns with the maintenance team who gave assurance that the air flow system was effective and working. The team acknowledged that the “air flow was reduced when and if the door was left ajar”. There was a sign on the theatre to indicate that the door must be closed at all times.

We escalated this post inspection with the senior leadership team. Senior leaders provided actions which included process mapping of the patients journey through theatre in relation to infection risk and the removal of the bolts from the theatre doors.

Maternity

We requested the Department of Health guidance Health Building Note 09-02 (HBN) yearly maintenance schedule to evidence the quality assurance on air flow. HBN 03-01 guidance recommends, 15 air changes per hour with a negative pressure. In birthing rooms and recovery areas where analgesic and anaesthetic gases are exhaled, the ventilation rate should be of sufficient capacity to control substances within the appropriate occupational exposure limits (COSHH).

The trust provided data for both theatres which showed their last annual ventilation inspection was undertaken in July 2021 for theatre one and April 2022 for theatre two. The inspection highlighted a number of concerns surrounding the duct work, air flow in and out and room air changes. The report recommended 'due to the bespoke design away from the recommended standard lay-outs of HTM 03-01, the external company who undertook the inspection considered 'maternity theatre 1' more of a delivery room rather than an operating theatre. There was no separate anaesthetic or recovery area as seen in most other maternity theatres and no prep area.

We requested actions taken by the trust to address the concerns raised in the annual inspection reports. The trust clarified that the director of estates was working with the maternity department to share updated action plans. Data evidenced the annual validation inspection for theatre one had not been completed as planned in November 2022. Remedial works had been intended to be completed prior to the revalidation inspection. However, works were not undertaken as the theatre was required to close for works to be completed over a three-day period.

Senior leaders informed us they met on the 10 November 2022 to consider next steps in terms of refreshing the refurbishment programme and backlog maintenance schedules to prioritise maternity theatre improvements required. This was considered in the context of the trust's capital investment prioritisation process for 2023-24 in readiness for submission to corporate finance team in January 2023. This remained a risk as theatre one did not meet all HTM 03-01 recommendations.

The annual validation inspection for theatre two had been completed. The estates team were working through remedial actions recommended by the external company.

The trust provided data to evidence a dedicated separate infection control (IPC) maternity theatre oversight group had been established. The immediate actions for this group were to support understanding and mitigate current IPC and health & safety risks with the current maternity theatres at York.

The maternity units were clearly signposted and easy to find. The entrance onto labour unit including antenatal and postnatal wards were covered by CCTV and entrance was accessed by swipe card only.

Staff carried out daily safety checks of specialist equipment.

Assessing and responding to patient risk

Staff did not always have available cardiotocography (CTG) equipment to assess and monitor women at all times. They did not have oversight of women who were high risk waiting in the triage area. The baby security tagging system was not effective. Staff did not always complete or update risk assessments for every woman.

Staff used a modified early obstetric warning score (MEOWS) which was a national recognised tool to identify women at risk of deterioration.

We reviewed the peer review audit completed for MEOWs (September 2022) and this showed that staff did not always comply with the recording of observations in line with process and did not meet the trust target of 90%.

Maternity

We were not assured that all junior and senior medical doctors had completed training for risk assessments through pregnancy. The training compliance rates showed 53% for January 2022 to September 2022.

Staff told us that MEOWS were recorded on paper records and the process was to upload to the trust's electronic platform retrospectively. However, staff told us this was not always completed due to staffing shortfalls. We found evidence to support that MEOWs were not being accurately completed and escalated.

We were not assured the care group had oversight of the ongoing risk given as this had been flagged as a should do action at the last inspection.

We reviewed clinical governance meeting minutes (August 2022) which confirmed MEOWS compliance remained low at 68%. Senior leaders had planned to instigate ward rounds to ensure every woman admitted to G2 had the correct MEOWS frequency updated. They planned a daily presence to ensure that this was happening alongside a weekly MEOWS newsletter; however due to gaps in leadership this was not instigated.

We had significant concerns regarding the availability of CTG machines. There were only 11 machines to monitor fetal well-being available across the care group. Staff raised safety concerns about not being able to continually assess and monitor fetal heart rates. There was no central monitoring or telemetry available on G2. Although this was in place on the labour unit there was no telemetry as this was broken. This meant there was a risk to women and unborn child due to lack of effective monitoring.

We escalated this at the time of the inspection. The care group provided assurance by completing an action plan to address concerns highlighted. They had ordered 20 new CTG monitors which were expected to be delivered by 30 November 2022. The systems and networks team had agreed immediate resource to install the new machines at point of delivery. Daily handovers were to include a dedicated review of CTG monitor availability and would confirm any incidents when they were not available.

We were not assured that the immediate risk had been fully mitigated given the low numbers of CTG machines, reduced telemetry, and no central monitoring (G2) and the high acuity and demand on the unit.

Staff told us CTG training was often missed due to time restraints on the training day. This meant we did not have assurance staff were competent in their roles.

We found significant concerns regarding the resuscitation call bell on the triage assessment unit which was located on G3. This alarm call could only be heard on G3 which was currently closed and had been merged with G2. Staff working on G2 confirmed it was difficult to hear this alarm in the event of an emergency. We escalated this at the time of the inspection. The care group provided assurance by completing an action plan to address concerns highlighted. Actions included the instalment of a new emergency call system for installation on G2 & G3. The system was fitted and integrated across G2, G3, triage and the labour ward.

We had significant concerns regarding the process management for security tagging of new-born babies and staff told us they had issues with the security tags which set off alarms when transferring babies to different areas on the unit. We were informed of a recent incident surrounding a safety alert due to the lack of activation of security tags. This investigation highlighted that tags were falling off easily and were not fit for purpose. A spot check on one ward in October 2022 identified only five out of 12 babies were wearing tags. We were informed there had been no recent baby abduction drills or related audits. Following the inspection senior leaders informed us they had planned an abduction policy walkthrough and drill.

Maternity

On our second inspection we observed three babies on a different ward who had not been security tagged. We escalated this at the time to the labour unit manager who assured us this would be addressed immediately. We were not assured of senior management oversight of the ongoing risk.

Staff told us they had requested the need for ligature cutters on the emergency trolley, however these had not been supplied at the time of inspection. There was no evidence to support that ligature risk assessments had been completed.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. The unit had no safe rooms for women who presented with mental health concerns. Staff told us that 1:1 care would be provided for these women. Staff had requested emergency panic buttons to wear; however, these had not been provided at the time of inspection.

Shift changes and handovers included all necessary key information to keep women and babies safe. We observed both midwifery and medical staff handovers during the inspection. We found the midwifery handover on antenatal and postnatal ward areas included key high-level information for each woman on the delivery suite and then a more in-depth handover between individual staff members was then completed.

Staff told us they had completed emergency retrieval scenarios for the birthing pool and showed us the equipment required.

We revisited the service six weeks following the original inspection and found additional concerns. We were not assured there were effective systems and processes in place for managing and responding to patient risk. This was to ensure all mothers and babies who attended the unit were cared for in a safe and effective manner and in line with national guidance.

We reviewed three patient medical records which showed incomplete assessments of risk and plans of care to mitigate such risks which exposed women and babies to the risk of harm. In one medical record we found one woman had an arterial line which was being managed on the labour unit. This was not line with the trust's "MEOWS guidance May 2020 v7" which stated that the management of women requiring invasive monitoring should be transferred to HDU/ICU/ITU. Senior managers acknowledged that midwives were not trained or competent in the management of women requiring high dependency care.

We reviewed eleven medical notes which showed staff were not interpreting, classifying, or escalating CTG appropriately. We found that "fresh eyes" had only been appropriately completed every hour for one patient. The CTG documentation was poor and not in line with NICE guidelines: Fetal monitoring during labour (June 2020). This meant that there was still a risk that women and their babies were exposed to the risk of harm. Staff were still unable to continually assess, monitor and identify deterioration of fetal well-being which meant there could be delays in responding to deterioration.

We revisited the triage assessment unit which was allocated on G2. The unit was open from 7am until 10pm, outside of these times women were triaged by midwifes on G2. There was a dedicated triage team. We reviewed 21 triage assessment forms. These showed there was a lack of information to support decision making and showed poor documentation compliances such as dates, times, length of calls and staff signatures.

Maternity

The triage unit was a three bedded bay. There was also a seated waiting area directly outside on a corridor which was not visible to staff. We spoke with women who were still waiting to be reviewed after an hour and in considerable pain. We noted that triage staff were also using beds in single rooms on G3 ward which was closed. Staff told us they used these rooms as overflow during peak activity. There was no call bell for these patients who had the potential to deteriorate.

Staff informed us the unit had triaged 28 women on one day of our inspection and this included women from the antenatal clinics due to temporary closure. We were not assured women were risk assessed in order of priority, had appropriate supervision and management. There was no robust process in place to support staff to manage the volume of women, assessment, and prioritisation of clinical need.

Staff escalated concerns regarding high risk patients waiting in an area without clinical oversight. There were no healthcare assistants (HCA) or clerical support working in the triage area to support the triage assessment process and fundamental standards of care. Staff said they had requested assistance of HCA's; however, this was declined at the time by senior staff.

Following a recent HSIB review from May 2022 there were recommendations which had still not been implemented. The trust's plan following the HSIB included guidance to support the telephone triage process. Senior leaders told us they were reviewing the triage process with regard staffing, environment, and telephone assessment. However, to date there was still no robust process and procedure in place.

Senior leaders clarified the care group did not undertake audit surrounding the triage process. The care group planned to instigate audit of the triage telephone proforma in January/February 2023.

In addition, there was no evidence that senior leaders had mitigated the risk of lack of CTG machines. There had been no traction with sourcing additional CTG monitors before the expected delivery at the end of November 2022.

The trust had submitted a SMART action plan following the first inspection which listed staff had to discuss the availability of the CTG monitors at daily handovers. However, this was not discussed in the meeting we observed on the labour unit.

We reviewed medical notes which showed staff were not interpreting, classifying, or escalating CTG appropriately. Documentation on CTG was poor and not in line with NICE guidelines: Fetal monitoring during labour (June 2020).

Following the second inspection senior leaders shared an action plan completed in December 2022 relating to CTG. This included timeframes up to April 2023 to cover all aspects such as of fetal monitoring such as improved training compliance, and robust escalation processes and fresh eyes.

We found evidence in medical notes which showed a lack of assessing and responding to risk which resulted in patients being exposed to the risk of harm as a result of inappropriate assessment.

We found evidence from the National Reporting and Learning System (NRLS) reported in September 2022 of a lack of recognition, management and appropriate response to risk surrounding PPH and 3rd / 4th degree tears. These had been inaccurately recorded as low or no harm. This resulted in patients being exposed to the risk of harm as a result of inappropriate assessment.

Maternity

Midwifery staffing

The service did not have enough midwifery staff with the right qualifications, skills, training, and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service did not have enough midwifery staff to keep women and babies safe and the actual staffing numbers did not always match the planned number.

For example, on the antenatal and post-natal ward (G2) two midwives had to be relocated to the labour unit to ensure continuity of care. This left three midwives to care for seven women in antenatal beds and 12 women in postnatal beds and two patients in transitional care.

The labour unit was regularly placed on divert due to the lack of available trained midwives. Staff told us they had requested agency staff to cover midwifery shifts. The vacancy rate of 15.59% for midwifery staff which meant this equated to 16.91 whole time equivalent (WTE) midwives.

There were fully established maternity support workers. The care group had recruited fifteen new midwives. Fourteen of the new starters were newly qualified midwives with one starter a band 6 midwife. Senior managers told us there were nine WTE midwifery gaps remaining following the recent recruitment drive.

Some staff reported the pressures of reduced staffing numbers had caused them to reduce their hours due to feeling that every day at work was unsafe and risking patient safety. They said they did not get regular breaks due to acuity on the wards. Staff reported they were constantly being pulled to work on the labour ward, leaving G2 with as little as two qualified staff at any one time.

Senior leaders held daily staff huddles with the band 7 coordinators to assess midwife staffing levels using the birth rate plus tool. They would review the number and grade of midwifery staff needed for each shift in accordance with national guidance.

The care group had RAG rated the staffing ratio for the acuity of the women. Red-Amber-Green (RAG) ratings, also known as 'traffic lighting,' are used to summarise indicator values, where green denotes no concern, amber denotes of concerns and red denotes concerns.

We reviewed the maternity dashboard information which showed an average of midwife to birth ratio of 1:31 from January to August 2022. They were focussed on providing safe care ensuring a ratio of one midwife to one woman in established labour and had an average of 99% for the January to August 2022 which was above the regional average of 95%.

There was no formal system reporting process for planned verses actual community staffing; however, this was reported Monday to Friday by the community band 7's forming part of the safety huddle reporting.

There was an escalation midwife on call every evening for the labour ward. If maternity gaps were not filled with staff, they would redeploy staff from the community which meant home births had to be redirected into the acute setting. We observed the rotas for September 2022 which showed there were days when there was no available home birth service or community midwives on call. For the reporting period January 2022 to September 2022, community midwives were called into the unit on 38 occasions. Senior management told us they worked clinically when acuity was high.

The sickness rate for midwifery staff across both sites had steadily increased from 2.9% in September 2021 to 7.6% in June 2022. The sickness rare for healthcare assistants at across both sites was 6.8% in June 2022.

Senior leaders used bank staff to try to support safe staffing, however, there continued to be shortfalls in staffing. In October 2022 there was 294 midwifery bank shifts filled and 36 HCA/MSW bank shifts.

Medical staffing

The care group did not always have enough junior medical staff with the right qualifications, skills, training, and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The care group provided staffing information for obstetrics and gynaecology medical staff for the rolling time period ending September 2022. This showed the numbers of junior staff did not always match the planned numbers for weekday shifts from 8.30am to 5pm.

Managers could access locums when they needed additional medical staff. There was a high fill rate of 94% for bank shifts which meant robust planning so that agency shifts remained low at 33% and costs were reduced.

There was a turnover rate for all medical staff of 16.1% and vacancy rate of 2.3%. The sickness rate was 5.3% for senior medical staff and 3.5% for junior medical staff.

We saw many examples when the actual number of medics was in excess of the planned number, this may have been due to the acuity of the women.

We reviewed evidence to support the consultants met the planned number of staff and had a consultant on call during evenings and weekends.

Locum consultants and registrars were either block booked or booked ad hoc to mitigate gaps in the rota during periods of transition from retirement/ leaving to new staff joining to ensure safe and sustainable rotas.

They worked to align the acute and on call rotas across the two sites to a 1 in 8 week cover pattern and the recruitment of five additional consultants had been progressed at pace during the last 12 months. This was to ensure that safe staffing could be achieved and supported by more cross-site cover if required with some core established shared on call non-resident weeks/ weekends now incorporated across site.

The medical staffing position for the day and the forward view for the week/ weekend is then confirmed at the care group bronze daily meeting with any requests for support and escalation requested. Additional scheduled bronze meetings had been put in place to ensure the plans for service continuity continued to be developed. These meetings were logged to support decision making and review of previous day's mitigations.

Handover meetings between shifts with the multidisciplinary team (MDT) confirmed the medical staffing and bleep holders in each team for the shift ahead.

There was a daily morning medical staffing huddle across the sites for the operational team supported by the clinical director and site clinical lead. They would confirm all rotas and mitigate any unplanned gaps as required.

Medical staff we spoke with told us there was excellent team working and they felt supported. They said, 'everyone was approachable' and they received appropriate supervision. This concurred with the 2022 General Medical Council national trainee survey which showed the overall satisfaction score was similar to the national aggregate.

Records

Records were not always stored securely, and patient leaflets had not been reviewed and updated. However, staff kept detailed records of women's care and treatment. Records were clear, up-to-date, and easily available to all staff providing care.

At the last inspection in 2015, the trust was told they should ensure that patients records trolleys were locked. At this inspection we found similar concerns with records not being stored securely as doors to offices were not always locked. We were informed that the service had ordered new lockable notes trolleys to mitigate this risk.

During inspection we observed several version control documents had passed the revision date; however, these records were still in use in clinical areas. For example, post-natal advice following a third or fourth degree tear after birth of baby (review date April 2020), external cephalic version (review date August 2021), what is induction of labour (review date October 2021), caesarean section (review date August 2022), emotional support in pregnancy (review date March 2021).

The service used paper medical records and planned to transition over to electronic records in the near future.

When women transferred to a new team, there were no delays in staff accessing their records.

We spoke with woman attending their outpatient appointments and noted their own medical records were kept in a plastic waterproof wallet.

Medicines

The service did not always store medicines safety however they used systems and processes to safely prescribe, administer, and record medicines.

We found several areas of concerns with the safe storage of medicines, which included controlled drugs. They were not being stored in line with best practice guidance.

For example, in two clinical areas we found drawn up medicines in a medicine cupboard and a fridge. Whilst across three clinical areas we found medicines fridges that were either unlocked or had broken locks and unattended unlocked controlled drugs cupboard.

We escalated this with staff immediately. The care group provided assurance by completing an action plan to address concerns highlighted. Actions included twice daily checks of drug cupboards (and after each theatre case) to ensure drug cupboards were locked and fluids were correctly stored. The broken lock on one ward had been escalated to estates and rectified. A communication brief relating to drugs cupboards and storage of medicines was implemented for discussion at each handover. Recruitment of a dedicated pharmacy technician was approved. In the interim pharmacy technician support was to be provided to support the review of medicines storage and medicines management.

We revisited the service six weeks following the original inspection and found additional concerns. For example, we found medicines unsecured within the labour department. We escalated this with staff immediately. Senior leaders confirmed that recruitment of a pharmacy technician for the department had been successful; however, there was an

eight-week delay until the employee commenced work. Senior leaders confirmed that pharmacy technician support was in place in the interim; however, the resource was split between urgent and emergency care and maternity. Midwifery staff we spoke with confirmed they had received no clinical pharmacy team support since our first inspection and were not aware of the recruitment of a dedicated pharmacy technician for the maternity service.

We were also not assured that medicines requiring refrigeration were being stored in line with manufacturer's instructions on G2. We found between 01 September to 23 October 2022 there were 35 occasions when the medicines fridge temperature had gone out of range with no action taken. We also reviewed records for the same fridge from 01 to 22 November 2022 when on 13 occasions the temperature was recorded as out of range with no action taken. We highlighted this to staff immediately as we could not be assured medicines in the fridge were safe to use. However, despite highlighting this to senior staff no immediate action was taken. We escalated this with the matron who instigated an immediate pharmacy review. A new fridge had been purchased, medications were disposed of, and the stock was replaced.

Controlled drugs (medicines which require heightened security and recording measures) were checked at least weekly by staff on both labour ward and G2 in line with the trusts service standard operating procedure. Staff told us that pharmacy staff came periodically to have oversight of the controlled drug records.

We also found daily checks of emergency medicines were not always completed. For example, on the labour unit between 01 to 22 November 2022 we found five occasions when there was no record made that any checks had been undertaken placing women at risk that emergency medicines may not be available.

On our second inspection visit we observed three babies out of nine on one ward who did not have patient identification bands on their wrist. Ankle identification bands were in place; however, this was not in line with trust policy which stated identifications bands should be in place on the wrist and opposite ankle. We escalated this with senior staff at the time.

In September 2022 the trust completed a review of the safer practice with epidural injections and infusions. They were compliant with the four of the seven National Patient Safety Agency (NPSA) recommendations. Senior leaders informed us an action plan had been implemented.

The trust used an electronic system to prescribe and record the administration of the patients' medicines; however, there was no medicines reconciliation process undertaken by pharmacy staff to ensure women were prescribed the correct medicines should they have an extended stay.

There was a monthly newsletter to disseminate learning with staff to improve safe practice.

The care group had recently reviewed their VTE guidance following a number of incidents relating to VTE prophylaxis and had created a new IV heparin chart to promote safe prescribing and monitoring. The anticoagulant pharmacist had recently carried out a review of three historic NPSA alerts relating to anticoagulation to ensure measures put in place at the time of the alerts were still appropriate and an action plan was approved March 2022 in the medication safety group.

Incidents

The service did not always manage safety incidents well. Managers investigated serious incidents, however there was a back log of low or no harm incidents to be investigated. Managers managed patient safety alerts but did not always ensure that actions were implemented or monitored. Managers did not always share lessons learned with staff in a timely way.

Maternity

Senior leaders confirmed there was a lack of suitably trained staff available to undertake serious incident investigations. Senior leaders acknowledged there was limited assurance staff had completed specific root cause analysis required for serious incident investigations.

There were 219 incidents outstanding investigations and was an increase from the previous month. We reviewed the clinical governance minutes for August 2022 which evidenced there were 35 open actions from SI's.

Staff we spoke did not have to time to complete these due to working clinically. Senior leaders acknowledged the quality of the actions were not robust, and no one had ownership of these actions.

We were not assured that learning and action was taken immediately following a serious incident reported to HSIB.

We were not assured that senior leaders had robust oversight of investigating incidents which were graded as low or no harm. For example, the maternity dashboard confirmed that post-partum haemorrhage (PPH) incidents for blood loss of 1500mls or more were being graded as low or minor harm (11 in August 2022, 14 in September 2022). In addition, they did not report PPH below 1500ml blood loss. This was not in line with RCOG guidance.

We reviewed evidence from the National Reporting and Learning System (NRLS) which evidenced there was a lack of recognition, management, and appropriate response to risk. For example, in September 2022 there were 108 incidents recorded as no harm and 52 as minor/low. In October 2022 there were 107 incidents which were recorded as no harm and 50 as minor/low harm. In addition, between 31 August 2021 and 16 September 2022 we found 31 incidents relating to CTG's which were graded as no harm and 18 as low harm.

There had been four intrauterine deaths / intrapartum still births reported in the last 12 months. These had been reported to HSIB for further investigations. At the November 2022 inspection we noted there had been a further two intrapartum still births.

The care group reported eight serious incidents (SI) to the NHS Strategic Executive Information System (StEIS) from March 2022 to August 2022 which were investigated.

Managers shared the learning from the recent never event of a retained swab and a retained tampon with their staff and across site. Staff confirmed they were aware of these incidents. We requested audits for swab counts following procedures however, the care group informed us these had been paused due to patient activity and low staffing levels. This meant we were not assured that this learning was being measured effectively to ensure safe outcomes for patients.

Consultants shared immediate clinical learning from incident reports to medical staff. However, senior leaders told us they needed to improve on the sharing of learning from incidents and safety messages of the week and proposed these were to be introduced during staff handovers.

Senior leaders confirmed they needed to engage more with midwives during investigation reports and had plans for a band 6 midwife to check reported incidents to disseminate immediate learning.

We reviewed the compliance rates for the role and specific midwifery training for the rolling time period ending September 2022. This evidenced that 77% of midwives and 45% junior and senior medical doctors had attended learning from incidents, complaints, and claims training.

Maternity

We saw evidence that the care group issued a newsletter to disseminate information following incidents. Learning was also shared using emails, and governance boards.

Women and their families were involved in these investigations.

Is the service effective?

Requires Improvement

We rated effective as requires improvement.

Evidence-based care and treatment

Policies were not always updated with national guidance and evidence-based practice in a timely manner. However, staff consistently protected the rights of women subject to the Mental Health Act 1983.

All policies were available on the intranet for staff to follow. Senior leaders acknowledged staff were unclear which policy version to use because not all policies had been reviewed in line with the planned review date. We reviewed the clinical governance meeting minutes from October 2022 which evidenced there were 14 guidelines which needed review and ratification. There were 12 overdue patient information leaflets, and three antenatal screening guidelines were significantly overdue.

The service did not always demonstrate full compliance with all elements of the saving babies lives care bundle (version 2). We identified cases where they did not meet the element for reducing preterm birth. In addition, the CTG's were not appropriately classified, risks had not been recognised and failure to record and escalate clinical pictures leading to delay in birth. We were advised the care group had ceased the gap audit in according to this guidance. They currently do not complete audits which would give assurance that fetal growth restricted babies were being identified. In addition, they did not have a current saving babies lives lead.

We reviewed the maternity dashboard which showed primary post-partum haemorrhage (PPH) which was equal to or greater than 1.5 litres (1500 mls). This was not in line with the green top guidance no 52 for the prevention and management of postpartum haemorrhage.

Senior leaders told us that practice had been updated to reflect changes to the fresh eyes approach to fetal monitoring. However, we did not see this during the inspection which meant this had not been embedded. There was low compliance with fresh eyes, and this was displayed on governance boards in the clinical areas.

At handover meetings, staff routinely referred to the psychological and emotional needs of women and their relatives. We received information from 17 women who said they had been asked about their general health and wellbeing at every antenatal appointment and 14 women had been given a named midwife throughout their pregnancy. All women who had given birth confirmed they had skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth. This demonstrated compliance with best practice and national guidance.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. However, the environment meant there were no safe rooms available for women who presented with mental health concerns.

Maternity

The monthly newsletter contained information related to best practice and latest guidance updates.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural, and other needs.

Staff made sure women had enough to eat and drink, including those with specialist nutritional needs such as diabetes. We observed women receiving adequate nutrition and hydration during our inspection.

Women and families were able to access the patient kitchen area and make a donation for hot drinks and snacks which were supplied by a local charity.

Staff fully and accurately completed women's fluid and nutrition charts where needed.

The service had a specialist infant feeding lead midwives. We saw that leaflets were available on promoting healthy pregnancy, post-natal exercise, infant feeding plans for parents as well as breastfeeding and formula feeding guidance. There was a dedicated breastfeeding area.

Diabetes and pregnancy cards were available which provide guidance on managing diabetes when planning pregnancy and actions to take when pregnant for example, liaising with the diabetic antenatal clinic.

All woman we spoke with who had given birth had said they were offered food during or after their labour and said it was good. Two women reported there was a varied choice of food available.

Water machines were not readily available on either G2/G3 or the labour unit. The senior leadership team advised that this was currently under review to provide access to water machines in each area.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way. They gave additional pain relief to ease pain when requested.

Staff prescribed, administered, and recorded pain relief accurately.

We received information from five women who had requested pain relief during labour, and all said it was managed well with one woman stated it was "given immediately on request".

We requested data to see if the trust audited pain management however, they did not complete audits relating to pain management.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment. They did not always use the findings to make improvements and did not always achieve good outcomes for women.

Maternity

The service carried out clinical and environmental audits. However, these audits had not been completed for July and August 2022 due to staffing shortages and patient acuity. Senior leaders told us that the care group did not have permanent band 7 midwives available to undertake tendable audits as they were required to work clinically. The onsite Allied Health Professional (AHP) manager had agreed to instigate some tendable audits in September and October 2022 until permanent band 7 matrons were in post.

There was no audit in place to evidence the quality and effectiveness of the telephone triage process or patient outcomes of women presenting. For example, they did not collect data for repeat callers or decision making to evidence appropriate risk assessment and safety advise.

The care group did not consistently audit all aspects of care. For example, they did not complete regular intrapartum fetal monitoring audits. They did not complete recovery care audits, World Health Organisation (WHO) safety check lists or assessments of risk during labour. This meant there was no robust oversight of potential risks surrounding unsafe clinical practice.

The service had a maternity dashboard to monitor clinical performance and governance. This displayed a visual chart to monitor performance over the previous six months.

The care group followed the national guidance from Royal College of Obstetricians and Gynaecologists (RCOG) by using a visual traffic colour code system to use for benchmarking performance. However, the dashboard did not always show the comparison data for the trust, regional or similar sized services for all metrics. For example, senior leaders were unable to compare the metrics for the number of babies born before arrival.

The maternity dashboard showed a high rate of.

- induction of labour. For the last five months up to October 2022 the rates were above the regional average of 36% and the national average of 34%.
- elective caesarean sections. For the last six months up to October 2022 there were fluctuating rates of 15.5% and 18.6% which were above the regional average of 14%.
- emergency caesarean sections. For the last six months up to October 2022 there were fluctuating rates of 16.6% to 21.3% which were above the regional average of 19%.

The maternity dashboard (January to September 2022) evidenced high numbers of women post labour had been admitted to the high dependency unit (HDU). The dashboard indicator listed ten or more women as a concern. For example, the numbers of women admitted to HDU included 17 in July 29 in August and 21 in September 2022. We escalated this with senior leaders who acknowledged that midwives were not trained or competent in the management of women requiring high dependency care.

Following a recent HSIB review from May 2022 there were recommendations which had not been fulfilled. The trust's plan included guidance to support the telephone triage process. Senior leaders informed us the process was currently under review and no changes had been instigated to date.

The service participated in some national clinical audits. There was an audit data plan for 2022/2023. However, this did not include start dates, expected completion date, committee group responsible for review, actions agreed or re-audit dates.

Maternity

We reviewed data which confirmed the trust was an outlier for still births. At the October 2022 inspection visit we identified there had been four intrauterine deaths / intrapartum still births reported in the last 12 months. At the November 2022 inspection we noted there had been a further two intrapartum still births. These had been reported to HSIB for further investigations.

We reviewed maternity dashboard data from January 2022 to September 2022 which showed an average of 4.1% for all births. This was above the Yorkshire and Humber regional average of 3.8%. Senior leaders shared results from an audit completed in September 2022 which showed an improvement in some aspects of PPH management since the previous audit results. However, there was still work to be done to improve compliance with the embedding of the risk assessment and proforma to aid the awareness of the woman who may be at high risk to bleed and assist in the management of PPH.

Following the inspection, the trust shared information that there has been ongoing work around the PPH rate at the Trust since October 2022. The PPH scrutiny panel meet monthly to discuss ongoing themes, action plans and regional and national guidance. The trust confirmed the main theme was on the identification of risk factors such as antenatal risk assessments.

The maternity data from January 2022 to September 2022 showed there had been 22 babies born before arrival (BBA). There was no regional or national average to use as a comparison.

Senior leaders recognised the correlation between intermittent suspension of the homebirth service and the rate of BBA. They had created a working group to review the triage processes. The care group had appointed a lead for triage and will be adopting the Birmingham symptom specific obstetric triage (BSOTS) framework by January 2023. They told us they would be working closely with the recruitment and retention team and focusing on community staffing levels and escalation on calls for the unit, to ensure a consistent and well-resourced homebirth team.

Senior leaders told us there was no formal audits undertaken recently for BBA data. However, following our second inspection they had completed a review which they intended to discuss at the next specialty governance meeting.

We reviewed the peer review audit completed for modified early obstetric warning scores (MEOWs) to show if observations had been taken within four hours, were frequency based and uploaded onto the trust's electronic platform or daily. The results were submitted as a rolling 30 days; however, no time period was provided. These showed that staff did not always comply with the recording of MEOWS observations every four hours, set frequency or daily checks and these results did not meet the trust target of 90%. Post inspection senior leaders told us they had successfully embedded improvements on the Scarborough site with MEOWS audits, priority was now working in collaboration cross site to ensure ongoing improvement.

Competent staff

The care group did not make sure staff were competent for their roles. Senior leaders did not always appraise staff's work performance and did not always hold supervision meetings with them to provide support and development.

We were not assured all staff were experienced, qualified, and had the right skills and knowledge to meet the needs of women.

Maternity

We had significant concerns midwives were undertaking both the scrub and recovery roles for caesarean sections on the labour unit. This was not in line with best practice guidance surrounding the staffing of obstetric theatres (College of Operating Department Practitioners 2009 (CODP)).

We saw evidence to support the scrub practitioner (midwife) supporting a dual role when handling the new-born baby. There was no dedicated theatre team assigned for this role other than the consultant anaesthetist and operating department practitioner. Midwives we spoke with confirmed they had not received training to support the recovery of women following a general anaesthetic.

We escalated this at the time of the inspection. The care group provided immediate written assurance by offering shifts with enhanced rates of pay to bank and agency staff who had scrub competencies. The care group planned to develop a substantive workforce plan and operational model for the dedicated team.

We revisited the service six weeks following the original inspection. We found limited progress surrounding theatre staff availability to cover day shifts Monday to Friday. Senior leaders confirmed enhanced rates of pay had been agreed for weekend and night shifts; however, rates had not been approved to cover day shifts Monday to Friday. This meant gaps in rotas still existed which had to be filled by midwifery staff.

The trust provided data for the period 10 October 2022 to 31 October 2022 to evidence staffing to support and cover maternity theatre cases. Data evidenced 41 additional bank shifts at double time rates had been released with 21 being filled alongside 21 shifts for main theatres with 10 shifts being filled. During November 2022 there were 60 additional bank shifts released with 26 filled and 30 shifts for main theatres with 15 shifts filled.

The trust had agreed funding to recruit a band 7 team leader for the maternity scrub team.

Shift fill is monitored weekly and reporting fortnightly to the maternity theatres oversight group

During the inspection we observed a high-risk patient on the labour unit requiring one to one care with an arterial line. Senior leaders acknowledged that midwives had not received or undertaken high dependency training. This was a risk as patients requiring one to one care should be transferred to HDU/ITU/ICU for ongoing assessment and management.

Senior leaders did not always support midwifery staff to develop through regular, constructive clinical supervision of their work.

At the last inspection in 2015, the trust was told they should ensure that all staff had their annual appraisals. At this inspection we found similar concerns. The appraisal rates were 44% for midwifery staff and 17% for midwifery care assistants both of which did not meet the trust target of 90%. The trust did not provide compliance rates for medical staff. This meant staff did not always have the opportunity to discuss ongoing training needs in order to develop their skills and knowledge. Senior leaders told us that the staff appraisal process required a robust review and work was ongoing to rectify this.

The care group did not have clinical educators who supported the learning and development needs of staff. There was a vacancy for this post at the time of our inspection.

We are not assured there were effective systems to ensure that medical and midwifery staff have the competence and skills to safely care for and meet the needs of women and babies. We reviewed the compliance rates for the role and specific training for the rolling time period ending September 2022.

Maternity

The compliance rates for midwives was;

- practical obstetric multi-professional training (PROMPT) 93%
- for newborn life support (NLS) 92%
- fetal monitoring 95%
- reduced fetal growth (part of SBLV2) 69%
- continuous fetal monitoring (CTG) (part of SBLV2) 63%
- reducing preterm birth training (part of SBLV2) 69%

The compliance rates for student midwives and healthcare workers was;

- PROMPT 90%

The compliance rates for consultants were;

- PROMPT 100%
- fetal monitoring 93%
- SBLV2 (reduced fetal growth, continuous fetal monitoring (CTG) reducing preterm birth training) 88%

The compliance rates for junior and senior medical doctors was;

PROMPT 53%

The compliance rates for junior and senior medical doctors for the last nine months (January 2022 to September 2022 was;

- fetal monitoring 74%
- reduced fetal growth 72%
- continuous fetal monitoring 72%
- reducing preterm birth training 72%

This meant midwifery and medical staff did not always meet the care group target rate of 85%.

This evidenced that registered midwives were 46%compliant for mentorship training. This was a concern given the number of recently recruited newly qualified midwives requiring mentorship and guidance during the preceptorship period.

Staff told us they had not received a full induction tailored to their role. They confirmed that team meetings were not always undertaken due to staffing shortages.

Maternity

The trust had employed two retention midwives to support the career development of new midwifery staff which included overseas midwives. There was a new maternity preceptorship package with a 12-18 month transition period with structured support to enhance the skills, knowledge, competence, and confidence of our newly qualified staff. This included a one-week trust induction followed by two weeks of maternity specific induction/training (off ward), one week of orientation shifts as supernumerary, then two weeks working alongside a band six midwife.

The care group recruited a practice learning facilitator midwife in September 2022. A learning environmental manager (LEM) had been appointed in each clinical area as a point of contact for student midwives. This supported the allocation of the roster, ensuring students were placed with a practice supervisor on each shift to ensure the facilitation of learning. There were plans to organise student professional midwifery advocate sessions to ensure student midwives had the opportunity for confidential reflection sessions if and when required.

There were specialist midwives which included infant feeding, fetal monitoring, perinatal mental health, and bereavement.

Sonography midwives confirmed they received three monthly peer reviews which they felt supported their clinical supervision.

There was consultant support in all clinical areas within and out of normal hours for the middle and junior grade doctors and this was provided on an individually assessed basis, in line with the Royal College of Obstetrician and Gynaecologists (RCOG). All middle grade doctors have allocated educational and clinical supervisors. The general medical council (GMC) national trainees survey 2022 evidenced that out of hours clinical supervision was rated as good or excellent showing a compliance rate of 84% and they had received supervision. All trainees also have an allocated educational and clinical supervisor with whom they meet regularly. This is monitored by the college tutors informally and through the GMC National Survey.

We were informed that the care group continued to employ a senior consultant on a retire and return contract specifically to provide supernumerary general and clinical support and supervision in theatre for new consultants.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed both the medical and midwifery handovers which had good MDT presence. They had clear, structured, and detailed MDT communications in situation, background, action, and result (SBAR) style. They discussed maternity personalised plans and high-risk patients.

We observed safety daily huddle meetings at different times of the day.

However, one of the recommendations from the Ockenden review was that the care group should ensure consistency with the timeliness of the ward rounds and accessibility of medical staff on antenatal and postnatal wards. Staff told us that ward rounds were completed; however, timings were inconsistent. Patient acuity and outpatient clinics often impacted on medical staff availability.

Seven-day services

Key services were available seven days a week to support timely care.

Consultants led daily ward rounds on all wards, including weekends. There was always a consultant obstetrician and consultant anaesthetist on call for any obstetric emergencies.

Staff were supported by other hospital services such as mental health services, diagnostic screening and pharmaceutical help and advice 24 hours a day, seven days a week.

The service had a midwife on call who could provide support to women 24 hours a day.

Women were advised to call the triage unit to discuss any concerns.

Health Promotion

Staff gave women practical support and advice to lead healthier lives.

Women had access to information from using own maternity electronic notes via a PC, tablet device or mobile phone. There were posters and leaflets on how to keep healthy and keep babies safe and well. For example, we saw an easy read poster encouraging women to stop smoking and the importance of healthy eating.

Resource sheets were emailed which included information on telephone help lines, websites, and apps.

Staff assessed each woman's health at every appointment and supported any individual needs.

Staff were trained to support women with newborn infant feeding. Mothers requiring additional support were identified through routine post-natal care and documented in the post-natal notes and safety net contact details provide to mothers outside of this appointment.

Breastfeeding women were signposted to local breastfeeding charities and leaflets were available.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health. However, midwifery and medical staff did not meet the trust target for training compliance.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. They gained consent from women for their care and treatment in line with legislation and guidance.

Staff made sure women consented to treatment based on all the information available and clearly recorded consent in the woman's records.

Midwifery staff received training in the mental capacity act and deprivation of liberty safeguard (DOLS) however, this did not meet the trust target of 85%. This was 66% for DOLS and of 77% for mental capacity act training.

Medical staff received training in the mental capacity act and deprivation of liberty safeguard (DOLS) however, this did not meet the trust target of 85%. This was 64% for DOLS and of 67% for mental capacity act training.

Maternity

Midwifery care assistants received training in the mental capacity act and deprivation of liberty safeguard (DOLS) however, this did not meet the trust target of 85%. This was 60% for DOLS and of 63% for mental capacity act training.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Good

We rated caring as good.

Compassionate care

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. They were welcoming and introduced themselves to women and their visitors.

We received positive feedback from 17 women who said the midwifery staff treated them well and with kindness. For example, they told us the staff were "very welcoming and professional" and "caring and informative". Woman commented that staff "went out of their way to care for me", the "best care I have ever received in hospital" and "care and treatment by staff is amazing and is above and beyond".

Feedback from social media and friends and family tests (FFT) were positive and confirmed that staff to be very caring. The care group had received 353 written compliments between October 2021 to September 2022.

We observed staff delivering personalised care to women and their family. We saw them complete appropriate baby checks and observations and also well-being checks for women on the antenatal and postnatal wards.

We received information from 13 women who confirmed staff respected their privacy and dignity. Staff demonstrated attention to detail when ensuring privacy and dignity of women and those accompanying them. For example, they ensured curtains were closed and kept them covered up when being transported from theatre to the labour ward and also asked for consent before removing blankets, sheets, and gowns for examinations.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs.

Emotional support

Staff provided emotional support to women, families, and carers to minimise their distress. They understood women's personal, cultural, and religious needs.

Maternity

Staff provided positive examples of when they provided emotional support and care to women and their families. Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. For example, staff discussed the emotional care of women during multidisciplinary team handovers and safety briefs. We received information from 17 women who said their emotional wellbeing was checked and re-assessed by staff at every antenatal appointment.

The chapel was always open to offer spiritual or religious comfort to patients, relatives, and staff. There was a remembrance book which displayed the names of deceased babies.

The chaplaincy team were available 24 hours a day seven days a week. The team was made up of chaplaincy staff and volunteers of all different faiths. They would visit the maternity unit when required to offer religious and non-faith blessings for mothers and babies. They felt it was important to offer some continuity to the family and meet them in hospital if they were also providing additional services. The chaplain lead said they would also visit special care baby unit (SCBU) once a week to check on women, their families, and staff well-being.

The chaplaincy team showed us pairs of knitted hearts which had been knitted by volunteers and explained one went into the baby's coffin and one remained with the family.

The specialist bereavement midwife was available to provide additional support and bereavement follow up support to family members.

We reviewed the compliance rates for the role and specific midwifery training for the rolling time period ending September 2022. This evidenced that 79% of midwives had attended bereavement training.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity. We were informed there was going to be a new bereavement suite within the maternity unit which will have appropriate facilities for women and their families. It had been designed so that women and families could exit the door without the need of walking through the unit. In the meantime, staff were able to use areas on the closed G3 ward as quiet rooms.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. The service had a care pathway for women who were expecting twins or multiple births.

They demonstrated the need for sensitivity, individualised communication, and good listening skills. Community midwives would continue to care for bereaved women and families at postnatal home appointments. Staff were able to signpost them to various charities and support groups.

Staff shared positive examples of how they understood and respected the personal, cultural, social, and religious needs of women and how they may relate to care needs. The service had a care pathway for women who were expecting twins or multiple births.

As part of baby loss awareness week, the trust took part in a "light a candle" in memory of baby or babies.

Sonography staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. However, we observed a member of staff delivering bad news in an empty waiting room area and the family reported they would have preferred this conversation to have taken place in a private area.

However, we observed antenatal and postnatal women waiting to be risk assessed in the corridor outside the triage unit. The triage staff told us that this impacted on the emotional needs of women and their families pre and post-delivery. This meant women who had lost babies had to sit next to women who had babies with them.

Understanding and involvement of women and those close to them

Staff supported and involved women, families, and carers to understand their condition and make decisions about their care and treatment.

Staff made sure women and those close to them understood their pregnancy care and treatment with clear information at every appointment.

Women could access their own maternity electronic notes via a PC, tablet device or mobile phone.

We received positive feedback from 16 women who said they were able to ask questions at appointments, however one woman reported that appointments "felt rushed".

Women were supported to make informed decisions about their own care and treatment depending on the stage of their pregnancy. We received information from 11 women who said they felt they had enough information to decide their own pregnancy birth plan based on discussed risks and benefits. However, two women reported they had to find out information independently and that the "community midwife provided little information".

Staff supported women to make advanced decisions about their care. All women we received information from said they had the opportunity to ask questions about their labour and birth. All their partners were kept informed and involved during labour.

Staff provided examples which demonstrated an awareness of how they used different communication aids to speak with women, families, and carers.

We received positive feedback from 17 women who had used the service especially about how staff helped them during labour and had "listened to our preferences" and "helped facilitate choices". The women who had given birth reported it was at their chosen location.

In the CQC maternity services survey published in September 2022 the service scored in the top 20% when compared with others trusts for eight questions. They scored high for the question "Did a midwife or health visitor ask you about your mental health" and 17 women we received information from also told us they were asked about their mental health at every appointment. They also scored high for involving women in the decision-making process and getting help during labour when they needed it.

The care group offered two breastfeeding clinics and had seven volunteers to provide breastfeeding peer support to woman. We received information from seven women who confirmed they had felt supported with breast or bottle feeding. They reported staff "stayed with me for first feed and answered any questions", "showed me how to sterilise and how to bottle feed" and provided "lots of check ins to see how feeding was going".

Maternity

Is the service responsive?

Requires Improvement

We rated responsive as requires improvement.

Service delivery to meet the needs of local people

The service did not always plan or provide care in a way that met the needs of local people and the communities served.

For the reporting period January 2022 to October 2022, there were 59 intermittent and temporary closures of the obstetric unit. This impacted on 27 women who had made a birthing care plan who had chosen their preferred birth location site. For the same reporting period there were 0.2% of planned home births achieved which was below the regional average of 1.2%.

We reviewed the June 2022 maternity voices partnership (MVP) meeting minutes which confirmed the service was "fragile" and had ongoing staffing challenges. Staff aimed to communicate what facilities were available if a home birth cannot go ahead.

The care group had three antenatal scan rooms with a fourth scan room due to be opened in October 2022. Scan room lighting was dimmed in order to clearly see scan pictures. In the outpatient's area there was a maternity scan payment kiosk for women and families to buy scan pictures.

Staff could access emergency mental health support 24 hours a day 7 days a week for women with mental health problems, learning disabilities and dementia.

Senior leaders monitored and took action to minimise missed appointments. They ensured women who did not attend their appointments were sent a further appointment. There was a flowchart process for staff to follow which included further investigation if there was a potential safeguarding concern.

Specialist midwives provided additional care and support to women. For example, there were clinics for diabetes, fetal medicine, and preterm birth.

Meeting people's individual needs

The care group was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

The labour ward allowed visitors between 8am and 8pm.

Staff told us that beds were not available for the women's birthing partner to stay on the ward / unit. However, two birth partners were allowed when women were in labour.

The service had information leaflets available to print off in differing languages spoken by women and local community. These could also be ordered. Information could also accessed in braille, large print, and electronic and audio versions.

Managers made sure staff, women, loved ones and carers could get help from interpreters or signers when needed. Interpretation services and sign language was available to help support women and their families if required. The care group had a tablet at both sites that could be used to access these services and be used as a visual guide when needed.

Women were given a choice of food and drink to meet their cultural and religious preferences.

We were informed of a recent audit to evaluate if women's communication requirements had been met and this was an ongoing quality improvement project.

We reviewed results from the National maternity survey (September 2022) which is required by the Care Quality Commission for all NHS trusts providing maternity services. The survey was completed in February 2022. The service scored in the top 20% when compared with other trusts on eight questions. These themes related to checking on women's mental health in antenatal and postnatal care, being involved in the decision making and also involving partners.

Access and flow

Women could not always access the service when they needed it to receive the right care promptly.

On the first day of the inspection the labour unit at York site was closed. The reason for these closures was unfilled staffing rotas. This impacted on a patient who was booked for an elective caesarean section on 11 October 2022 at York Hospital; however, due to insufficient staffing the labour unit had to be closed. The patient was transferred to Scarborough hospital for a planned procedure on 12 October 2022 however due to urgent activity this had to be cancelled. The patient was then transferred back to York Hospital for an elective caesarean on the 13 October 2022.

In addition, we were informed that both sites were closed on 14 October 2022. However, women could not be diverted elsewhere so the unit had to continue to accept admissions including labouring women.

For the reporting period January 2022 to September 2022, there were 54 intermittent and temporary closures of the obstetric unit to avoid serious incidents and suboptimal care. The labour ward manager and the consultant on call made the decision to close or divert women elsewhere. This was due to an increased demand for bed capacity, or in the event of reduced staffing levels. Staff informed us they did not have an escalation process to follow.

We revisited the service six weeks following the original inspection and found the unit had closed five times during October 2022.

It was unclear how senior leadership had oversight and management of this risk because it was not recorded on the risk register. There was no clear process for the recording of unit closures or reporting to the local maternity neonatal system (LMNS).

We raised this at the time of the inspection and were informed an escalation policy had been drafted and was awaiting sign off by the senior leadership team. They had also implemented a new on-call staffing model to support escalation. We were informed this policy would be relevant across both sites to provide consistency. It would enhance decision-making processes, communication and multidisciplinary working relationships and escalated to senior management and board members. It would also include a standard operating procedure (SOP) when the unit was on divert to include contacting the women to ensure there was no harm caused and/or to provide duty of candour. This work was also being completed in collaboration with the LMNS.

However, this had not been embedded when we re-visited the service six weeks later. Staff were not aware of this draft escalation policy.

Staff informed us there was a five to seven days of waiting time for antenatal scans and the new scan room was intended to support the increase. The care group were considering an increase in out of hours scanning.

The minutes from the clinical governance meeting from August 2022 confirmed the care group did not have enough capacity for inductions of labour or elective caesarean sections. Staff informed us they had recently commenced audits relating to delayed caesarean sections. However, we did not see evidence of this.

The elective lists for caesarean sections were planned every Monday, Wednesday, and Friday. However, these were not always fulfilled due to staffing shortages and emergency caesarean sections.

Senior leaders and staff worked to make sure women did not stay longer than they needed to. Although there was no dedicated discharge team available there were plans to refurbish a dedicated area on G3 as a discharge lounge to assist flow throughout the service.

Women who had reached full term or whose waters had broken were encouraged to attend the antenatal induction clinic to have a balloon catheter dilator fitted. This was to promote labour contractions with an expected delivery within 24 hours. This meant the delivery coordinator could plan admissions and deliveries more effectively and improve patient experience. We were not assured regarding the decision making surrounding the length of time required for balloon catheters to remain insitu as this was not in line with manufacturers recommended guidance of 12 hours.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

Women, relatives, and carers knew how to complain or raise concerns.

Staff understood the policy on complaints and knew how to handle them. The care group shared their complaint response data for the period of April 2022 to June 2022 which showed the average time taken to respond was 33 days for 25 complaints with 44% had been resolved within target of 30 working days.

The care group shared their patient and liaison service (PALS) complaint response data for the period of April 2022 to June 2022 which showed the average time taken to respond was 12 days with 64% being resolved within target of 10 working days.

The care group had received 22 complaints from October 2021 to October 2022. We reviewed the quality and patient safety committee complaints annual report 2021-2022 which identified themes and trends. For example, the attitude of midwifery staff. The care group had developed action plans which included values training, staff listening events and band 7 staff were being supported with writing complaint responses.

Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint.

Maternity

Managers shared feedback from complaints with staff and learning was used to improve the service. We also saw feedback being shared on newsletters and governance whiteboards. For example, we read safety recommendations to help identify and recognise the signs of post-partum haemorrhage (PPH) and the use of correct episiotomy scissors.

Is the service well-led?

Inadequate

We rated well-led as inadequate.

Leadership

The care group had recently restructured the leadership team. This meant roles and responsibilities had changed and were in their infancy and had not yet been embedded. They were sighted on the priorities; however, we were concerned that they were not effective in implementing immediate changes according to risk to improve safety. They were not always visible and did not always support staff to develop their skills and take on more senior roles.

The care group had recently made changes to their senior leadership team and structure. The senior leadership team included four new roles, which included a director of midwifery (DoM), associate director of midwifery (ADoM), lead matron intrapartum / deputy head of midwifery (DHoM) and inpatient services matron.

There were future plans to recruit an outpatient's services matron, community matron and a transformation lead midwife which was funded by the local maternity and neonatal system (LMNS).

These senior leadership roles were in their infancy and needed time to embed within the structure. This meant there were challenges to progress key themes.

The maternity care group did not have a specific continuity plan regarding succession planning; however senior leaders informed us this would be aligned to the long-term recruitment plan and was high priority within maternity services.

Staff we spoke with reported senior leaders had not fully recognised the challenges they faced on a day to day basis, and we saw evidence to support this on inspection.

They said they would appreciate a more visible presence from the senior leadership team. The newly appointed ADoM had completed some clinical shifts and staff informed us that she was supportive. Leaders were aware of their lack of visibility and gave us assurance that this would be addressed. We were informed of plans to organise a daily presence across both sites.

The service had a non-executive director who reported to the board. They met with other maternity safety champions at bimonthly meetings and completed walkarounds.

The trust safety champions which consisted of midwifery, obstetrician and neonatal staff met bimonthly with board level safety champions to escalate concerns, issues, and blockers to improvement work.

Maternity

When the new Humber and north Yorkshire health and care Partnership, LMNS and maternity voices partnership (MVP) lead commences in post in November 2022 the plan was for them to lead a full MVP review around capacity, roles and workplans with a plan for implementation April 2023.

We reviewed action plan from the most recent staff survey in 2021 which highlighted the following,

- leadership and management development for all leaders
- values ambassador training for all leaders
- Human resources team to provide additional appraisal training for all managers. Work had also been undertaken to review appraisal allocation amongst managers.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. However, leaders and staff could not fully articulate or know how to apply them to monitor progress.

The care group had a vision and strategy in place which supported:

- Personalised care and support plan: care that is individualised and meets cultural needs
- Local integrated care: developing services with partners across LMNS and co-produced with women and families underpinned by cultural awareness training
- Maternal mental health service: to meet the needs of women with birth trauma
- Transitional care: strengthen model as additional staff join the team
- Bereavement care: purpose-built bereavement suite is developed to meet the recommendations of the National Bereavement Care Pathway
- Continuity of care: increased ability to provide named midwife throughout women's pregnancies
- Pelvic health: access to post-natal specialist physiotherapy for pelvic dysfunction

The strategy had a purpose, ambition, and highlighted the care groups key challenges. In the next 12 months the care group intended to:

- Build a more sustainable model of delivery on and across our sites building on our extended obstetric workforce
- Develop our midwifery workforce to support the delivery of enhanced safety and continuity of care in line with Saving Babies Lives

The trust had an overlying strategy which included maternity services highlighting a commitment to outstanding care for women, children and young people enabling them to live their healthiest lives. However, there was not an effective approach to monitoring, reviewing, or providing evidence of progress against delivery of the strategy or plans. The strategy was in its infancy and had not been translated into action in maternity services at the point of our inspection.

Leaders spoke of their future plans for the merged G2 and G3 wards and discussions for this area included a discharge lounge and bereavement suite.

Maternity

Culture

Staff did not always feel respected, valued, and supported. The service did not have a culture where staff could raise concerns without fear as they were not always managed appropriately. However, staff were focused on the needs of patients receiving care.

Staff informed us the recent changes in senior leadership, visibility and oversight had impacted on the care group as a whole. Staff felt disillusioned, unsupported, and lacked clarity with regard the clear vision and strategy of the care group. Due to staffing shortages and patient acuity staff informed us they often missed regular breaks which impacted on staff wellbeing.

We were informed by staff of the toxic culture which was historical surrounding the lack of leadership support, lack of equipment and the impact of staffing shortages. We received mixed information surrounding historical bullying and harassment concerns. Staff did not feel confident in reporting concerns as they felt they were not managed appropriately.

We reviewed the staff survey results (2021) which highlighted a completion rate of 38%. Responses to 87% of the questions were below the national benchmark. Responses corroborated what staff told us on inspection. The care group had commenced an action plan to address concerns highlighted; however, this was in its infancy and results were not yet visible.

It was evident during the inspection that midwifery and medical staff made every effort, under difficult circumstances, to meet the needs and care for women and babies.

Governance

The current governance systems and processes were not always effective. The care group had recently proposed a new governance structure. This meant staff were not always clear about their roles, responsibilities, and accountabilities. Staff did not always have regular opportunities to meet, discuss and learn from the performance of the service.

The maternity service was part of the women's health care group which included Gynaecology.

The care group recognised the need to formalise the governance framework and processes to support the safe and effective delivery of care.

Most staff we spoke with informed us they were not clear of how governance addressed current challenges and risks. Although these had been recognised by senior leaders this was not reflected in immediate action planning. There was no clear leadership of how this was going to be addressed. Senior leaders could not clearly articulate the governance framework. There were no regular meetings for staff to receive updates surrounding governance and action planning.

However, we were informed there was a newly proposed governance structure. This included senior midwife leads assigned to each key line of enquiry including safe, effective, caring, responsive and well led. They had reporting responsibilities to the newly appointed quality and governance lead.

Staff informed us there were newly recruited quality governance band 7 managers at each site with a band 5 coordinator.

The care group were embedding a new team meeting cascade and action tracker including a fortnightly specialist midwives forum with a cross site approach.

The quality and governance lead attended clinical governance meetings. We saw evidence of meeting minutes from October 2022 which demonstrated quorate attendance and covered relevant aspects of governance. For example, this included discussions surrounding the maternity dashboard, audit, risk register and infection control. There were appropriate methods of escalation up to the quality, performance, and safety (QPAS) meeting.

We reviewed a shared learning presentation embedded in the October 2022 clinical governance meeting minutes. This evidenced the review of a reported serious incident, inclusion criteria, learning points and referencing to national guidance.

We were assured that the care group attended a quality assurance group with changes to the agenda and structures. A quality and patient safety (QPAS) meeting was instigated monthly. There is a trust-wide Quality Committee meeting on a monthly basis which was attended by the Director of Midwifery and chaired by a non-executive director (NED). The Clinical Director attends the Clinical Governance meeting, following this meeting there is a session where the junior doctors present audit to colleagues.

We saw evidence this information was disseminated on the governance information white boards on each area. This included challenges, risks, and training information.

Senior leaders informed us they were unsure of the outcome of the Ockenden proposed recommendations of the birth rate plus assessment which was presented to the board in July 2022. This meant the birth rate plus assessment would need to be recommissioned. The care group clarified that the midwifery workforce paper July 2022 was to be resubmitted to the board in January 2023.

We found several policies which were out of date and some that required ratifications following amendments. For example, the waterbirth policy was changed to reflect recent RCOG guidance in March 2022 and was still awaiting sign off at governance meetings.

The care group produced governance newsletters.

Management of risk, issues, and performance

Senior leaders did not always use systems to manage performance effectively. They did not have clear oversight of the key risks highlighted on inspection. Action plans put in place did not immediately address these risks.

Staff, including senior leaders, could not clearly articulate how risks were identified and managed. We were not assured that the care group had an effective risk system to support safe and quality care. The care group did not address the issues found on our first inspection.

Divert / closure

During inspection we highlighted concerns regarding significant risks surrounding the closure of the labour units at both sites. This meant some women were diverted elsewhere. The reason for these closures was unfilled staffing rotas. This decision to close / divert units was made by the midwifery coordinator and consultant. However, there was no senior leadership oversight of this. Staff informed us this was not always reported on datix as an incident and no follow up was in place to check diverted women.

Maternity

Staff informed us closure and diverts had not been escalated with the local maternity neonatal system (LMNS). This impacted on local hospital infrastructure within the region.

The care group gave assurance that recruitment of midwives had been implemented. Senior leaders informed us there was an escalation policy to manage the decision of closure / divert however, this was awaiting ratification.

Following our second visit six weeks later we found similar concerns. The escalation policy was still in draft, and staff remained unsure of the process.

Therefore, we were not assured the risks had been mitigated in the short term.

CTG

During inspection we highlighted concerns regarding significant risks surrounding the lack of CTG equipment, lack of central monitoring and low competence rates surrounding staff training. The care group informed us they had ordered additional CTG's. However, we were still not assured the risk had been fully mitigated given the low numbers of CTG machines currently available until receipt of the order which was expected at the end of November 2022.

It was evident from still birth audit findings there was a key theme of reduced fetal movements and delayed presentation with reduced fetal movements (over 4 hours minimum) which could be potentially related to the lack of CTG machines.

Senior leadership acknowledged there was poor compliance rate of 63% CTG training which was included in the practical obstetric multidisciplinary training (PROMPT) training.

Senior leaders had not mitigated the immediate risk surrounding the lack of CTG equipment. On our second inspection they still only had 11 CTG's on site.

Scrub / recovery

During inspection we highlighted concerns regarding significant risks surrounding the midwives undertaking both the scrub and recovery roles for caesarean sections on the labour unit. There was no dedicated theatre team which was not in line with best practice guidance. Midwives we spoke with confirmed they had not received training to support the recovery of patients following a general anaesthetic.

Senior leadership acknowledged there was a poor staff compliance rate of 10% for scrub competency training. In addition, there was no evidence to support that bank staff had completed scrub competency training. They acknowledged there was no recovery competency training package.

On our second inspection senior leaders informed us they had limited cover from agency staff to cover the scrub roles during the week (Monday to Friday).

Management of medication risks

During inspection we highlighted concerns regarding significant risks surrounding the management and safe storage of medications. Senior leadership acknowledged immediate review and some actions were implemented.

However, following our second visit six weeks later we found similar concerns and actions had not been completed. For example, we found medicines unsecured on different areas of the labour department. We escalated this with senior leaders who confirmed that additional support is being provided by pharmacy with regards to safe and secure handling on the maternity areas and a pharmacy technician role was being recruited to focus on high risk patients. Midwifery staff we spoke with confirmed they had received no clinical pharmacy team support since our first inspection and were not aware of the recruitment of a dedicated pharmacy technician for the maternity service.

We received audit data from the trust which showed medicine management remained a concern and therefore was an ongoing risk.

Environmental risk factors within the theatre setting

During inspection we highlighted concerns regarding theatre ventilation. We escalated this at the time and were given assurance by the estates team that ventilation was appropriate. Post inspection we reviewed the annual inspection reports which were undertaken in July 2021 (theatre one) and April 2022 (theatre two).

The reports stated there was several compliance issues which did not meet HTM 03-01 guidance. For example, the air volume and the extract air volumes were low. We did not receive action plans to address the concerns raised at the time of receiving the inspection reports. The remedial works required were not listed on the care groups risk register. Therefore, we were not assured the theatres were fit for purpose.

We requested actions taken by the trust to address the concerns raised in the annual inspection reports. Data evidenced the annual validation inspection for theatre one had not been completed as planned in November 2022. Remedial works had been intended to be completed prior to the revalidation inspection. However, works were not undertaken as the theatre was required to close for works to be completed over a three-day period. Senior leaders informed us they met in November 2022 to consider next steps in terms of refreshing the refurbishment programme and backlog maintenance schedules to prioritise maternity theatre improvements required. This was considered in the context of the trust's capital investment prioritisation process for 2023-24 in readiness for submission to corporate finance team in January 2023. This remained a risk as theatre one did not meet all HTM 03-01 recommendations.

The trust confirmed a joint theatre risk assessment had not been undertaken; however, they intended to progress this in January 2023 as part of a new unified approach. We noted the ventilation risks had not been added to the care groups risk register.

Following the second inspection senior leaders confirmed they had instigated an environmental review. This was evidenced in an action plan with assigned leads and time frames for completion.

Fire risk factors within the theatre setting and the labour unit

During inspection we highlighted concerns regarding significant risks surrounding the fire safety. There was unsafe practice surrounding fire risks, unclear and unsafe evacuation controls, and the lack of recent fire drills. We observed poor storage of equipment which were left in the corridor and blocked fire exits. Senior leadership acknowledged immediate review. They provided an action plan which stated they had completed a full review of the departmental risk assessment and they were fully compliance with the fire evacuation plan.

However, following our second visit six weeks later we found the initial assessment undertaken by the trust had not mitigated or identified the key risks. We observed blocked fire exits and poor storage of equipment. We found that not all staff had swipe access exiting a fire door leading to HDU. This included the coordinator in charge of the day shift on the day of inspection and the labour unit manager.

We escalated concerns with senior leaders and requested an immediate zoned fire test to be instigated to observe the release of the emergency exit leading to HDU. The fire test evidenced that the doors did not release during a zoned test. Senior leaders instigated an immediate review and escalated to board directors.

Due to the immediate safety risk, we escalated this externally to the local fire service. Senior leaders told us they had commenced immediate review and repair of all fire doors within the trust. The review highlighted seven double fire exit doors at the York site were found to be faulty this included two of the fire exits on the maternity unit. The trust clarified an external review of all fire exits would be instigated. We saw staff relocate the metal cages to a storage space on G3 which mitigated the fire risk.

We found there was a lack of robust governance systems and processes to assess, monitor and manage risks within maternity services. Staff, including senior leaders, could not clearly articulate how risks were being managed, the actions put in place to mitigate risks and reduce the reoccurrence of incidents.

Appraisals

We had significant concerns regarding senior leadership oversight of poor mentorship training, competency training and appraisal compliance rates which did not always meet the trust target.

Senior leadership acknowledged the appraisal rates were low and had extended the time for appraisals to be completed. They informed us the increase in the numbers of senior leaders would help to expediate the appraisal process. We found there was a lack of robust governance systems and processes to assess and monitor staff performance.

Audit

We had significant concerns regarding senior leadership oversight of the audit process. The care group had not been able to complete weekly and monthly environmental and clinical audits in July and August 2022 due to band 7 staff having to work clinically.

We reviewed the most recent audit for swab and needle count safety in February 2022. This showed that compliance for this was low showing a compliance rate of 80% of 20 sets of medical records. Following the inspection, the trust sent evidence of a recent theatre safety audit which showed the overall compliance for safety checks during procedures was 87%.

From April to July 2022 there had been one never event which related to poor compliance surrounding swab and needle count. We were therefore not assured of ongoing improvement and senior oversight of safe effective practice within the theatre environment. Senior leadership acknowledged these audits will recommence in October 2022.

We did not have assurance how learning and action planning was disseminated following the audits which had been completed. For example, there was poor compliance of the most recent fresh eyes audit. This meant women's observations were not always being monitored every 15 minutes during labour. We did not see any formal action planning to address this although the senior leadership acknowledged there were specific areas for improvement.

We reviewed the care group's risk register. This highlighted that not all risks found on inspection had been acknowledged by senior leaders. Some risks that were recorded high with a potential for severe harm such as the lack of CTG machines did not have appropriate mitigations in place and for example there were gaps in control and assurance.

Security

We observed multiple examples when members of the public gained access to the unit behind other staff/ patients and relatives when entering or leaving the unit. We did not see members of the public being challenged by staff and we were not assured that staff were able to view this area at all times. This meant there was a security risk of potential baby abduction.

Staff informed us that they had historically not undertaken baby abduction drills. However, a recent drill had been undertaken on one, but not all, the wards/ units. We observed and staff informed us that babies were not consistently tagged in line with trust process. On our second inspection we found three babies on one area who had not been security tagged.

Post-partum haemorrhage (PPH)

We had significant concerns regarding senior leadership oversight of the management of PPH risk. From 16 October 2022 to 24 November 2022 there had been 21% of women who had a PPH.

The care group were not reporting post-partum haemorrhage (PPH) below 1500mls despite trust's guidance of obstetric haemorrhage recognising primary haemorrhage is 500ml, minor 500-1000ml and major (moderate) 1001- 2000ml and major as 2000ml. It was clarified they were not reporting PPH of 1500ml following a serious incident review which was not in line with RCOG guidance.

We reviewed the service's incidents from September 2022 and found 32 incidents graded as low harm and 63 incidents as no harm. 17 of these incidents were related to post-partum haemorrhage (PPH) and of these 16 incidents described an estimated blood loss (EBL) exceeding 1500 millilitres. This amount of EBL met and, in many cases, far exceeded the national guidance threshold for categorising these incidents as serious (SIs). This meant these incidents level of harm did not reflect the level of risk to women.

We reviewed trust data of the numbers of PPH from 16 October 2022 to the second inspection date which showed the care group had not reported 80 cases. This is not in line with RCOG national guidance.

We reviewed the trust's compliance with the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme. This showed the care group were only compliant with three elements. This meant there were seven safety actions which had not been achieved to improve the delivery of best practice.

Maternity

Information Management

The care group did not always collect reliable data, and this was not always analysed to understand performance, make decisions and improvements. The information systems were not always secure. However, staff could find the data they needed, in easily accessible formats.

Staff informed us there were not enough computers and could not use them in every area because of the lack of data points and bedside space.

Staff did not always meet the trust target of 85% for information governance training which was included in mandatory training.

We reviewed the maternity dashboard. This did not always show comparisons with the regional, national, or similar size services. In addition, not all performance metrics were RAG rated against this.

We saw three laptop computers stored in an unlocked clinical storage room which had written passwords attached to the keyboard.

Staff informed us the digital transcription service was poor and did not work with the trust system.

The care group had a digital midwife and they had invested in the digital care record system which was expected to go live in February 2023. This will also give other hospitals within the LMS access to maternity records if women were diverted into their care.

The care group had launched electronic software system in Summer 2021 for medicines management.

Staff could easily access the electronic patient record systems and care records and women had access to their own patient records.

Notifications were submitted to external organisations as required.

Engagement

Senior leaders actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

Leaders we spoke with acknowledged the impact of system wide issues such as recruitment, retention, sickness, and shift fill on staff experience.

They acknowledged that staff felt unsupported of staffing issues and also being asked to work on different areas.

Senior leaders informed us they were going to offer various engagement opportunities for staff. We reviewed a list of these which included work streams for retention rates, working with a clinical psychologist and looking at different kinds of flexible working models.

There was a culture, communication, and leadership workstream for the maternity improvement plan. This was a multidisciplinary monthly meeting. Members included medical and midwifery staff and organisational development and improvement learning team, human resources.

The care group had piloted an approach with a dedicated occupational health link who provided a monthly overview of any concerns identified through occupational health. This had resulted in some initial work looking into the rosters, where it had been identified some staff were not being given appropriate rest between shifts. They were also going to review the rotation of midwives.

The care group also intended to commence staff engagement with community road shows and listening events.

We reviewed a newsletter which encouraged staff to seek additional support if they had been involved in intrapartum stillbirths. The purpose of the newsletter was to highlight ways to improve the service and also included staff recognition and employee of the month award.

The care group were going to commence a workstream for reviewing the NHS England "we can talk project" in response to poor communication with patients. This was highlighted as a trust wide theme and trend following a recent patient survey.

Senior leaders told us they intended to collaborate with another trust to benchmark and learn about baby abduction drills and related audits to help improve services.

Following recommendations from the Ockenden review the care group regularly attended LMNS meetings and also to work with them more closely in the future.

The maternity voice partnership (MVP) meetings had recommended as face to face meetings in June 2022. The MVP was a multi-disciplinary group of women and their families, commissioners and professionals from local maternity services who are working together to review and contribute to the development of local maternity care.

We reviewed the minutes from the June 2022 meeting which highlighted themes around negative feedback which included communication and attitude of staff. We also read the specialist maternal mental health practitioner was engaging with a wide range of communities across the area to understand their different needs. This included the traveller community and ethnic minority group.

Learning, continuous improvement and innovation

Senior leaders needed time to embed the vision and strategy for the care group. This meant learning and innovation was in its infancy.

We heard positive examples at ward level where staff recognised the need to make improvements. However, it was difficult to progress with new ideas or innovations due to the current staffing issues. In addition, the low compliance rates for appraisals meant there was limited opportunity for staff to learn and develop.

Staff participated in a fundraising event for new bereavement suite.

Urgent and emergency services

Inadequate ● ➔ ➔

Is the service safe?

Inadequate ● ➔ ➔

Our rating of safe went down. We rated it as inadequate.

Mandatory training

Staff did not always meet the trust target for mandatory and role specific training.

The overall compliance for ED nursing staff was 77.6% which did not reach the trust target of 85%. Of the 15 core training modules there were six that achieved the 85% completion rate. Only three of the seven required learning modules had completion rates of 85% or more. For example only 21.4% of nursing staff had completed the prevention and management of patient falls training. We followed this up with senior nursing staff who told us this was a new module for all staff so compliance was improving.

Only 58.4% of nursing staff had completed the aseptic non touch technique (ANTT) practical training.

The overall compliance for ED medical staff was 64.2% which did not reach the trust target of 85%.

The service only met the trust target for two out of 17 modules. The modules with the lowest completion rates were paediatric life support (13.3%), adult advanced life support (48.7%) and paediatric advanced life support PALS (50%). However, PALS was not mandatory and the ED staff rota had a PALS trained clinician on every shift. Only 12.2% of medical staff had completed the aseptic non touch technique (ANTT) practical training. We heard until recently before our inspection staff could only access one senior nurse trainer so there had been limited provision for completing this module. This had changed so that staff could now undergo peer assessment and attend mentor days.

The mandatory training programme was comprehensive and met the needs of patients and staff. Staff we asked said they had access to several new training modules recently, and the falls module was a good refresher. However senior nurses told us they did not hear much feedback about training from staff unless prompted during 1-2-1s. They expected clinical educators probably gained more staff feedback but were unsure if or how this was used.

Managers monitored mandatory training. All staff members received learning hub system alerts when their training was due to expire, and then if it did expire.

Safeguarding

Staff did not always meet the trust target for safeguarding training or know how to recognise and report abuse.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. However, this was not always completed.Most roles which did not meet the trust target of 85% for safeguarding training were medical staff. Medical staff's overall compliance for safeguarding adults level 2 was 74.6%, safeguarding children level 2 was 71.4% and safeguarding children level 3 was 59.6%. They were 76.3% compliant for PREVENT awareness level 3. This training prevents radicalisation, extremism and the threat of terrorism. This meant medical staff did not meet the trust training target of 85%.

However, staff nurse and consultant roles both achieved trust target for the PREVENT training.

The overall compliance for nursing staff was for safeguarding adults level 2 was 85.7%, safeguarding children level 3 was 79.8%. They were 82.2% compliant for PREVENT awareness level 3. This meant nursing staff were close to meeting the trust training target of 85%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. They worked with other agencies to protect them. However, staff did not always know how to make a safeguarding referral and who to inform if they had concerns. ED staff we asked confirmed they had a safeguarding lead but were unsure how to contact them. Not all staff could explain how they followed safeguarding processes or guidance.

However, staff could use the NHS England safeguarding app which gave information on how to report safeguarding concerns with a directory of all local authority safeguarding contacts.

We saw ED had a named paediatric safeguarding lead from the liaison nursing team along with children's social care contacts. The lead promoted awareness, understanding and guidance of safeguarding children processes and procedures in the department. Staff could raise referrals through their trust intranet and sent a copy to the team for information.

Specialist teams who worked with ED such as the rapid assessment team (RATS), respiratory specialist nurses and the specialist palliative care team (SPCT) considered the care needs of patients and their families living situation post-discharge.

Some clerical staff we asked knew how to raise safeguarding alerts or concerns to their local authority multi-agency safeguarding hub (MASH). Agency nursing staff we asked said they had to inform the nurse in charge (NIC) about any safeguarding concerns. They had no trust intranet access so could not report these themselves.

Staff followed safe procedures for children visiting the department. Child patients had their own assessment area pathway within the department, but they had to navigate areas mixed with adults to access. However, all child patients we saw in the area were accompanied at all times.

On our follow-up inspection we saw a sign on the entrance corridor reminding parents and carers not to leave ED with their child without discussing this first with a nurse or doctor. The sign stated that if staff identified a cause for concern, they would escalate this to the safeguarding children's team due to their duty of care to all children.

Cleanliness, infection control and hygiene

The service did not control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. They did not keep equipment and the premises visibly clean.

Areas were not clean and did not always have suitable furnishings which were well-maintained. Throughout the department, we identified areas that were visibly unclean. For example, in October 2022 we saw what appeared to be old blood stains on the floor within the majors waiting area. We saw some chairs and stretchers used in the department had broken furnishings and were not consistently well-maintained.

However, on our follow up November 2022 visit the department's environment and equipment was cleaner.

Cleaning records were up to date but could not always demonstrate all areas were cleaned regularly. This was due to the department's deep cleaning process and lack of cleanliness audits. The weekend after our inspection in response to our letter of intent, leads told us the department had 24/7 cover from the domestic team. The domestic supervisor carried out quality checks three times a day and completed documentation to demonstrate this. The assistant head of facilities worked with the domestic team to understand any potential barriers to cleanliness and ensure domestic staff took learning onboard to drive improvements in ED.

Leads recognised there were challenges in maintaining the cleanliness standards required at times of peak demand. Bins had been installed in high footfall areas to promote appropriate waste disposal. A cleaning provision review was being undertaken which included options for times of peak demand.

On our October 2022 visit we observed one patient had been placed in a side room due to their COVID-19 positive status. We saw this patient was subsequently moved from this room, and another patient then placed in this area without the necessary cleaning taking place between patients. A domestic staff member told us they had cleaned it but had not removed the red sticker as nursing staff had to check this met the required cleaning standard. When we asked if it had been deep cleaned they were unable to show us evidence. This meant there was no written documentation the room had been deep cleaned. Furthermore, we raised this with senior leaders who did not address this and changed the colour coded symbols placed on the door from red to amber without any additional cleaning. On our follow up inspection senior nurses clarified ED's deep cleaning process was they visually checked rooms after deep cleans before new patients were transferred.

We observed a patient at the ED entrance who staff had identified as displaying COVID-19 symptoms and was awaiting test confirmation. This patient was located in a high traffic area where staff and patients were continuously passing. We observed later that day, the patient had been moved to the majors waiting area – and confirmed as COVID-19 positive. Staff had not taken any precautionary measures to isolate this patient, and when questioned, had not escalated this to the trust infection, prevention and control (IPC) team. This was a risk to other patients within the department. We spoke with domestic staff who confirmed there was no pro-forma or checklist in place for when deep cleaning of areas was required. We escalated our concerns around infection, prevention and control in a letter of intent after our inspection.

On our follow up inspection, the NIC confirmed ED standard practice was not to put a COVID-19 positive patient in the waiting area. However, staff often had no isolation rooms such as a door cubicle available so they had to separate infectious patients as best they could in the interim. The NIC explained staff sometimes used a side room down by the main entrance's GP service for urgent care centre (UCC) patients if no rooms were available in the department.

We reviewed the care group's standard operating procedure (SOP) for managing acute admissions with previous positive COVID-19 results from September 2021. This was for patients with a positive polymerase chain reaction (PCR) test swab upon admission. Any patients with positive COVID, SARS or community test results within the last 14 days were admitted into COVID-19 red ward side rooms where possible.

However, we found ED staff did not follow any formal procedure for the management and isolation of patients with infectious diseases such as COVID-19. They could not adhere to the separate COVID-19 care pathways guidance of high, medium and low risk structured to enable service restoration. We asked staff if they followed diarrhoea and vomiting, and COVID-19 outbreak pathways. They could not show us any evidence of these or how they informed the IPC team as there was no IPC folder for reference in the department.

After our inspection service leads told us mitigations against COVID-19 currently in place included enhanced cleaning. Leads said the IPC link nurse supported ED staff with their hand hygiene practices. The Head of Nursing completed IPC audits, not the IPC team. There were also IPC walk rounds with the IPC team. However, staff told us the IPC team were completely separate from the department and were not visible or did not attend to support them.

We found no evidence onsite of any ED cleaning or standardised IPC audits such as hand hygiene. Post-inspection leads sent us the matron's tendable weekly assurance report from 14 September 2022. This gave scores of 100% for IPC and hand hygiene. We were unsure how the report's key findings were shared with staff for focused learning and improvement in the right areas.

Care group leads explained they undertook walk around audits of areas at random. As a result of these, and from the daily IPC SITREP, leads knew their levels of nosocomial infections such as methicillin-resistant Staphylococcus aureus (MRSA). However, we found no procedures or reliable systems to prevent healthcare associated infections.

Staff told us the department did not undertake any regular audits or complete relevant checklists in relation to infection, prevention and control. We were not assured how senior leaders had oversight of this within the department. Nursing staff we asked about cleaning audits told us these were completed by domestic staff. We found they only kept a list of jobs to do to tidy the department.

We heard the care group undertook tendable audits which included hand hygiene and BBE compliance data. These audits specifically covered the fundamentals of care so many questions did not directly correlate with the documentation in ED areas which meant leads devised no action plans. Actions in ED were around the compliance of ED specific documentation completion. Staff were unaware of the tendable audits carried out in ED. This meant it was unclear how learning from the audits were shared or embedded in the department.

The national patient led assessments of the care environment (PLACE) inspections had not taken place since 2019 and had been postponed during the pandemic. The trust's working group continued to meet to provide oversight of outstanding actions, most of which were resolved except several estates issues, also featuring within accessibility and dementia-friendly audits. The compliance lead maintained regular contact with the national team and services were awaiting confirmation this year's assessments would go ahead in the autumn. Training plans had been refreshed and training dates for both patient and staff assessors were circulated in August 2022.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). Not all staff we saw and spoke with in the department were compliant with surgical face masks and wore appropriate PPE which they correctly donned and doffed. On our follow up inspection we saw one medic not wearing a face mask on three occasions. At one stage they coughed onto their hands at the nurses station then did not sanitise them. They donned PPE such as gloves and an apron before entering a patient cubicle without changing their mask.

Staff and volunteers asked visitors and patients to wear a face covering or mask. However, patient compliance with this was limited as masks were often poorly tolerated by acutely unwell patients. Staff we asked were aware of the need to decontaminate their hands where sinks were not immediately available.

Within the majors waiting area, we observed patients receiving treatment within an area that did not have access to a sink or hand washing facilities. Leads recognised their department had insufficient sinks until completion of the new

build. This was an identified short-term risk for which several potential mitigations had been considered including portable sinks. However due to decreased space within ED whilst the interim build was taking place, these were not feasible. these were not feasible. We observed throughout the department staff that were not compliant with bare below the elbow standards and did not adhere to best practice regarding regular hand washing.

Due to overcrowding in the department, social distancing was difficult to achieve whilst space was limited during the building works. Many of ED's cubicles had no external windows to make use of natural ventilation.

Staff did not always clean equipment after patient contact and label equipment to show when it was last cleaned. On our October 2022 visit we found old blood on sharps bin lids in the majors resuscitation area. The majors resus back room staff office had a water bottle with old mould inside. We also saw used sanitary pads on top of the bin in the department's mixed sex toilets which had 'cleaned' door signs displayed. We did not see any green 'I am clean' stickers with latest cleaning dates on equipment.

Environment and equipment

The maintenance, use of facilities, premises and equipment did not always keep people safe. Staff did not always manage clinical waste well. However, staff were trained to use equipment.

Patients could reach call bells, but staff did not always respond quickly when called. For example, we saw staff did not assist one patient in the cubicle along the ready for transfer corridor for 15 minutes until other staff and we intervened.

The design of the environment did not follow national guidance. On our last inspection in September and October 2017 we told the trust they must ensure paediatric patients are treated within appropriate places within ED due to not having a dedicated paediatric area.

On this inspection we found the department now had a separate children's assessment area. However, this sometimes had to be closed due to a lack of suitably trained staff. The department's (purple) children's resuscitation bay was flexible to accommodate adult patients. It was designed to make optimum and pragmatic use of all areas during the interim build. However, staff told us this bay could be utilised inappropriately as it could also be used for treatments such as plastering and joint manipulation. This meant in the event a child suffered a medical emergency, staff could not guarantee it was free for immediate use.

The ED and trust sites lacked a high consequences infectious diseases (HCID) room. This meant the management of patients with high consequence diseases such as avian influenza would become unsafe for staff and other patients. Efforts to put in place HCID facilities as safe as possible were undertaken for the department. However, these fell below the required standard and remained a risk. The EDs capital building project included a bespoke HCID room.

At the time of our inspection major building works were underway to redesign and reconfigure the department layout. The ED was operating with a temporary reduced footprint and was midway through a planned £15 million extension. Trust and service leads felt this build was necessary to significantly improve the environment and experience of care for their patients and staff. It would also provide fit for purpose facilities and infrastructure.

As a result, the six trolley ambulance assessment area was unable to be used. This meant patient arrivals from ambulances queued and were often seen and treated along a corridor.

Urgent and emergency services

The department's majors waiting room had seats for up to 33 people although when full it became overcrowded and patients had to wait outside on over spill chairs where they could not easily be seen by the streaming nurse. Staff had concerns about this waiting area which was utilised for patient treatments.

The department's interim layout during these building works was fragmented. This meant ED staff had a large footfall to cover and move between different areas as there were several one-way corridors and bottleneck corners. Also, staff lacked oversight of patients in waiting rooms and other areas unless they consciously did safety, welfare or intentional rounds or sweeps to check for signs of deterioration. After our inspection trust leads acknowledged their resuscitation space challenges. They confirmed staff could always move patients to ensure resus capacity was available when needed. There had been no incidents when resuscitation could not be maintained.

However, security support completed loops of the department and were available 24 hours a day.

We found numerous issues with the environment potentially putting patients and staff at risk. The department had several patient cubicles which were not large enough for a hospital bed. Staff adjusted the beds to be diagonal in at least two cubicles, but this meant they could not easily manoeuvre around patients. These rooms fitted a trolley but due to long stays patients were transferred onto hospital beds which did not fit the room. There was no risk assessment of where long stay patients should be cared for, except the RTF corridor where cubicles were not large enough for a hospital bed. We saw one door to a patient room was propped open with an oxygen cylinder. This was unsafe as it contained pressurised gases and was a potential trip hazard.

All toilets we checked had ligature risks such as hanging pull cords or call bells. This included the toilet closest to the mental health assessment (MHA) room within the department. We found portable appliance testing (PAT) labels were blank on multiple pieces of electrical equipment. Lots of equipment was stored was along corridors and communal areas of the department. All oxygen cylinders we saw were insecurely stored loosely on the floor in waiting areas and treatment rooms. Some cylinders were under a sink along the paediatric assessment corridor with no warning signs despite medical gas cylinder storage posters being displayed nearby.

After our inspection leads told us these ED cylinders had been moved. Their team were exploring temporary arrangements for the safe storage of medical gases whilst the department was reduced in size for the new build works. Service leads had purchased storage racking to install at designated points ensuring all medical gases were stored in line with guidance and policy.

On our follow up inspection we saw oxygen cylinder racking had been installed in the amber resuscitation bay. ED staff were still awaiting another rack for smaller cylinders along the RFT corridor. We found some oxygen cylinders had been placed on small wheeled holders along a main corridor. However, they were still loose and directly beneath a laminated sign requesting these are kept secure. Staff we spoke with had not recognised this remained a concern that should be addressed.

We found the department's one designated MHA room was unsuitable. Although the room complied with some psychiatric liaison accreditation network (PLAN) standards (such as limited ligature points within the room itself, heavy furniture), we saw multiple environmental risks in close proximity to the room. We saw cages stored outside the room covered in plastic which presented as a significant asphyxiation hazard. Equipment with thick power cords was stored on the floor outside of the room which could be used as ligatures. The room had large pieces of equipment such as stepladders blocking the corridor despite the room's door sign stating, 'please keep this area clear'. We saw loose ceiling tiles with drooping tape above one of the room's two-way doors.

Staff told us only one of the room's doors swung both ways as activated using a specialist key fob.

We reviewed the trust's latest mental health in the ED standard operating procedure (SOP). Under section 12 'placement of patients within the ED' this stated both sites had a dedicated PLAN compliant MHA room. It added the room was the most appropriate place to place patients awaiting or following mental health assessments. Patients would still need to have enhanced observation as agreed with the liaison team onsite as per the MH triage tool completed on arrival in the department. Patients who were considered very high risk, highly agitated or at risk of absconding, may need to be placed under continual observation with or without assistance from York Hospital security team, ideally in the designated MHA room.

However, the MHA room was located in a dark corridor at the bottom of the department. We found a blind spot through the second door out of the room where roof tiles were damaged. The corridors were poorly lit and unseen from the nursing station. This meant a patient would potentially be able to exit via this door without being seen. We escalated our concerns around the MHA room's suitability in a letter of intent after our inspection. After our inspection leads told us staff had checked this room which contained the required seating compliant with relevant standards. They confirmed equipment outside the room had been removed and would be discussed in their safety brief.

The weekend after our inspection, leads told us the nurse in charge (NIC) completed a documented check of the MHA room three times a day. They identified support services previously delivered linen to the area just outside this room. As a result, these staff would now deliver linen to a more appropriate location.

In addition staff told us these pull cords had been replaced with hygienic anti-ligature versions to reduce potential risks. They planned to replace these across all areas of ED to be complaint with mental health best practice. We saw these upon our return November 2022 visit.

Staff did not always carry out daily safety checks of specialist equipment. We reviewed resuscitation trolley checklists for adults in the waiting room and paediatric areas. We found these were not accurate or consistently completed by staff. The adults checklist had been rolled up and torn in a plastic wallet. The checklist had several dates left blank during September and October 2022. We followed this up with the NIC who told us when their department was under severe pressure staff did not carry out these checks. The ED matron's tendable weekly assurance report from 14 September 2022 also showed staff had not checked resuscitation equipment daily as required.

On our follow up inspection, we reviewed resuscitation trolley checklists in the department and found there were still blank dates, for example 16-17 October and 6 November 2022 on the trolley by the RFT corridor. These three blank dates and the 7 November checks were unsigned. Nursing staff were told if any resuscitation trolley equipment needed replacing at shift handover.

In the paediatric assessment area, we found on six occasions from 1 to 21 November 2022 staff did not record any children's resuscitation trolley checks. We also found two expired paediatric defibrillator pads with no replacements. Despite this, staff the day before had signed to say all equipment checked was in date.

The service did not have suitable facilities to meet the needs of patients' families. The department had no provision to accommodate relatives or carers in a designated or overnight room. Nursing and medical leads tried to mitigate this by offering families any available side rooms not in use due to equipment awaiting repair.

The service had enough suitable equipment to help them to safely care for patients. The service's manual handling lead acquired the department a new hoist on wheels which fit into the smallest patient cubicles. At the time of our follow up inspection staff still needed training how to use this equipment.

However, the department lacked any storage areas to keep equipment off corridors. We saw lots of equipment boxes on a trolley, a cabinet with RPE kits on top and loose oxygen cylinders piled up in front of the wall to the new ED building works with a sign requesting this area was kept clear. The RFT corridor linen store door could not close as it was full of trolleys, a broken chair and wheelchair in the doorway.

Staff did not always dispose of clinical waste safely. Clinical waste was not always managed in a way that kept people safe. Upon our arrival into ED on 13 October 2022, a secure door had been left open which allowed access to a small courtyard where waste bins should be securely stored. As the doors were left open, anyone had direct access to this area. We saw clinical waste had been left on the ground and not disposed of correctly. On our return November 2022 visit, we again found loose clinical waste on the ground.

Sharps bins we checked were signed, dated and not above the fill line. However, they were not always clean and in some cases were filled with equipment other than sharps.

Assessing and responding to patient risk

Staff did not complete risk assessments for each patient swiftly. They did not remove or minimise risks or update their assessments. Staff did not identify and quickly act upon patients at risk of deterioration.

Staff did not identify and escalate deteriorating patients appropriately. However, they used a nationally recognised tool. The department used the national early warning score (NEWS2) but staff did not manage this well.

Staff's placement of patients in the ED did not lead to the most optimal oversight. For example, patients with high NEWS were in corridors with restricted observation and minimal staffing.

We found ineffective identification and management of deteriorating patients throughout the department. The department had no recommended parameters for national early warning scores (NEWS) for patient's clinical deterioration. This meant service users were exposed to the risk of harm as findings were not always acted upon. We escalated our concerns around the identification and management of deteriorating patients and the management of patients within the department in a letter of intent after our inspection.

Three patients we reviewed with identified NEWS2 scores between 5 and 10 had no evidence of any escalation or review within the required timeframes, even though some scores had increased since. For example, one patient we reviewed had an identified NEWS2 score of 10 at 10:10am on 13 October 2022. We found no evidence in the patient notes reviewed staff had followed any escalation and we did not observe any documented ceiling of care. Staff confirmed they had not escalated these patients; despite being concerned about their high NEWS score. We escalated these patients to the trust during our inspection, and no further assurances were provided regarding their escalation during their time within the department.

We saw staff recorded no follow up actions for one patient at risk of sepsis whose NEWS and temperature was high. Another patient we reviewed had no NEWS observations undertaken by staff for 12 hours overnight; their score stayed at 1.

In all these cases this was a risk to patients as a timely appropriate escalation, care and treatment was not evident and the patient's health could have deteriorated further without appropriate intervention.

The weekend after our inspection leads also told us they had amended the nurse in charge (NIC) checklist and held a debrief from the care group team. ED staff documented evidence of two hourly acuity checks within the department. The NIC and emergency physician in charge (EPIC) discussed any patients with a NEWS2 score of 5 or above and took appropriate action as required.

The department included a ready for transfer (RFT) corridor. We observed this was staffed by two registered agency nurses. The senior team told us this area was for patients who had been assessed, had a plan in place and were suitable for transfer to a ward. Care group leads told us no unstable patients would be placed on this RFT back corridor. However, during our inspection we found some patients in this area did not meet this criteria. After our inspection leads confirmed the corridor was used more flexibly. If patients had a treatment escalation plan of ward level care they may also be cared for in this area.

ED staff were concerned about patient safety in the department when it was busy. For example, they had concerns about the resuscitation areas and their limited capacity as they had no other room to respond to emergencies when these three rooms were in use. An ED consultant told us they always tried to keep one flexible child or adult resuscitation bay free for this reason.

During our inspection staff, including the department's senior management team, told us there was no formalised or documented plan of how to manage patients waiting within the department. In addition, there was no formalised or documented plan of how staff should manage and provide clinical oversight of patients left in the waiting room.

Care group leads confirmed there was no written criteria for which patients in the majors waiting room areas could have treatment as this was based more on staff's clinical judgement.

The EPIC and NIC maintained oversight of all patients in the department. Waiting room patients were recorded on CPD and could be filtered on the ED screen. For example, by area or NEWS score with each patient colour coded to reflect where they were in the department.

However, we saw limited oversight of the majors waiting room. We were told there had been times when this waiting room was staffed by only a healthcare assistant (HCA). We escalated this at the time of our inspection. Care group leads confirmed there was no written criteria for which patients in the majors waiting room areas could have treatment as this was based more on staff's clinical judgement.

The majors waiting room had become a ward with no oversight. We were told there had been times when this waiting room was staffed by only a healthcare assistant (HCA). We escalated this at the time of our inspection.

We reviewed one patient in the waiting room with an intravenous (IV) drip in their arm who had been awaiting admission all night. ED staff had undertaken no reviews of their pain or observations. We escalated this patient during our inspection, and the trust confirmed there was a delay in this patient's observations being completed. The patient had initial observations undertaken 10:30pm on the 10 October, which were not repeated until 8:10am the next morning of the 11 October.

Patients we reviewed in the majors waiting area did not have any associated nursing documentation or recording of observations taken. We escalated this to the trust who provided an observations checklist. However, this only captured

if observations had or had not been completed and did not include the details of observations. Furthermore, patients within the waiting area were not always included in the electronic oversight system. This meant it was unclear how staff-maintained oversight of how long patients had waited within this area, or how staff kept a contemporaneous record of patients conditions whilst awaiting review.

Staffing data provided by the trust outlined there was a staff nurse dedicated to maintaining majors waiting area oversight. This allocated staff nurse was also responsible for escorting patients.

However, we observed periods where the majors waiting room was not staffed in accordance with trust policy and no staff nurse was present. There was a call bell in the waiting room to attract the attention of staff. The department was utilising space outside the waiting area to seat patients. This meant staff could not always observe patients in both the majors waiting area and main areas of the department. This could cause delays in staff alerting the resuscitation team promptly in the event patients deteriorated.

The weekend after our inspection leads told us a band 5 nurse and band 2 HCA were allocated to the waiting room. This increased resource supported the nurse with maintaining effective patient oversight, particularly at times of peak demand. We were told an effective call bell system was in place in the waiting room which linked to the main nurses station. If nurses needed assistance they could call for help using this system.

On our follow up inspection, we saw ED staff used discrete numbers on the back of chairs in patient waiting areas. However, this was not always communicated to staff outside ED so we saw a speciality doctor call in one patient for review who did not return to the same seat.

We saw ambulance crews managing patients along the corridor. At times there was up to seven patients in this area. These crews reported ED staff checked on the patients occasionally, but we found no planned management of the queue. Crews or ED staff could not complete patient's skin checks on intentional rounding, as they were unable to roll patients on trolleys. We saw staff toileting patients using screens in the corridor which didn't always maintain the patients privacy or dignity. Staff told us they had concerns about the lack of nursing care which could be carried out along the ambulance corridor.

We heard a medical support provider team were introduced to manage the ambulance corridor. This team consisted of one band 6 nurse and healthcare practitioners, with a paramedic on occasion. They felt this led to safer management of patients. However, staff could not tell us when the team were available in the department. This team were stopped with no communication to ED staff or ambulance crews about how to mitigate or how staff should manage corridor patients without them.

The weekend after our inspection leads told us a band 6 nurse streamed ambulances and maintained effective oversight of the ambulance corridor. A band 5 nurse undertook this role on the Saturday night shift with oversight and support from other ED nursing staff. A medical consultancy delivered ambulance cohorting support on the Sunday night shift comprising band 6-7 senior nurses from other EDs.

Receptionists could alert their nearest triage nurse or push an emergency alarm if patients became unwell. We heard nurses held a handover safety brief daily attended by all outgoing staff.

Urgent and emergency services

Staff did not complete risk assessments for each patient on admission or arrival, or review this regularly, including after any incident. There was a lack of screening tools for patients such as sepsis, PURPOSE-T and malnutrition universal screening tool (MUST). When we could find these in patient notes they were not always accurate or consistent. This meant service users were exposed to the risk of harm as findings were not always acted upon.

During our inspection we continued to observe patients without wristbands in situ in the majors waiting room, despite having escalated this concern on our first day.

Staff did not always know about and deal with any specific risk issues. One group of medical staff felt no hospital staff outside ED proactively helped them or the department's patients. They said this meant ED staff were constantly dealing with most of the hospital's risk, which was not evenly shared with other specialities, wards, or care groups. They told us bed and operational managers were not responsive enough when they needed wider support. Senior nurses felt they sometimes had to do the bed manager or community matron's job as they put the onus back on them to find solutions when they escalated severe pressure issues in their department.

We reviewed the service's latest sepsis training compliance rates for nursing and medical staff. Medical staff's overall compliance was 46.7%. Nursing staff's overall compliance was 78.6%. These rates did not meet the trust target of 85%. This meant service staff were not trained in sufficient numbers to recognise or respond to the warning signs of sepsis in patients.

In five patient's sets of notes we checked, only one had been screened for sepsis. We found no evidence ED staff monitored patients in accordance with the recommended pathways such as sepsis 6 or response times such as administering antibiotics within the first hour. This meant no risk indicators were recorded to which staff could respond promptly.

We reviewed the most recent sepsis audit completed in April 2022. This showed the hospital's ED had a sepsis screening compliance rate of 16% with 24% of patients receiving antibiotics within one hour of recognition. We were informed sepsis audits had paused after this month for two quarters as the trust developed a revised sepsis screening tool rolled out from May and in September a new sepsis pathway was relaunched with updated audit questions. We followed up this very low compliance rate with leads. They told us compliance should drastically improve once staff followed the new pathway in the last quarter of 2022.

We raised this with nursing leads who admitted their staff rarely complete sepsis screening. We did not see any sepsis trolleys, grab bags, folders or reminder notices anywhere throughout the department ready for emergency intervention. This department had no sepsis lead contacts, visible signage or education information. On our follow up inspection, we saw these placed in resuscitation areas. A sepsis education folder was also made available to all staff.

The trust used the sepsis six care bundle. This was the latest adult sepsis screening and immediate action tool (version 21) approved by the deteriorating patient group. Staff should follow a flow chart to determine if patients were at low, possible or high risk of sepsis. If patients had any one red flag for sepsis present staff should commence the sepsis 6 care bundle immediately. We saw instances where staff had ticked a red flag but recorded no follow up actions, name, signature, date or time.

Urgent and emergency services

The trust recently relaunched their sepsis pathway on World Sepsis Day (13 September). This included additions based on learning from incidents and serious incidents. Their associated policy was next to be updated. The trust's sepsis audit tool had been revamped with support from clinicians in both EDs. The tool would move digital platforms to enable the automatic reporting of data, encouraging clinical time to analyse the findings and drive improvement. The question set and dashboard was scheduled for completion by 21 October 2022.

The service planned to revise and relaunch a new sepsis screening tool by 4 November 2022 to include pre-hospital NEWS and chemotherapy complications. The lead ACP would then undertake a trustwide quarter 3 audits of this tool by 22 December 2022.

ED staff used the pressure ulcer (PU) risk primary or secondary evaluation tool (PURPOSE-T) for patients. This was an evidence-based PU risk assessment instrument used to identify adults at risk of developing a PU and supported nurse decision-making to reduce that risk.

During July 2022 ED saw an increase in newly developed and deteriorated PUs. This was the highest number in the last 15 months. The department were accountable for 14 of the 62 total category 2 PUs reported. In August 2022 the department's number of PUs reduced to five from a total of 47. However, newly developed PUs still remained above the upper control limit. Only a small number of those reported both months mention the patient's length of stay or wait for a hospital bed being a result of the PU developing.

We saw evidence staff did not always fully complete pressure ulcer checks for patients. As patients on stretchers had extended waits, their risk of pressure ulcers developing or becoming worse increased. We found a lack of clarity from staff in patient notes about which pressure areas were acquired in the department.

Nursing staff told us service leads had undertaken five recent pressure area root cause analysis (RCA) investigations. However, when we asked leads, they said ED had no recent category 3 or above hospital-acquired pressure sores to investigate. This meant we were unsure how many higher category pressure ulcers had been investigated or learnt from with recommendations taken.

One ambulance streaming nurse explained they could not always effectively monitor patients for potential pressure ulcers as they were triaged whilst sat on the ambulance stretcher. Often nurses would ask patients to disclose if they had any skin integrity issues themselves. We saw staff had evidenced these in patient records.

We found no evidence ED staff utilised alert cards for patients with cancer. For example, with patients who were neutropenic.

During July 2022 ED saw nine falls reported. This was the same figure as previous month. Three of these falls caused minor harm to the patient.

The service had 24-hour access to mental health liaison and specialist mental health support. During the inspection we saw the psychiatric liaison team were supporting a patient in the department. Staff told us they could access psychiatric liaison any time of day. They explained patients experiencing mental health crisis would often attend the department due to difficulty accessing community-based resources.

Shift changes and handovers did not always include all necessary key information to keep patients safe. We reviewed continuation sheets and found staff's notes were inconsistent.

We reviewed the service's missed opportunities audit from June 2022. One of the 20 randomised patients audit leads reviewed was referred to the emergency assessment unit (EAU) but remained in ED for a further three hours before being transferred. The audit concluded delays with transferring or accepting patients to the frailty service was also evident with further work required to overcome these barriers.

Nurse staffing

The service did not always have enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers did not always regularly review staffing levels. However, they reviewed skill mix and gave bank and agency staff a full induction.

The service did not always have enough nursing and support staff to keep patients safe. Senior staff told us nurse staffing levels were deemed to be unsafe, but we found no evidence they resulted in harm to patients.

Managers did not always accurately calculate and review the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Matrons and managers utilised the acuity tool for only two weeks when the minimum rota period is six weeks. This reflected their safer nursing care data tool collection period. Leads lacked clarity on how to flex staffing levels for expected surges in demand such as during bonfire night, New Year's Eve or specific days of the week. This meant they would not have an accurate indication of staffing figures within the department. As a result, ED still had only vague ideas for nurse staffing figures and the baseline safe levels needed.

However, we heard senior nursing staff carefully planned and scrutinised their allocation of staff on the rota. This ensured the right staff had the right skills to work in the different ED areas. Nursing leads escalated and covered any shortfalls within the department appropriately. Staff could be moved around on the day. The nurse in charge (NIC) attended daily 8.30 staffing meetings to see if extra staff could be offered to ED. Leads told us matrons sent staff to help. The matron reviewed staffing daily when first arriving onsite, the trust also held cross care group staffing meetings.

Trustwide work was commencing on the use of SAFECARE and how red flags were used to escalate and articulate concerns around nurse staffing levels. This adhered to the National Institute of Clinical Excellence (NICE 2014)'s six red flags highlighted to be considered which they believe impacted upon delivering safe patient care.

The number of nurses and healthcare assistants did not always match the planned numbers. On our follow-up inspection, nursing leads told us they struggled to allocate enough healthcare assistants (HCAs) to cover shifts in the department in recent weeks. On 22 November 2022, we saw both amber and red resuscitation bays had no HCAs for the early, late or night shifts.

Furthermore, two cubicle areas had no HCAs on the late shift and three cubicle areas had none for their night shifts. Only three HCAs were on the roster for the shift we observed instead of the required six. Managers had transferred two HCAs from the wards into ED who were not always comfortable caring and treating some patient cohorts.

ED's lack of HCAs meant managers could not always offer 1-2-1 enhanced care to patients when required, such as those who needed mental health crisis support. Managers told us the department was seeing more of these patients for whom a 52-hour wait for an available bed was a regular occurrence. Senior nurses understood and managed the risks around their lack of HCAs. They told us an ongoing HCA recruitment campaign was underway.

The department manager could adjust staffing levels daily according to the needs of patients. ED had a daily staffing level care meeting with the head of nursing. Despite this, nursing staff told us the department was run on goodwill where they were often expected to work over and above their shift hours and were not always guaranteed breaks.

We heard the relationship between ED and SDEC could sometimes be difficult as ED felt like SDEC should take more patients they identified as suitable when under pressure.

ED's paediatric assessment area resource was taken from their main staffing allocation. A missed opportunities audit from October 2021 identified that mapping this service separately could better indicate resourcing needs.

The service had low and/or reducing vacancy rates. We reviewed ED nursing staff's overall vacancy rate from July to September 2022. This had increased slightly by 1.79% FTE vacancies from 5.03% to 6.82%. However, their band 5-7 registered nursing staff rate had reduced by 4.4% FTE over these three months.

The department had ten new registered nurses (RNs) starting throughout October 2022. Clinical educators had made some recruitment achievements in the months before our inspection from July to September 2022. They had recruited five new starter band 6 nursing staff, 13 band 5's registered PRNs (pro rota) and one band 4. As of 21 November 2022, the department had 8.76 WTE band 5 vacancies, 8.4 WTE band 2, three WTE band 3 and one WTE part-time band 4 clinical educator all out to advert.

The service did not have low and/or reducing sickness rates. In the two months before our inspection the service's nursing workforce had been impacted by increased sickness. This exacerbated the fill rates on inpatient wards due to a recent increase in COVID-19. Trustwide work was commencing to offer further support to care groups to monitor sickness and ensure all HR processes were in place.

On our follow up inspection nursing leads confirmed ED was fully established for HCAs. However, three were on long-term sickness.

The service did not have low and/or reducing rates of bank and agency nurses. Senior nursing staff told us ED had a 40% uplift of bank staff and often used agency staff. The NIC told us they used mostly agency nurses on night shifts. They were familiar with the department, did not work anywhere else and could access all required systems such as the automated drug dispensing cupboard to help manage patient's medicines.

We reviewed the service's latest total number of bank nursing shifts requested and filled for the six months up to our inspection. They were unable to fill 547 bank shifts during this period. This was a rate of 15% of the total shifts.

We also reviewed the service's latest total number of agency nursing shifts requested and filled from 22 April to 21 October 2022. They were unable to fill 337 agency shifts during this period. This was a total rate of 29.3%.

We reviewed the service's latest total number of agency nursing shifts requested and filled from 22 May to 22 September 2022. They were unable to fill 14 shifts during these five months. This was a total rate of 19.7%.

For the three months from August to October 2022 ED nursing bank and agency usage saw little variation. ED bank usage tipped over 25% and agency usage was 17.25% of the total hours worked for September. These figures were both the second highest usage of any area within the care group.

Managers could not always limit their use of bank and agency staff. However, they requested staff familiar with the service. We heard as a result of ED staff burnout, the service used high numbers of agency staff and gaps in cover presented inconsistencies.

Managers made sure all bank and agency staff had a full induction and understood the service. We heard both band and agency staff had received training and were working through their competencies.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave locum staff a full induction.

The medical staff matched the planned numbers. We reviewed the service's medical staffing rotas for August, September and October 2022. Any gaps on single shifts were covered by cross cover from adjoining shifts. There were no consultant gaps for this period and mitigations were in place where gaps occurred for medical leads to follow.

However, at the time of our inspection the department had some medical staff shortages. On 11 October 2022 ED were two medics below their planned numbers who were absent. The ED consultant for the weekend before our inspection told us they had been three medical staff short. This increased patients' waiting times to be often over 24 hours. On our follow up inspection ED had all three day shift consultants allocated.

The service had low and reducing vacancy rates for medical staff. The service's latest total emergency medicine vacancies was 15.87 wte. This meant the department was over established for the number of full-time equivalent (FTE) medical staff it needed.

Sickness rates for medical staff were not low or reducing. Two consultants missed shifts due to sickness in August 2022; one day and one evening but none were off sick during September or October 2022. However, junior medical staff only missed six shifts due to sickness in August, but 16 in September and 23 in October. At the time of our inspection sickness rates were rising for junior medical staff grades.

The service did not have low and/or reducing rates of bank and locum staff. The service used middle grade bank, agency or locum staff for 68 shifts in August 2022 but 105 in September 2022. However, this dropped to 79 during October 2022. The service's number of junior level bank, agency and locum staff during this period dropped slightly in September 2022 but saw no significant change.

Managers made sure locums had a full induction to the service before they started work. Locum doctors we asked said they were orientated and familiar with the department, worked frequent shifts and knew who to ask for help. We reviewed the service's medical staffing rota and saw junior doctor grades had protected induction and study days.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Medical leads uploaded any rota gaps onto a healthcare workforce solution in advance and the service had a contact group used by locums where last minute requests were sent. The service could use an additional consultant on shift to cover any junior or middle grade gaps.

The service always had a consultant on call during evenings and weekends. ED consultant cover was two on day shift, two on evening and one on-call for the night shift. If the department had a ST4+ grade gap on a night shift, the on-call consultant would be expected to cover. The paediatric department could support and cover any significant gaps in the children's ED.

Managers could access locums when they needed additional medical staff. Leads had mitigations in place for any consultant gaps such as an agency doctor or locum shifts with escalations if required. They could also swap doctors from well staffed shifts which suited their working pattern or seek assistance from other specialties in the hospital.

Records

Staff did not keep detailed records of patients' care and treatment. Records were not always clear, up-to-date or stored securely. However, records were easily available to all staff providing care.

Not all patient notes were comprehensive, but staff could access them easily. All patient notes we reviewed were inconsistent, inaccurate or illegible. Although staff completed initial patients checks upon arrival, we saw gaps in NEWS scores, pressure care management, fluid charts and medicines management documentation.

During our inspection staff handed us two sets of patient records which had been rewritten in retrospect since our arrival in the department. These records had a significant amount of medical information added. We confirmed this with one of the relevant staff who agreed they had reviewed content and rewritten their documentation. This meant we could not always ensure staff maintained patient's records accurately or contemporaneously.

Staff did not document malnutrition universal screening tool (MUST) or fluid balancing charts in patient's notes. We reviewed these and found two were completely blank. In one set of patient notes staff had retrospectively added 'stated no pressure areas'. This patient's record contained no staff notes of their diagnosis, heart rate, national early warning scores (NEWS) either on admission or since, sepsis screening or pathway, blood cultures taken, pain scores or PURPOSE-T pressure ulcer risk assessment.

We escalated the situation with these rewritten patient notes to trust and service leads.

One patient we reviewed and escalated had weeping bilateral leg ulcers. ED staff had completed no body chart mapping in this patient's notes to indicate the severity of their wounds. This meant staff would be unsure how often to check or redress them and they could be treated inappropriately.

Records were not always stored securely. We saw some patient's medical records which were kept face down and accessible on the majors staff station counter. This meant these records were not locked away in trolleys when not in use.

Medicines

The service did not use systems and processes to safely prescribe, administer, record and store medicines.

Staff did not follow systems and processes to prescribe and administer medicines safely. Medical staff checked neither patient details or to see if they wore wristbands before administering medicines. We saw staff taking patients in and out of waiting areas with no wristbands.

ED staff did not allocate wristbands to patients with known allergies such as penicillin. Staff also administered patients, controlled drugs (CDs) without a wristband or completing any identification checks prior. For example, we observed an

instance where staff were due to administer morphine (a CD) to a patient who had no wristband without asking them to confirm any personal details. ED staff did not always demonstrate awareness of GMC guidelines in relation to this concern. The staff member we challenged told us the patient had capacity so a wristband was not required. He added he would put a wristband on the patient before prescribing fentanyl. Nurses then attached two wristbands including a red one to the patient to indicate they had allergies. We escalated this at the time of our inspection.

We also saw staff administer paracetamol to patients not wearing a wristband without checking their details or known allergies. Staff came over whilst we spoke to patients and checked their details, name and date of birth then put on their wristbands.

Staff did not complete medicines records accurately and kept them up to date. We found CD records were not always completed in line with national guidance, for example we found entries completed in pencil and missing signatures. The errors in recording were being picked up by the internal department daily stock checks. However, the department had not had a pharmacy-controlled drug audit since June 2022. Staff on the unit were unaware how often pharmacy checks took place. As the referenced SOPCD4 guidance was no longer available online, we could not evidence staff oversight. However, the service adhered to guidance on frequency of controlled drug inspections in the medicines code and SOPCD3 in relation to the checks carried out by their staff.

On our follow up inspection, we found staff ensured time-critical medicines were administered on time. ED staff prescribed and administered one patient at risk of sepsis time-critical medications within the required hour.

After our inspection leads told us their care group team had reviewed the audits pertaining to CD management. They explained further comprehensive audits of documentation quality was required and pharmacy would lead on this work in conjunction with the ED team.

We reviewed a patient's prescription for a diuretic infusion to increase fluid output. However, as staff had not recorded fluid input or output on the patient's fluid balance chart, they were unable to assess the effectiveness of the treatment.

We attended a nursing handover where staff were reminded to clearly document when, if and why any patients refused their medications.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. We saw evidence of pharmacy input into the department. The ED had a weekday pharmacy service consisting of a pharmacist and technician. Their primary role was to focus on medicines reconciliation specifically targeting those with critical medicines to ensure they were not missed by patients. The team raised concerns they were unable to see everyone due to minimal pharmacy staff working in the department. They recognised the trust were recruiting further pharmacy team support into ED.

Staff did not store and manage all medicines and prescribing documents safely. We observed a CD cupboard was unlocked, and staff were unaware of this. We identified instances of oral antibiotics suspension which had not been disposed of after the in use expiry date had passed.

Staff were unable to locate the CD cupboard keys as they had been removed from the clinical area by another staff member escorting a patient. On both inspection visits we found staff missed CD stock checks in the red resuscitation

area. We reviewed the trust's CDs policy which stated at least weekly checks were required, and daily for all 'high frequency use environments. This meant we could not ensure ED staff were checking and maintaining CD stock as often as required. We escalated our concerns around ED medicine management and controlled drugs in a letter of intent after our inspection.

On our follow up inspection, we found ED staff did not always complete daily checks of medicines to be used in an emergency or equipment to ensure it was in date. For example, a medicines fridge remained unlocked and contained an out of date medicine. We found staff recording of CDs was still not always in line with policy, for example the book contained missing signatures. These omissions were being picked up on ED staff's stock checks. However, it was unclear if pharmacy were aware of these issues or what action was being taken.

We asked the nurse in charge to demonstrate how they check the oxygen cylinder's supply level on the children's resuscitation trolley. They were unable to release the child safety catch to see how much oxygen the cylinder contained and subsequently if it needed refilling.

The department operated two systems in relation to prescribing. Patients were initially clerked in on a paper prescribing document known as a 'CAS' card where immediate medications were prescribed and administered. Once patients were seen by medical staff, any prescribing was then completed on the electronic prescribing and medicines administration (EPMA) system. A manager we spoke with raised concerns around using two prescribing systems concurrently. This meant staff ran the risk of duplicate prescribing and administration.

Since our last inspection the service had increased pharmacy presence in both EDs, increasing the range of medicines stocked, introducing a drug trolley and staff's use of the EPMA for critical medicines for patients staying in ED for prolonged periods. An automated drug dispensing cupboard was being used in ED to improve medicine accessibility.

Staff did not follow national practice to check patients had the correct medicines when they were admitted, or they moved between services. There were examples of unidentified medications left loose in pots, and medicine storage areas left easily accessible and unlocked throughout the inspection.

During August 2022 ED staff reported an increased number of incidents involving medicines. We reviewed these medicines incidents and found none relating to staff not giving patients wristbands. However, we found two incidents where ED staff had not communicated effectively during the discharge resulting in an incorrect dose being administered on discharge. Two other incidents involving medicines concerned patients transfers to wards where infusion fluids were not prescribed or administered. This meant we could not be assured staff always replaced or mitigated patient's lost fluids where they were unable to take these orally.

Staff did not always learn from safety alerts and incidents to improve practice. The trust's two EDs were the joint most common locations for medication incidents, comprising 9% of the total. We reviewed the service's medicines incidents for August 2022; one resulted in minor or low harm and the other moderate harm. The moderate harm incident involved ED staff not administering a prescribed long acting insulin dose or completing hourly blood sugar checks for a patient who developed hospital-acquired diabetic ketoacidosis (DKA). Leads had completed agreed actions and learnt lessons from the SI investigation. For example, ED nursing and medical staff received education on VR111 management and findings were shared at the ED and acute directorate meeting and governance meetings.

However, the trust's latest medication safety strategy 2021-23 stated many measures put in place around their 69 historic national patient safety alerts (NPSAs) relating to medicines were no longer relevant and needed review. One of the trust's priorities for 2021-22 was to establish an audit programme to ensure ongoing compliance with historic alerts.

Urgent and emergency services

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers ensured that actions from patient safety alerts were implemented and monitored. Managers investigated incidents and shared lessons learned with the whole team and the wider service. However, this was not always done promptly. When things went wrong, staff did not know how to apologise and give patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust/provider policy. During July 2022 ED staff reported 149 incidents. This was the service's highest number raised for the last 12 months. The most common incident categories related to pressure ulcers and clinical incidents.

ED staff raised incidents around nutrition and hydration issues arising from a lack of staffing and intentional rounding not taking place as required. During July 2022 the care group reported 64 incidents which included a food, nutrition, hydration or fluid element. Of these 64 incidents, 34 relating to staffing shortages resulting in a delay to patients having assistance with food and drink. Three of these were in ED. One of these incidents described a short staffed department shift full of ready for transfer (RFT) patients in every cubicle which meant patient care was compromised as doctors had no space to see patients. This led to long waits for patients, delayed ongoing treatments and ambulance turnarounds.

We reviewed themes and trends from ED incidents in the last 12 months. Several incidents reported patient safety issues as a result of unsafe staffing levels or shortages. This left staff morale low and patient care below the standards staff expected.

The service had no never events in the department However, managers told us learning from never events that happened elsewhere were not shared with their staff, including other trust sites.

Staff reported serious incidents clearly and in line with trust policy. ED staff reported 12 STEIS incidents from 1 August 2021 to 1 September 2022 which averaged one per month. The most common incident type was slips, trips or falls (meeting SI criteria) which accounted for four STEIS or 33.33% of the total. All four resulted inpatient fractures. We followed this up with senior nursing staff who could outline their recent serious incidents involving fractures and actions taken to prevent reoccurrence. One entailed a patient in ED with cerebral palsy who fell over their bed rails causing a leg fracture. Managers explained their staff since had clearer oversight and safeguards in place to spot escalations early enough to intervene.

Treatment delay and diagnostic incident including delay were the next most common STEIS type with two incidents each.

Emergency medicine had 128 incidents that needed review, approval or closure in August 2022. Care group and operational leads prompted staff with outstanding incidents to complete their investigations and move them onto the next stage in order to close their raised incident reports as soon as possible.

Agency nursing staff we asked said they did not report incidents but had a point of contact if needed.

Staff did not understand the duty of candour. They could not always give patients and families a full explanation if and when things went wrong. We found no evidence or staff understanding of any knowledge, training or visible procedure for the duty of candour process. We asked the divisional chief nurse who could not confirm if ED staff had this training.

Urgent and emergency services

As of August 2022, ED had one outstanding stage two written apology due to the patient being critically ill on ICU from a medication error incident graded as moderate harm in September. However, the department had no stage one outstanding verbal apologies.

Staff received feedback from investigation of incidents, both internal and external to the service. On our last inspection we told the trust it must ensure it has a robust process for identifying learning from deaths and serious incidents and ensure this is systematically shared across the organisation.

On this inspection we found the service had made significant improvement around learning from incidents. For example, ED's clinical governance forum agenda included reviews of all reported, serious and safeguarding incidents to identify any areas for shared learning. We saw the minutes from September 2022 focused on staff's poor discharge instructions and inappropriate tablets to take home (TTOs) for a patient with learning disabilities. The clinical governance team also shared structured judgement case reviews (SJCRs) and related good practice. We saw examples in governance reports of 72-hour reports awaiting and post-senior review along with those completed and taken to the quality and safety committee for learning.

Staff met to discuss the feedback and look at improvements to patient care. Staff held safety briefs and debriefs after any incident to address the most common incident types. Clinical leads feedback any new learning from reported incidents to all staff on safety briefs.

ED clinical staff had created a 'hotshots' social messenger service group where they shared policies and updates for example around antibiotics prescribing or the royal college of emergency medicine (RCEM) emergency news flashes often duplicated by email. Staff could also access integrated care board (ICB)-wide feedback from their care group which then disseminated the same information through their news bulletin.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. As of August 2022, ED had 13 clinical SI actions of which six were overdue and seven were due by November and December 2022. Of the six overdue, one each related to falls and pressure ulcers. The governance team were chasing the collected evidence to show the action had been completed and embedded into practice.

Is the service effective?

Requires Improvement ● ↓

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983. However, managers did not check to ensure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. However, we saw no evidence of how managers checked to ensure that staff followed guidance. For example, we saw incomplete capacity assessments and risk assessments in patient records.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We observed effective conversations between staff regarding the mental health act which demonstrated a good level of understanding.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Morning shift handovers we observed with nurses and medics included consideration of patient's mental health and wellbeing.

Nutrition and hydration

Staff did not always give patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Trust staff used the malnutrition universal screening tool (MUST) to monitor patients. This was a five-step nationally recognised and validated tool to identify adults at risk of malnutrition.

We saw poster guidance for staff to help them ensure patients were supported at mealtimes and modify patient's diet and fluids. If nursing staff had any concerns or queries about patient's food or drink requirements, they could contact the speech and language therapy (SALT) department. The nurse in charge updated a ward nutrition board in the department frequently.

Staff did not always ensure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Several patients we asked waiting in the department for a few hours or more had not been given or offered any food and drink. As a result, at least three patients we spoke to asked us for drinks.

One patient on the same day emergency care (SDEC) ward told us there was no water or milk for tea and coffee available and staff had not yet offered them anything to eat after 3.5 hours. We checked and saw the SDEC waiting room had water jugs available. Some patients had been there for over 12 hours.

Patients including those with capacity were not always clear if or why they were or were not allowed food or drink. We spoke to one patient in the majors waiting area who lived alone and had arrived hungry in the early morning hours. Staff had not explained that due to treatment they could not give the patient any food.

Staff did not always fully and accurately complete patients' fluid and nutrition charts where needed. ED staff had completed no MUST scores in one patient's notes to manage or modify their diet in aiding recovery from dressed bilateral leg ulcer wounds.

The care group had an improvement plan which included nutrition and hydration actions for review. ED nutritional standards were still being agreed in July 2022 at the nutrition steering group. The group had arranged a meeting to look at breakfast trolleys and evening meal provisions to ensure patients in ED were receiving adequate nutrition. The hospital's tenable audit questions had raised a lack of assurance around nutrition and hydration. This concern was taken to a tenable question task and finish group.

On our follow up inspection, we found available food and drink for patients in waiting areas and bays. Fluids were easily accessible throughout the department, and fluid charts we reviewed completed by ED staff were reasonably accurate. Triage nursing staff screened patients upon arrival and offered them something to drink and eat using a ward assurance matrix document.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. At the time of our inspection ED staff used a 0-10 numeric pain rating scale between none and severe. We heard the Abbey Pain Scale was being rolled our across the care group. This tool is an instrument designed to assist in the assessment of pain in patients unable to clearly articulate their needs, for example, patients with dementia, cognition, or communication issues.

We saw ED staff guidance on promoting comfort and alleviating pain for patients. Intentional rounding was the structured process whereby nursing staff carried out regular checks using a standardised protocol. As part of this rounding staff completed patient safety checklists hourly. This checklist involved asking patients various questions and undertaking tasks to keep them comfortable and pain free.

Patients received pain relief soon after it was identified they needed it, or they requested it. For example, we saw staff had administered one patient nitrous oxide. They were inhaling this to alleviate their pain before staff manipulated their shoulder.

Staff recorded pain relief accurately but did not always prescribe or administer this correctly. For example, one patient we interviewed using nitrous oxide with no identification or allergy wristbands was struggling to confirm their name. Their doctor claimed the patient had been able to confirm their name before they administered this to the patient. We escalated this oversight at the time and raised with service leads.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. For example, ED staff were submitting audit data for pain in children and assessing for cognitive impairment in older people to the royal college of emergency medicine (RCEM). These audit results were expected to be completed in 2023. The hospital reported similar rates of survival after trauma to those expected for 2020/21.

Outcomes for patients were not always positive or consistent and did not meet national standards. The service admitted 34 patients with a severe head injury directly from the scene of the injury who had a computerised tomography (CT) scan between January 2019 and December 2021. Their median time for patients receiving a CT scan was 0.8 hours. This met the NICE guidelines national standard of under 60 minutes.

The service participated in a paediatric ED audit with monthly observations using five sets of notes. In the nine months before our inspection from January to September 2022 the hospital's compliance of undertaking observations in the

initial 15 minutes of attendance as per the royal college of paediatrics and child health (RCPCH) standard was 88.8%. Compliance was affected by skill mix, agency staff or vacancies and level of activity or demand in the department. Audit results were shared with the team every month and monitored through the monthly paediatric emergency department operational delivery group.

Managers and staff carried out a programme of repeated audits for some areas to check improvement over time. For the three months before our follow up inspection the emergency physician in charge (EPIC) had completed a clinical effectiveness compliance in ED audit. This included criteria such as diabetic ketoacidosis (DKA) management in accordance with NICE guidance. The audit's benchmark was 95% compliance. If outcome results were lower than a consultant and junior doctor were assigned to undertake quality improvement (QI) using the clinical governance platform through teaching, training and disseminating knowledge.

However, we saw no audit information, results or actions on display throughout the department. This meant we could not ensure results and actions taken from audits for improvement were shared with staff, patients or others.

We were informed the care group did not complete audits for pain assessment.

Managers and staff sometimes used the results to improve patients' outcomes. We reviewed an overview report of the service's missed opportunities audit from June 2022. The audit period covered April to May 2022 from a random sample of 20 patients covering all ED attendances. The audit's key findings and recommendations were used by the care group to inform current and future pieces of work. The audit found seven of the 20 cases identified the potential of missed opportunities if additional services or facilities were available by bypassing ED and being seen in other areas such as the emergency assessment unit (EAU), SDEC or the urgent care centre (UCC). The audit concluded direct streaming from ED to alternative pathways was effective and efficient where these services were available. The audit identified 35% of attendances did not require treatment in ED and could have been treated elsewhere. Audit leads concluded EAU services 24/7 would help alleviate some of these pressures when available. However, further work was needed with delivering consistent out of hours (OOH) UCC services.

Managers used information from the audits to improve care and treatment. Improvement was checked and monitored. We reviewed the matron's monthly assurance inspection summary of the trust's tendable audit. The hospital's paediatric ED achieved 82% for September 2022. The ED overall scored 84%. This was also an improvement on August's score of 73%. EAU achieved 90% which was an improvement on August's score of 83%.

The department's latest 12-hour stay as part of their quality and safety audit showed improvement. Staff met 80% compliance for completing patient's falls risk assessments. We observed nursing and medical staff morning handovers at the end of the RFT corridor. The NIC shared any updates and latest audit scores at the nursing handover such as CD order book issues and frailty scoring reminders for staff improvement.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. However, the care group medical staff's additional learning compliance did not meet trust target.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Urgent and emergency services

On our last inspection in September and October 2017 we told the trust they must ensure they continue to recruit staff and ensure they are sufficiently suitably qualified, competent and experienced on duty to meet the needs of patients. This included staff with additional training to treat children in an emergency setting. We also told the trust they must ensure paediatric patients are managed safely and staff are trained in how to manage paediatric patients and situations.

On this inspection we found the department's separate children's assessment area had two qualified children's nurses at all times and one healthcare support worker (HCSW). Staff could also request support from children's wards 17 and 18.

However, at the time of our inspection senior nursing staff told us some staff moved from other hospital areas were not fully ED trained. We were also unclear how security staff's training and suitability was monitored as this was provided by a third party contractor.

Managers gave all new nursing staff a full induction tailored to their role before they started work. We heard the department's two clinical educators held structured induction planning with all new starters into the department. They based this training around the royal college of nursing (RCN) emergency nursing level one and two. All nurses started as supernumerary for four weeks, giving them the required clinical skills days and knowledge for ED work.

The CEs also held structured mentor days where all ED nursing staff from band 2s up to 7s were divided into teams and one team a month had a study, training or update day. CEs had planned a future induction package which needed competency sign off before staff commenced in the numbers.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. The CEs focused on staff development through leadership and management courses.

We heard some HCAs undertook band 4 and 5 training to ensure succession planning. Care staff from other areas did not have all required ED competencies so they were only asked to carry out duties such as cleaning rounds, personal care, basic observations and nutrition and hydration.

The clinical educators supported the learning and development needs of staff. We heard about the clinical education achievements in ED. These included organising a faculty to roll out two trauma intermediate life support (TILS) courses for ED nurses for the first time in over five years. TILS courses ran monthly from January 2022. They also provided Manchester triage (MTS) training and audited the nurse's assessment.

The clinical educators undertook ED training for children's nurses but not specialist paediatric training. The CEs were introducing new training for adult nurses to gain the 'care for the sick child' recognised qualification.

The department planned to include deteriorating patient training in their clinical educator's preceptorship of new supernumerary nursing staff by 31 October 2022.

However, a CE's presentation to ED explained barriers to achieving their aims were limited resources and staff time due to clinical demand along with multiple different needs of the department.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. ED senior nurses held monthly meetings and encouraged any link nurses to attend. Information they discussed was disseminated to all relevant staff groups. Attendees added actions and updates to the safety brief,

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The CEs gave staff access to an education hub to provide sims training. They had used this room for chemical, biological, radiological, nuclear or explosive (CBRNe) incident response practices and plaster cast training. One CE provided clinical skill days on such topics as catheterisation, venepuncture, cannulation and point of care testing (POCT).

The department's two CEs were appointing a band 4 CE support role into ED to support their work, the team and deliver on the spot training.

ED's mentor groups focused on each of the fundamental standards of care in turn, to refresh staff's understanding and reemphasise any learning. At the time of our inspection ED leads were communicating with the local university regarding newly qualified nursing staff recruitment.

Managers made sure staff received any specialist training for their role. For example, ED staff could undertake an in-house AIRA training course run by the critical care team atop their intermediate life support (ILS) mandatory training. This training had to be refreshed every three years. Staff were also offered training in preventing and managing burnout.

We reviewed the service's compliance rates in specialist competency assessments. ED had achieved 100% compliance for triage training of their existing workforce and three out of four agency block bookings, or 75% of agency staff.

ED planned to roll out the RCN competency assessments within the paediatric area in January 2023 with a new nurse educator.

Their paediatric department was fully recruited with HCAs, all of which had undertaken paediatric observation competencies. This had also been rolled out in the adult teams for registered nurses and HCAs. The paediatric nurse educator commenced this training throughout the department and handed this work over to the adult teams for ongoing training in March 2021. At the time of our inspection paediatric ED were recruiting to a paediatric ED nurse educator and this work would be in their remit.

However, ED had only achieved 47% compliance in their paediatric observation competency.

Medical staff's additional learning compliance in dementia and learning disabilities (LD) awareness did not meet trust target across the care group. This was only 41% for dementia and 45% for LD awareness.

Managers did not always identify poor staff performance promptly such as outstanding training. However, they supported staff to improve. The ED educator had created a quality calendar with a specific focus on certain themes occurring in the department. The calendar was created from audits, complaints and staff feedback themes to address their knowledge gaps.

Managers recruited, trained and supported volunteers to support patients in the service. We heard the care group were increasing their number of volunteers to help communicate with relatives.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. However, patients with mental health issues often stayed in the ED for prolonged periods.

Urgent and emergency services

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We attended a multidisciplinary team (MDT) handover meeting where medics reviewed all patients in the department. They considered patient's clinical observations including escalating or improving NEWS along with viral screenings and presentations to see which could be stepped down.

However, we heard about conflict on the same day emergency care (SDEC) ward between the medical and nursing staff which could cause issues. When nursing staff had introduced protocol changes which improved ways of working, some medics were resistant to change. The sister and matron felt the medical team had a more negative picture of how they believed the ward was operating due to their changes.

Some staff felt the SDEC and frail elderly unit communicated poorly with them about if they were closed or taking patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. However, the service's missed opportunities audit from June 2022 concluded patients with mental health (MH) issues awaiting review by the MH team often stayed in the ED for prolonged periods.

ED staff could use EAU for some cases but at the time of our inspection the unit was not operational 24/7 to support patients receiving intravenous (IV) therapy before MH reviews.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. The acute frailty service (RAFA) capacity was currently available seven days a week with intensive care staff input 12 hours per day.

Health Promotion

Staff sometimes gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. We saw leaflets staff gave patients on discharge and for their aftercare around peripherally inserted central catheters, reducing their risk of falls and pressure ulcer prevention and treatment.

However, the main ED had little to no information displayed for patients to see. We located some small posters relating to COVID-19 PPE requirements for clinical areas and sepsis.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty. However staff did not meet the trust target for training compliance.

Nursing staff received training in the mental capacity act (MCA) and deprivation of liberty safeguard (DoLS). Their compliance for DoLS was 63.1% and 76.2% for MCA training. These did not meet the 85% trust target.

Medical staff also received training in the MCA and DoLS. Their compliance for DoLS was 59.3% and 66.1% for MCA training. These did not meet the 85% trust target.

When patients could not give consent, we were not assured staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. We saw no examples of best interest decisions being recorded in any patient notes that we reviewed.

We saw no evidence managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. We also saw no evidence managers monitored how well the service followed the Mental Capacity Act and how they would make changes to practice when necessary. We saw no information on display in the main waiting areas or throughout the department promoting staff's awareness and understanding of the MCA and its key principles.

Staff could not always guarantee they responded accurately to patients with potentially compromised capacity and/or experiencing the effects of infection and delirium.

Staff did not always fully evidence how and when to assess if a patient had the capacity to make decisions about their care. We saw examples of patients who potentially had reduced capacity to consent but on upon review of their records found no completed capacity assessments.

However, staff we spoke with understood how and when to assess if patients had the capacity to make decisions about their care. They gained consent from patients for their care and treatment in line with legislation and guidance.

Staff clearly recorded consent in the patients' records. We reviewed two do not attempt cardiopulmonary resuscitation (DNACPR) orders and found ED staff had completed these correctly.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

All paediatric staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

Is the service caring?

Requires Improvement ● ↓

Our rating of caring went down. We rated it as requires improvement.

Compassionate care

Staff did not always treat patients with compassion and kindness. They could not always respect their privacy and dignity, and take account of their individual needs.

Staff took time to interact with patients and those close to them in a respectful and considerate way. However, staff were not discreet and responsive when caring for patients. ED staff could not always maintain patient's privacy and dignity.

For example, upon arriving into ED we saw one patient with a full catheter we had to prompt staff to empty. Staff left cubicle curtains fully or partly open when they were providing personal care for patients. Staff often had to provide care interventions and treatment to patients in communal public areas. We saw patients intimately assessed and helped to use commodes on the ambulance corridor. Ambulance crews told us patients experiencing long waits in the ambulance arrival corridor often had to use toileting equipment there surrounded by a temporary screen. Staff wheeled patients on trolleys into toilets to use bed pans. They did not always ensure patients were covered with gowns or blankets to maintain their dignity.

Staff also asked and recorded patient's medical history in corridors and communal areas. For example we saw a student nurse discussing the personal needs and issues of an elderly patient on seats outside the waiting area where there was no privacy.

Upon arrival in ED on 11 October we saw one patient had a full catheter bag which we had to prompt staff to empty. This patient was on hourly urine checks but when we reviewed their notes we found this bag had been full for two hours 20 minutes. When staff emptied they did not update the record as the patient did not have a fluid balance chart.

Staff tried to mitigate the ED environment's limited ability to offer patients privacy and dignity. For example, as equipment lead the NIC had ordered quick screens where curtains could not be used such as on the ambulance corridor to protect this for patients.

Most staff showed genuine compassionate care towards the patients. Staff worked very hard and were polite and professional to patients and each other. All staff we spoke to want their department to improve and most could outline how to achieve this. They wanted us to support them with the pressures they were under.

However, ED staff said they felt very unhappy they were unable to care for patients to a high standard they wanted to.

Not all patients said staff treated them well and with kindness. One patient in the ED X-ray area was very unhappy with their treatment. They had also been in the department the Saturday before our inspection. On this occasion they were in lots of pain with a badly bruised back after falling. They told us ED staff had completed no observations and made errors in their notes; for example, recording they fell from a standing position. This patient self-discharged at 3am with a prescription for low-level pain killers against consultant advice. They could not access any pain relief until pharmacy opened on Sunday morning. Fracture clinic staff had called them back to ED at the time of our inspection to confirm their shoulder and hand were broken. This had not been identified on their previous attendance to the department.

Emotional support

Staff could not always provide emotional support to patients, families and carers to minimise their distress. However, they understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help but could not always give emotional support and advice when they needed it. Nursing staff felt they could not give patients enough emotional support, particularly if they were at the end of life. This was due to the environment, staffing numbers and lack of resources for patients who needed to be in side rooms.

On our follow up inspection, we heard the overnight registrar and nurses supported the mother of a trauma patient who had attempted suicide and shown her the intensive care team of 30 people to provide reassurance.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. We heard staff sometimes used a PPE donning and doffing room next door to their flexible resuscitation bay for breaking bad news to patients and families. However, as this room was not soundproofed staff's emotional support could be compromised.

Staff supported patients who became distressed in an open environment but could not always help them maintain their privacy and dignity. At the time of our inspection ED had no designated space where staff could provide emotional support to patients or their families. Nursing leads had identified a side room on the RFT corridor which could be used as a relatives room to support patient's families as the sink had broken.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. For example, staff kept the mother of a patient in the red resuscitation bay updated and explained what was happening.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. On our follow up inspection, we saw signs asking patients to scan a QR code to tell ED about their experience. Patients could request paper feedback forms at reception.

The feedback from the emergency department friends and family survey test for November 2022 was 72% positive. This was slightly below the monthly national average of 75%.

Is the service responsive?

Inadequate ● ➔ 🡐

Our rating of responsive went down. We rated it as inadequate.

Service delivery to meet the needs of local people.

The service did not always plan and provide care in a way that met the needs of local people and the communities served. However, leads worked with others in the wider system and local organisations to plan care.

Managers did not plan and organise services, so they met the needs of the local population. Senior leads confirmed no specific workpiece around health inequalities or demographics was undertaken on their new ED building as this was designed to meet patient demand. Instead, they had researched frequent attenders and had a well-established working group with the local ambulance trust to divert patient pathways.

As a result of audit findings, ED staff also had ongoing work with the trust to enable a pathway to support direct referral to emergency assessment unit (EAU) services. This was currently constrained with capacity and opening hours. Audit leads concluded the trust's other same day emergency care (SDEC) units should explore initiating this pathway.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. We reviewed the trust's winter resilience plan 2022-23. This stated the hospital's compliance with mixed sex

accommodation in EAU resulted in an inability to utilise all beds in busy periods. EAU staff would have to review the balance of risk of timely treatment versus patient dignity during periods of extreme operational pressure. As a result, the plan recommended a risk assessment of the relaxation of mixed sex accommodation guidance was conducted for EAUs in times of extreme pressure.

Facilities and premises were not appropriate for the services being delivered. For example, the department's majors waiting room had seats for up to 33 people although when full it became overcrowded, and patients had to wait outside on over spill chairs where they could not easily be seen by the streaming nurse. Staff had concerns about this waiting area which was utilised for patient treatments.

However, a chapel was located just outside the ED with a multi faith room patients and visitors could use.

The service had systems to help care for patients in need of additional support or specialist intervention. For example, we saw the diabetes team reviewed patients who needed extra input along the ambulance corridor. This team consisted of two staff nurses and a student nurse. Team staff told us they visited ED daily.

The service undertook a missed opportunities audit in October 2021. This found when ED staff needed to contact the RATS team, they were responsive and demonstrated joined-up care. Patients received assessment, support and follow up.

The service relieved pressure on other departments when they could treat patients in a day. Care group leads felt their EAU was really positive as they had seen a yearly doubling of patient numbers for a same day emergency care episode. Although SDEC was still capped at no more than ten overnight patients, leads had identified more opportunities for this area. As a result, ED had seen a 50% increase in direct streaming to these areas. Leads hoped in future SDEC would be co-located for a seamless transition between the end of a patient's clinical care episode before they were re-streamed directly to their relevant specialty. ED emergency medics completed regular four-hour shifts on the EAU.

Meeting people's individual needs

The service was not inclusive and did not always take account of patients' individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services. However, they coordinated care with other services and providers.

The trust used a 'this is me' documents and booklets for patients living with dementia but we did not find any in patient records we checked. Wards were not designed to meet the needs of patients living with dementia. We saw no provision in the department for patients with dementia. We also found no information on display for mental health help, support or advice for patients.

Staff did not always understand and apply the policy on meeting the information and communication needs of patients with a disability or sensory loss. We spoke to immobile patients in the same day emergency care (SDEC) waiting area. They reported long stays on trolleys and poor communication from and between staff. For example, one patient was unable to walk due to experiencing back issues. They explained three staff members had all asked them to walk through to be examined, despite telling the first staff member they could not walk. They added staff had not updated them about their MRI scan results or their onward care pathway.

However, staff ensured recorded and written information was provided to patients in different formats as required such as letters in large print.

Urgent and emergency services

The service and care group complied with the accessible information standard (AIS). This is a legal requirement for all NHS organisations and sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. ED staff could book appropriate interpreter services to meet patient needs. This was done through an automated DA languages phone line service where linguists were available 24 hours a day seven days a week.

Staff had access to communication aids to help patients become partners in their care and treatment. ED staff were made aware of patients preferred communication methods. The trust's digital patient records system CPD could prompt users and display alerts when staff selected any letter for printing, for example text message or email. Staff could access tablets and communication aid boards for patients who needed extra support.

Access and flow

People could not access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

The service did not make sure patients could access emergency services when needed or receive treatment within agreed timeframes and national targets. Waiting times were monitored and visible on CPD and the SDEC board. However, we could not be sure managers always monitored them in all areas such as the waiting room. The trust's percentage of patients waiting more than four hours from the decision to admit to admission was consistently considerably higher than the England and North East and Yorkshire regional averages from December 2021 onwards.

As of August 2022, the trust percentage was 43.4% compared to the England average of 36.5% and regional average of 32.2%.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - York and Scarborough Teaching Hospitals NHS Foundation Trust

In August 2022, 924 of the trust's patients waited more than 12 hours from the decision to admit to admission. This was the fourth highest number in England, and the highest in the North East and Yorkshire region.

The trust reported the highest figure in the North East and Yorkshire region for this metric every month from December 2021 to August 2022.

(Source: NHS England - A&E SitReps)

Managers and staff could not always work to make sure patients did not stay longer than they needed to. The trust's median time from arrival to treatment was consistently worse than the England average from summer 2021 onwards. There was a considerable increase from one hour 20 minutes in January 2022 to one hour 44 minutes in July 2022.

(Source: NHS Digital - A&E quality indicators)

Urgent and emergency services

The trust's median total time in A&E was consistently considerably longer than the England average from August 2021 onwards. As of July 2022, the trust median was three hours and 40 minutes, compared to the England average of three hours and 10 minutes.

Median total time in A&E per patient - York and Scarborough Teaching Hospitals NHS Foundation Trust

The trust's median time from arrival to initial assessment deteriorated considerably during the winter for 2021/22. From 11 minutes in June 2021, this deteriorated to 26 minutes in December 2021.

However, this was followed by a considerable improvement to 16 minutes in July 2022.

(Source: NHS Digital - A&E quality indicators)

The service's missed opportunities audit from October 2021 found senior clinicians at the front door in addition to the main ED managed risk and flow well. Leads advocated this model as a best practice mechanism to decompress the ED and facilitate speedy decision making.

Leads told us the department had a dedicated ambulance streaming nurse based on shift 24/7. This senior nurse streamed patients to appropriate areas of the department. A trained HCSW supported the nurse by undertaking diagnostic scans then alerting them of the results. After our inspection feedback we heard the streaming nurse's roles and responsibilities were being reviewed immediately to ensure consistent management of the ambulance queue.

We found the department's patient flow and management was poor due to demand and capacity issues. For example, during our inspection medical staff sometimes had to utilise their red resuscitation area to see and treat patients due to a lack of other suitable spaces. Nursing leads told us the department's flow had stopped since lunchtime, so they had nowhere to put patients. We saw patients often stayed in the department for over 24 hours. We were advised by a nurse based in the majors waiting area one patient recently stayed for 36 hours.

Both days we attended ED for inspection the first reception area displayed a waiting time for patients of three hours to see an ED doctor after initial assessment from a triage nurse.

On our follow-up inspection, we saw the department's front triage waiting room displayed a sign informing patients they had a ten-hour wait to see an ED doctor. Nurses told us overnight there had been 100 patients in the department with 30 awaiting admission. Due to a shortage of chairs and space, people were sat on the entrance corridor floor. Triage nurses could only see patients for initial observations after a two to three hour wait and majors had dealt with seven resuscitation calls overall, four of which were within 20 minutes.

The trust's number of patients spending over 12 hours from decision to admit to treatment (black breaches) for the six months from April to September 2022 was 4,912. This was by far the most in their region.

We spoke to multiple paramedic staff who confirmed they would often spend an entire shift based in the ED corridor due to delays handing over patients to the hospital's care. In some cases, we were told crews were relieved when their shift ended as patients were still awaiting a bed in the department. Ambulance crew described the lack of flow into the department as a constant issue.

During particularly busy periods, ambulance crews would cohort patients in order to free-up crews to return to their duties. However, this could present challenges for the crews left to support patients around assisting with their toileting needs and ensuring safe monitoring. On 11 October 2022 the department's average ambulance turnaround time deteriorated from 62 minutes upon our arrival at 9.35am to 79 minutes an hour later.

Some crews told us the ambulance triage nurse would complete checks of patients in the corridors. However, we were advised by one band six nurse completing ambulance triage, this was not always possible due to the high workload they were already completing within the triage room. One ambulance triage nurse described the situation as "the worst it has been in 20 years". We heard the department only had one porter allocated to transfer patients.

The number of patients leaving the service before being seen for treatments appeared to be low. However, the department was unsure of their total number of patients leaving before being treated as their data did not include those who left from waiting areas.

The service's missed opportunities audit from October 2021 found some patients who did need to be seen self-discharged as a result of delays in the department.

Managers and staff started planning each patient's discharge as early as possible. We discussed the department's pathways with nursing staff. These were all available in the ED office and resuscitation areas and included those for sepsis, stroke and alcohol withdrawal. However, some such as the asthma pathway were not in folders.

Nursing staff told us a recent sepsis pathway audit carried out found good outcomes. However, this staff member was unsure where to access the results.

We heard ED's stroke patient pathway entailed staff bleeping a stroke nurse who attended the department to complete an assessment. The patient was then directly admitted to the stroke unit. However, we observed one patient in the ambulance queue waiting longer than anyone else to access the unit. Unit staff came down to carry out their bloods.

Paramedic staff told us scanning was done from the ambulance queue as a priority.

We saw patient's pathway paperwork in trollies in resuscitation areas, except for the red area where staff had no clear organisation for this.

Staff did not always plan patients' discharge carefully, particularly those with complex mental health and social care needs. The service's missed opportunities audit from October 2021 recommended that a clinical decisions unit (CDU) would better facilitate the flow of patients having ongoing decisions and time-critical treatments before discharge.

We reviewed a clinical incident in ED from August 2022. This involved paramedics returning to ED and they had found staff discharged the patient still attached to their fluid drip, with no discharge record and two bottles of amoxicillin oral suspension with no patient details or administration instructions. When service staff followed up with hospital ED staff, the trust said they would not send discharge information as this was not needed and had been emailed to the patient's GP. They also refused to send the patient any updated prescription despite the lack of prescribing information causing their antibiotics to be delayed.

The service saw large increases in the percentage of ambulance handovers taking over 60 minutes from the summer of 2021 onwards. This reached 23.5% in December 2021 for the hospital. There was then a further increase to 30.5% in August 2022.

Urgent and emergency services

The trust's performance was considerably worse than the overall performance for ambulance handovers from their regional NHS ambulance service. This saw a deterioration to 12.1% in October 2021, followed by broadly similar performance until August 2022 (12.7%).

Trust leads told us they had a good working relationship with their local NHS ambulance service, whose teams frequently liaised with the department's streaming nurse.

The ED had a dedicated pre-alert phone to receive patients into their trauma unit.

We spoke to the local ambulance trust's crew in the department. One crew had booked their patient into triage upon arrival but confirmed no ED staff had reviewed them for 30 minutes. They could contact the ED team if patients deteriorated but were often left to monitor and observe patients as there was no consistent medical oversight.

Another crew told us they had concerns as they were sometimes asked by ED staff to discharge patients after they had treatment in the corridor. This was not always agreed by their emergency operating centre. Crews had asked ED staff if they could accommodate patients into an unused clinical area round the corner from the corridor but were told this was not possible. They often cohorted patients to relieve other crews but patients who deteriorated required nursing care and treatment within the department.

Managers did not always monitor patient transfers and follow national standards. Within the department there was a 'ready for transfer' (RFT) patients corridor. We observed this was staffed by two registered agency nurses and healthcare assistants (HCAs). On our first inspection we saw no medical oversight of this corridor. However, on our follow up inspection leads assigned a medic with EPIC oversight. The senior team told us this area was for patients who had been assessed, had a plan in place and were suitable for transfer to a ward. We identified two patients who were unsuitable to be cared for within this area.

Shortly after our inspection leads told us this so-called RFT corridor was not a designated space for RFT patients and could be used for any patients needing care. They added the cubicles were a core part of the ED, as were all other cubicle spaces. Leads said the ED team took the decision to clinically risk assess patients and moved the most stable patients awaiting admission to this corridor.

However, we could not be assured staff had documented plans in place. We did not see a risk assessment process and patients without plans were placed in the corridor.

We reviewed a policy led by the Medical Director in the few months before our inspection. This demonstrated insight and plans to address the long waits within ED.

The ED's EPIC and NIC updated an operational report chart every two hours which gave the current state of their department as a bird's eye view, with waiting times for triage and all clinical statistical data. This report was scanned and uploaded onto the trust's internal drive for any staff to access.

The department included a same day emergency care (SDEC) ward which is on the same floor as the ED. Before our inspection a recent length of stay audit found patient's average time in SDEC after ED transfer was 26 hours. However, the ward manager advised us there were cases of patients waiting in their department for 90 hours. In August 2022 they had seen 849 attendances which increased to 1110 in September.

The service moved patients only when there was a clear medical reason or in their best interest. Where ED needed beds to admit patients urgently, staff would assess the clinical position on wards and identify their least acutely unwell patients. The trust and care group followed a full capacity protocol. This was managed through action cards. Senior leads used the Bristol boarding clinical assessment document which they felt was a more explicit boarding protocol.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Investigating officers contacted complainants to inform them they were investigating their concerns. They would then feedback to complainants once their investigation was complete then write and send them a response letter.

Managers investigated complaints and identified themes. We reviewed the number of complaints received by the service. From 17 September 2021 to 16 September 2022 the hospital's emergency medicine received 94 complaints. This was over four times more than any other speciality during the same period.

The hospital's ED service had the highest number of complaints (11) about a 'delay or failure in a treatment or procedure' or 'delays in testing or scanning etc' in the 12 months of 2021/22. The department had complaints about long waits on a trolley.

As of August 2022, emergency medicine had nine open complaints in total, five of which were new that month and one was overdue. The top two complaint themes for the financial year since April 2022 up to the time of our inspection were attitude of nursing staff and waiting times.

At the time of our inspection the service had no parliamentary and health service ombudsman (PHSO) complaints in progress.

We also reviewed the number of compliment letters, care opinion and friends and family responses from October 2021 to October 2022. Care group 1 which comprised ED generally received far more compliments than other care groups. For example, they received nearly twice as many compliment letters and care opinion responses as care group 2.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Service leads acknowledged all complaints within three working days and care groups had 30 working days to investigate a complaint and send a final response. However, care group 1 had poor compliance with closing complaints within the required trust target. For example, from September 2021 to September 2022 they never exceeded closing 60% of their complaints within the 30 day timeline.

We also saw during quarter 1 of 2021-22 care group one had seven complaints which were not closed until between 51-100 days after the complaints were received. For the same quarter care group, one also had five patient advice and liaison service (PALS) complaints not closed until 21-50 days after being received. These did not meet the trust target of closing PALS within 10 working days.

As of August 2022, emergency medicine had no open PALS. The care group's top PALS themes for the financial year were attitude of nursing staff and privacy and dignity issues.

Urgent and emergency services

The care group had planned actions to improve their performance around closing complaints. These entailed holding weekly patient experience meetings to try to reduce delayed responses. The associate chief nurse checked these responses and added a process to the local standard operating procedure (SOP).

Staff could give examples of how they used patient feedback to improve daily practice. The trust's improvement plan was a dynamic document to capture new improvement actions, including in response to newly identified patient experience themes. The trust's patient experience steering group further considered actions around improvement of ED waiting times along with additional ways to improve communication. Waiting times were a main theme they reviewed as service users reported were unhappy with these and the environment. The group hoped to improve patient experience despite waiting times and measure this through a future reduction in complaints and concerns. However, at the time of our inspection the care group's number of complaints were increasing.

Is the service well-led?

Inadequate ● ➔🡐

Our rating of well-led went down. We rated it as inadequate.

Leadership

Leaders did not always manage the priorities and issues the service faced. However, they understood them. They did not always support staff and were not visible or approachable in the service for patients and staff. Leaders did not have all the skills and abilities to run the service.

The care group leadership structure consisted of a care group director who oversaw a quad of associate chief operating officer, associate chief nurse, AHP senior operational managers and clinical directors. We interviewed the care group quad leads. They told us as a leadership team they worked really hard to manage the severe pressures ED faced and discussed all options during such a difficult time. Their conversations had taken a greater integrated care board (ICB) perspective as they felt more could be done from a system wide divisional point of view.

ED staff told us they wanted more support from managers before their departments hit crisis level. They explained that management waited until the department hit this point, and then had no de-escalation policy or process. Nursing staff told us it was hard for them to provide holistic care as leads did not facilitate timely systems and processes which allowed joined-up care within both the department and other services. The operations manager said 60 or more patients in ED felt unsafe. At the time we were told this the department had 87 patients, but they could see up to 100.

Matrons and senior nurses had concerns for patient safety as they felt they could not look after both acutely ill patients and those waiting to be admitted onto wards. A streaming nurse also shared these patient safety concerns in the department and felt they had poor input from bed managers.

Senior trust and medical leads were not always responsive to their staff raising ideas and concerns. One group of medical staff told us leads never approached or communicated with them. As a result they felt leads had no understanding of the amount of risk and escalation they dealt with and gave examples of their lack of risk oversight.

For example, on our follow up inspection medical staff told us they had fed back to medical leads that ED was essentially operating as a ward with no routine speciality input. They suggested specialist consultants should start the day in the department, as after 12 hours half the patients in ED either needed discharge, speciality assessment or review.

Urgent and emergency services

On our follow up inspection nursing leads told us they asked the trust's executive team to come and visit the department at peak times and discuss their issues. In response, senior executives held a question time with ED staff, but nursing leads felt their concerns were still not heard or addressed.

We observed processes to facilitate flow that we were not assured were embedded or part of routine practice. The department had a full establishment of medical staff. However, nursing, and medical leads explained operational leads and managers were unresponsive and took no action at other times when they sought help. This had made them feel ignored, overworked and undervalued by the trust.

Senior nurses told us they were upset as care group and senior leads had challenged their decision to keep the flexible resuscitation bay free. We arrived in ED at 6.30am just after a full cardiac response team and lead surgeon had stabilised a trauma patient in this bay before their transfer to theatre. This only left one other staff nurse to manage and maintain oversight of the rest of the department.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders monitored progress but did not always listen to staff who understood and knew how to apply strategy principles.

Leads for ED's care group felt the new ED building extension due to be completed in April 2023 would double capacity at the hospital's front door to support acute and emergency care.

At the time of our inspection service leads had started to redesign clinical care models to develop a revised model within ED. They planned to take a proposed model to the executive committee the week after our inspection. This would co-locate and mobilise their emergency assessment unit (EAU), medical same day emergency care (SDEC) with frailty services and urgent treatment centre at the front door. They aimed to mobilise this model soon after the completion date of 23 April 2023.

However, medical leads on both our original and follow up inspections felt the hospital's version of boarding patients was ineffective as there was no patient outtake from the department and staff did not complete risk assessments prior. Staff had devised a 'strategic principles of acute and emergency care document based on the NHS principles published in 2017 to address all acute specialities having their own assessment areas. They submitted this to senior trust and care group leads on three occasions in the 18 months before our inspection but had received no response. This meant we could not be assured leaders engaged or consulted with clinical staff trying to improve service delivery and flow.

Culture

Staff did not feel respected, supported and valued. The service did not always have an open culture where staff could raise concerns without fear. However, staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development.

We were not assured the leadership and management culture at the trust meant staff always felt they could speak up. We were told of occasions when staff leads investigating concerns raised did not behave in line with the trust's whistleblowing policy, and made staff afraid of reprimand.

Senior nursing staff felt staff's concerns about not being able to deliver treatments to patients on time or meet their basic care needs impacted upon staff morale.

We observed staff behaviours could be very challenging to inspectors when we raised concerns. For example, some nursing staff ignored requests for patients to be reviewed when we flagged concerns. We escalated this to senior board leaders including the CEO.

During our inspection, our inspectors witnessed and experienced poor staff behaviours including inappropriate challenging when concerns were raised. We found staff did not always respond promptly to our concerns about patients health, care or experience which led to us escalating patient concerns repeatedly. We observed this during both onsite visits and this was escalated to senior executive staff in the trust including the Chief Executive to ensure actions were taken.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Leads were unrealistic about the service's ability to meet or benchmark targets and plan staffing rotas. However, staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

ED leads attended a monthly clinical governance forum chaired by the EPIC which had a standard agenda with guest speakers. Leads told us the forum captured a wide staggered cross-section of staff group representation as any band could attend as part of a rolling rota. This forum was held offsite so staff would not be distracted or pulled back to work in the department. A general manager told us 18 months before our inspection the trust had no offsite clinical governance meeting on the same scale and now learning was better and more widely shared. For example, the ED sepsis lead shared updates about training and other relevant issues.

We reviewed agendas from the ED clinical governance forum from July to October 2022. The agenda included operational issues such as overcrowding, lack of capacity and staffing as well as updates about patient safety including the emergency care standard, breaches and time patients spent in the department.

However, we found care group and department leads did not take a proactive response to a lack of documented or formalised actions, plans policies or procedures for the concerns we identified through the inspection. Leads drafted and approved a COVID-19 pathway after we raised concerns around the lack of a protocol.

Care group leads told us very vulnerable patients in ED with pressure ulcer damage were moved onto beds within six hours as staff could maintain this benchmark criteria. However, we saw patients with pressure ulcers waiting on chairs or trolleys for well over this length of time.

We heard any pressure ulcers graded 3 or 4 went to a review panel and RCA investigations were shared. Leads attended a weekly harms group where any newly acquired PUs and falls were discussed and reviewed. The Deputy Chief Nurse chairs Trustwide improvement groups with RAG rated improvement plans which Care Group representatives attend these plans include Pus and falls. A designated lead attended these groups and feedback to the quad other wider trust developments as a two-way process.

Senior nursing staff suggested the budget with which they needed to plan staffing rotas did not match. They only had vague clarity from the finance department's figures which were not shared.

Urgent and emergency services

Management of risk, issues and performance

Leaders and teams used systems to review performance effectively. They identified and escalated relevant risks and issues, however, leads could not always identify actions to reduce their impact. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Trust and service leads acknowledged the environment of their current ED footprint remained an ongoing risk. They felt they would be able to give assurance regarding the future environment and were confident in the timescale for improvement through the mobilisation of the new build.

Leads explained the current ED environment was not to the standard they strived to achieve. They reached a balanced decision to accept the risk to subsequently enable the building works which would ultimately give the department superior facilities. We reviewed the risk assessment and quality impact assessments undertaken at the time. These demonstrated insight into the issues the department would face with some mitigations implemented.

However, we found the senior management team, care group and service leads had not considered how best to manage patient flow and pathways through ED. This would better mitigate the environmental and infection control risks of the department's interim layout.

We asked care group leads about their three main risks. The first was patient safety as all staff said they had concerns about this and could not provide timely treatment to patients. Nursing staff said they were unable to complete basic nursing care due to staff shortages. Leads second highest risk was department flow as they received poor support from higher managers and the bed manager. The third risk was staff's sepsis competencies and skills resulting in poor screening of at risk patients. On 11 and 13 October 2022 we observed almost no sepsis screening for patients in ED despite this being identified as a risk and a concern for leaders we saw limited action to make improvements.

Trust and care group leads were aware their sepsis care delivery was not where it needed to be. They conceded this posed a significant risk to patient safety and the effectiveness of treatment provided to patients. The trust paused their monthly sepsis screening audits from April 2022 to focus on updating the sepsis policy, agreeing new roles and responsibilities within emergency care, and develop updated sepsis screening and audit tools. Their revised sepsis screening tool was rolled out from May 2022. Their audit programme was relaunched from quarter two (Q2) 2022/23 to measure improvements.

We reviewed the care group's latest risk register and found the main risk was sustained significant pressure on the ED workforce. This risk scored 16 out of a possible 25 and was somewhat likely and able to cause severe harm. Leads acknowledged the risk of staff stress and burnout and felt the contributing factors were reduced flow out of the hospital along with staff vacancies and illness throughout acute care. Interventions to reduce ED crowing were in place such as diverting ambulances to other acute hospital trusts and restreaming more patients to alternative providers and other hospital delivered services.

We reviewed the department's improvement plan in response to issues we identified on inspection under six main categories. Most actions related to their lack of recognition of deteriorating patients and appropriate escalations. All actions were due to be completed by 22 December 2022 or sooner, in many cases the end of October.

The senior triumvirate leadership team held a senior management meeting chaired by the associate COO which the clinical governance director attended. An in-phase system dashboard template was used to structure conversations around all CQC's latest inspection data where all ED improvement actions were discussed with key performance indicators (KPIs) and metrics.

Urgent and emergency services

The trust's winter resilience plan 2022-23 sought to explore opportunities for increasing extra capacity in their hospitals and wherever possible prevent avoidable admissions. The plan stated EAU's outstanding risk remained the provision of appropriate nursing and medical staffing overnight to maintain safe levels of care and prevent closure of the unit. This risk would be monitored by the winter tactical group.

Some of the plan's mitigation measures included 'hot' outpatient services, consultant connect or ALERTIV, out of hospital home based pathways and virtual wards. Where admission was required, the plan sought to protect EDs by improving flow, reinforcing alternative treatment pathways and facilitating timely ambulance handovers through robust ED escalation plans. The hospital would establish a children's ambulatory treatment (CAT) hub over winter to manage admission avoidance and reduce the pressures on ED of low acuity attendances better managed in out of hospital settings.

Service leads mentioned as part of winter planning, they should get some help with additional staff to look after ambulance patients in the ED corridor. After our inspection a trust lead told us they had secured the services of a professor with extensive experience in supporting emergency care from mid-November 2022 to help drive ED's required improvements.

The department had an ambulance cohorting standard operating procedure (SOP) in place which identified a dedicated cohorting space. However, paramedics within ED told us there was no such space. The local NHS ambulance trust were planning to provide paramedic staff to cohort patients so they could be handed over and crews could be released quicker. To further enhance the escalation plan, leads considered reviewing the boarding protocol within the full hospital capacity protocol to determine if the "Bristol Model" of boarding would have utility over winter 2022.

Information Management

The service collected data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Nucleus was being rolled out two weeks after our follow up inspection. This was a new care management software designed for care providers. Managers monitored staff's training compliance of the Nucleus module as some groups were still below the 80% target.

The trust's EPMA rollout had reduced some medication related risk for ED staff by ensuring clear prescribing and access to decision support. However, at the time of our inspection this was not rolled out universally and required IT support to manage outstanding risks on the action log.

Engagement

Leaders and staff did not actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. However, they collaborated with partner organisations to help improve services for patients.

The trust performed within the expected range for all nine sections in the CQC Urgent and Emergency Care Survey 2020.

There was one question where the trust performed significantly better than other trusts:

- Before you left the hospital, did a member of staff discuss your transport arrangements for leaving A&E? The trust scored 6.4 out of 10. Other trusts' scores for this metric ranged from 2.9 to 6.9 out of 10.

- There were no questions where the trust performed significantly worse than other trusts.

The trust had star, long service, and celebration of achievement awards. These recognised the exceptional achievements of individuals and teams working in the department. Staff could nominate others on the trust's website. ED had a Love box in the RFT staff room where staff could post positive recognition and gratitude to others.

We saw one mentor team had focused on equality, diversity, and inclusivity (EDI) in August 2022 as part of their fundamentals of care refreshers. This reminded staff that encouraging EDI brought numerous benefits to the department and outlined the equality act 2010's protected characteristics.

Nursing leads told us staff walk-throughs of their new ED build were available with representatives from all bands. Tours allowed staff to look at safety areas and helped familiarise themselves with the layout.

On one day of our follow-up inspection care group leads were holding a session to explain their new clinical model to staff. However, some medical staff groups said leads had not consulted with them about how this was planned or devised.

Some groups and bands of medical staff told us the trust had no set agenda of pay and barter. This meant their salary and wages were not equitable.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service established a development group for fractured neck of femur patients onsite. This addressed their time from presentation in ED to operation which was above average. After work with stakeholders over the past 18 months and using quality improvement (QI) methodology, the hospital's position was below the national average. There was now a clear process for managing the patients from presentation in ED and all staff were clear of their roles and responsibilities. This work had been shared with the Scarborough site who were adopting some of the learning. It had also encouraged cross-site working with clinicians and an agreed standardisation of processes.

The department's EPIC had created an emergency medicine research York (EMRY) platform on the trust' internal drive. This logged every completed QI project and audit to date which was accessible to staff and included any available training links and resources.

We heard about a QI project ran over six weeks by an assigned senior nurse on the ambulance assessment unit. During this period the corridor's compliance rate in assessing all patients arriving by ambulance within 15 minutes improved from 50% to 80%. The project also found staff were more compliant at identifying deteriorating patients in the ambulance queue.

Care Quality Commission

Scarborough Hospital

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Description of this hospital

York and Scarborough Teaching Hospital NHS Foundation Trust provides a comprehensive range of acute hospital and specialist healthcare for approximately 800,000 people living in York, North Yorkshire, Northeast Yorkshire, and Ryedale.

Scarborough Hospital is the Trust's second largest hospital. It provides acute medical and surgical services, including trauma and intensive care services.

Maternity

Inadequate ● ↓↓

Is the service safe?

Inadequate ● ↓↓

Our rating of safe went down. We rated it as inadequate.

Mandatory training

The service did not always meet the trust target for mandatory and role specific training.

The overall compliance for midwifery staff was 78% which did not reach the trust target of 85%. Only five of the 14 statutory training courses had more than 85% completion rate. Sepsis awareness training compliance was 86%. None of the required learning courses for midwifery staff achieved the 85% target.

The overall compliance for medical staff was 74% which did not reach the trust target of 85%.

Only eight of the 17 statutory training courses had more than 85% completion rate. Sepsis awareness training compliance was 33%. None of the additional learning or required learning modules achieved the 85% target.

Additional clinical staff which included healthcare assistants and midwifery support workers had an overall completion rate of 90% which did meet the trust target of 85%. Of the 16 statutory training courses, 12 had completion rates of over 85%. The four remaining courses all had completion rates above 75%. Sepsis awareness training compliance was 100%. Two of the four required training modules achieved the 85% trust target.

Staff we spoke with told us they did not have protected time to undertake mandatory training and staff were regularly requested to return to work clinically.

The mandatory training was comprehensive and met the needs of women and staff.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Midwifery and medical staff did not always meet the trust target for safeguarding training however they knew how to recognise, and report abuse and they knew how to apply it.

The overall compliance for midwifery staff was 83% for safeguarding adults level 2 and 88% for safeguarding children level 3. They were 79% compliant for PREVENT awareness level 3 which is a training designed to prevent radicalisation, extremism, and terrorism. This meant midwifery staff did not always reach the trust training target of 85% in safeguarding level 3 and PREVENT training.

The overall compliance for medical staff was 86% for safeguarding adults' level 2, 50% for safeguarding children level 2 and 79% for children level 3. They were 77% compliant for PREVENT. Medical staff did not always reach the trust training target of 85% in all aspects of safeguard training.

Maternity

The overall compliance for additional clinical staff which included healthcare assistants and midwifery support workers was 94% for safeguarding adults level 2, 92% for safeguarding children level 2 and 75% for children level 3. They were 100% compliant for PREVENT.

All staff we spoke with confirmed they had received, and kept up to date, their safeguarding training.

We saw whiteboards in various managers offices which showed high levels of compliance with children and adult safeguarding training (levels 2 and 3).

Midwives undertook refresher safeguarding supervision training four times each year.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a woman's mental health.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Cleanliness, infection control and hygiene

Staff did not always use equipment and control measures to protect women, themselves, and others from infection. They did not always keep the premises visibly clean. However, the equipment was clean.

We found several areas of concern in the maternity unit relating to infection control risks. We found high and low levels of dust. Staff told us this had been highlighted as a concern following domestic supervisor's audits.

We found a window inside one of the delivery rooms which was dirty and the floor in the corridor leading to theatres was cracked and dirty. In the triage delivery room, we found a bottle of surgical scrub solution with no lid.

Staff were unsure of the policy or the process when asked how often theatres were deep cleaned.

Ward areas were mostly clean and had suitable furnishings which were clean and well-maintained.

The service generally performed well for cleanliness. However, the national patient led assessments of the care environment (PLACE) inspections had not taken place since 2019. Inspections had been postponed due to the COVID 19 pandemic. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Environment and equipment

The design and use of facilities and premises did not always keep women and staff safe. However, they managed the safe storage of clinical waste.

We found several areas of concern in the maternity unit and theatre relating to environmental risks.

The fire exit on the Hawthorn antenatal and postnatal ward was sealed up with tape. This was to prevent patients coming through from the adjacent elderly medical ward. This was a fire risk and was not in line with trust policy. We

discussed this with estates staff who informed us the door had been sealed due to an outbreak of infection. The door had been noted to be a risk by the IPC team, who recommended the door be taped to prevent infection outbreak in the adjoining ward. We escalated this at the time of inspection. The fire door was reassessed and unsealed. This was clarified by estates staff following inspection.

There were areas within the labour unit which were accessible to all staff, women, and visitors. The doors into utility rooms were left unlocked and the digilock on the clean utility room was broken. This was a risk because the room contained consumables for the unit including, sharps, venflons and intravenous fluids etc.

The theatres entrance doors did not have a swipe card access. The theatres did not have signage to demonstrate they were in use when undertaking minor and or major cases including caesarean sections. This meant these areas were accessible to all staff, women, and their visitors. There was a potential risk of lack of privacy and dignity for women and an increased risk of infection.

There was a lack of lockable storage facilities on the ward and unit. We observed large metal storage cages in corridors containing stock consumables.

We requested the Department of Health guidance Health Building Note 09-02 (HBN) yearly maintenance schedule to evidence the quality assurance on air flow. HBN 03-01 guidance recommends, 15 air changes per hour with a negative pressure. In birthing rooms and recovery areas where analgesic and anaesthetic gases are exhaled, the ventilation rate should be of sufficient capacity to control substances within the appropriate occupational exposure limits (COSHH).

The trust provided data that showed the last annual ventilation inspection was undertaken in October 2022. The trust provided data which showed the last annual ventilation inspection was undertaken in August 2021. The inspection highlighted a number of concerns which required action. The care group confirmed the estates department was currently working through remedial actions.

We saw painted areas which were in need of refurbishment in the reception and in one of the delivery rooms there were lots of scuff marks on the wall.

We observed shared shower and toilet facilities in adjoining patient rooms which meant privacy and dignity could not be maintained.

We found equipment that had not been safety tested. For example, on Hawthorn ward there were four baby cots and two extension cables which had expired their safety check date. In the linen room on the maternity unit, we found one pulse oximeter unit and two infusion pump machines which had expired their safety check date.

Staff stored clinical waste safely.

The maternity unit and wards were clearly signposted and easy to find. The entrance onto labour unit including antenatal and postnatal wards were covered by CCTV and entrance was accessed by swipe card only.

The obstetric theatre was on the labour ward.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each woman and took action to remove or minimise risks.

Maternity

Staff used a modified early obstetric warning score (MEOWS) which was a national recognised tool to identify women at risk of deterioration and escalated them appropriately.

We reviewed the peer review audit completed for MEOWs and this showed that staff did not always comply with the recording of observations in line with process and did not meet the trust target of 90%.

We were not assured that not all junior and senior medical doctors had completed training for risk assessments through pregnancy. The training compliance rates showed 32% for January 2022 to September 2022.

We had concerns regarding the process management for security tagging newborn babies. We were informed there had been no recent baby abduction drills or related audits. Following the inspection senior leaders informed us they had planned an abduction policy walkthrough and drill.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a woman's mental health. If patients presented as a safeguarding concern the trust had an individual crisis plan which documented the concerns.

Shift changes and handovers included all necessary key information to keep women and babies safe. We observed both midwifery and medical staff handovers during the inspection. We found the midwifery handover on ante and postnatal ward areas included key high-level information for each woman on the delivery suite and then a more in-depth handover between individual staff members was then completed.

Staff told us they had completed emergency retrieval scenarios for the birthing pool and showed us the equipment required.

Midwifery staffing

The service did not have enough midwifery staff with the right qualifications, skills, training, and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service did not have enough midwifery staff to keep women and babies safe and the actual staffing numbers did not always match the planned number.

The labour unit was regularly placed on divert due to the lack of available trained midwives. Staff told us they had requested agency staff to cover midwifery shifts. Senior managers acknowledged that the care group had a vacancy rate of 15.59% for midwifery staff which equated to 16.91 whole time equivalent (WTE) midwives. Clinical Governance meeting minutes from October 2022 evidence there was an increased vacancy rate.

Some staff reported the pressures of reduced staffing numbers had caused them to reduce their hours due to feeling that every day at work was unsafe and risking patient safety. They said they did not get regular breaks due to acuity on the wards.

Senior leaders held daily staff huddles with the band 7 coordinators to assess midwife staffing levels using the birth rate plus tool. They would review the number and grade of midwifery staff needed for each shift in accordance with national guidance.

Maternity

The service had RAG rated the staffing ratio for the acuity of the women. Red-Amber-Green (RAG) ratings, also known as 'traffic lighting,' are used to summarise indicator values, where green denotes no concern, amber denotes of concerns and red denotes concerns.

We reviewed the maternity dashboard information which showed a midwife to birth ratio of 1:23 for January to August 2022.

They were focused on providing safe care ensuring a ratio of one midwife to one woman in established labour and had an average of 99% for the January to August 2022 which was above the regional average of 95%.

There was no formal system reporting process for planned verses actual community staffing; however, this was reported Monday to Friday by the community band 7's forming part of the safety huddle reporting.

There was an escalation midwife on call every evening for the labour ward. If maternity gaps were not filled with staff, they would redeploy staff from the community which meant home births had to be redirected into the acute setting. For the reporting period January 2022 to September 2022, community midwives were called into unit on 51 occasions.

Senior leaders were currently reviewing the home birthing service and structure at this site.

The sickness rate for midwifery staff across both sites had steadily increased from 2.9% in September 2021 to 7.6% in June 2022. The sickness rate for midwifery health care assistants across both sites was 6.8% in June 2022.

Senior leaders used bank staff to try to support safe staffing, however, there continues to be shortfalls in staffing. In October 2022 there was 83 bank shifts filled with a mix of HCA and midwifery staff.

Medical staffing

The care group did not have enough junior medical staff with the right qualifications, skills, training, and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The care group provided staffing information for obstetrics and gynaecology medical staff for the rolling time period ending September 2022. This showed the numbers of junior staff did not always match the planned numbers for weekday shifts from 8.30am to 5pm.

Managers could access locums when they needed additional medical staff. There was a high fill rate of 82% for bank shifts. However, there was 78% fill rate for agency shifts which correlated with the high sickness rate of 15.15% for senior medical staff and 4.74% for junior medical staff. The turnover rate for medical staff was 35.71% and the vacancy rate of 2.29%.

We reviewed evidence to support the consultants met the planned number of staff and had a consultant on call during evenings and weekends.

Locum consultants and registrars were either block booked or booked ad hoc to mitigate gaps in the rota during periods of transition from retirement/ leaving to new staff joining to ensure safe and sustainable rotas.

They worked to align the acute and on call rotas across the two sites to a 1 in 8 week cover pattern and the recruitment of 5 additional consultants has been progressed at pace during the last 12 months to ensure that safe staffing can be achieved and supported by more cross-site cover if required with some core established shared on call non-resident weeks/ weekends now incorporated across site.

The medical staffing position for the day and the forward view for the week/ weekend is then confirmed at the care group bronze daily meeting with any requests for support and escalation requested. Additional scheduled bronze meetings had been put in place to ensure the plans for service continuity continued to be developed. These meetings were logged to support decision making and review of previous day's mitigations.

Handover meetings between shifts with the multidisciplinary team (MDT) confirmed the medical staffing and bleep holders in each team for the shift ahead.

There was a daily morning medical staffing huddle across the sites for the operational team supported by the clinical director and site clinical lead. They would confirm all rotas and mitigate any unplanned gaps as required.

Medical staff we spoke with told us there was excellent teamworking and they felt well supported. They said, 'everyone is approachable' and they received appropriate supervision. This concurred with the 2022 General Medical Council national trainee survey which showed the overall satisfaction score was similar to the national aggregate.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, and easily available and secure to all staff providing care.

The service used paper medical records and planned to transition over to electronic records in the near future.

Women's notes were comprehensive, and all staff could access them easily.

When women transferred to a new team, there were no delays in staff accessing their records.

We spoke with woman attending their outpatient appointments and noted their own medical records were kept in a plastic waterproof wallet.

Medicines

The service did not always store medicines safety however they used systems and processes to safely prescribe, administer, and record medicines.

We found several areas of concerns with the storage of medicines, which included controlled drugs, and cleaning tablets which were not stored in line with best practice guidance.

We found several concerns regarding the safe storage of medicines which included:

We saw a gas cylinder of nitrous oxide with oxygen stored in the community midwifes car.

On one clinical area we found an unlocked clean utility room which contained an unlocked fridge. The fridge contained several different medications including insulin. This was not in line with best practice guidance surrounding the safe storage of medicines.

In another clinical area we also found an unlocked medicines cabinet within an unlocked clean utility room. We escalated this with senior staff who confirmed the lock on the door was broken. This had been escalated with the maintenance team and was awaiting repair. The medicines cabinet was checked and locked following escalation.

We escalated this with staff immediately. The care group provided assurance by completing an action plan to address concerns highlighted. Actions included twice daily checks of drug cupboards (and after each theatre case) to ensure drug cupboards were locked and fluids were correctly stored. A communication brief relating to drugs cupboards and storage of medicines was implemented for discussion at each handover.

Senior leaders confirmed that recruitment of a pharmacy technician for the department had been successful to support the review of medicines storage and medicines management. However, there was an eight-week delay until the employee commenced work. Senior leaders confirmed that pharmacy technician support was in place in the interim; however, the resource was split between urgent and emergency care and maternity. Midwifery staff we spoke with confirmed they had received no clinical pharmacy team support since our first inspection and were not aware of the recruitment of a dedicated pharmacy technician for the maternity service.

On our second visit to the service six weeks later, staff we spoke with confirmed they had received no pharmacy team clinical input.

We also found concerns with the checking of the crash trolley on both labour ward and the ante-natal/postnatal unit. For example, on labour ward we found between 1-31 October 2022 no checks of the crash trolley had been recorded on four occasions.

In September 2022 the trust completed a review of the safer practice with epidural injections and infusions. They were compliant with the four of the seven National Patient Safety Agency (NPSA) recommendations and an action was implemented.

The trust used an electronic system to prescribe and record the administration of the patients' medicines however, there was no medicines reconciliation process undertaken by pharmacy staff to ensure women were prescribed the correct medicines should they have an extended stay. Staff reviewed each woman's medicines regularly and completed medicines records accurately and kept them up to date.

There was a monthly newsletter to disseminate learning with staff to improve safe practice.

The care group had recently reviewed their VTE guidance following a number of incidents relating to VTE prophylaxis and had created a new IV heparin chart to promote safe prescribing and monitoring. The anticoagulant pharmacist had recently carried out a review of three historic NPSA alerts relating to anticoagulation to ensure measures put in place at the time of the alerts were still appropriate and an action plan was approved at the March 2022 in the medication safety group.

Incidents

The service did not always manage safety incidents well. Managers investigated serious incidents, however there was a back log of low or no harm incidents to be investigated. Managers managed patient safety alerts but did not always ensure that actions were implemented or monitored.Managers did not always share lessons learned with staff in a timely way.

Maternity

Senior leaders informed us there was a lack of suitably trained[BR1] staff available to undertake serious incident investigations. Senior leaders acknowledged there was limited assurance staff had completed specific root cause analysis required for serious incident investigations. We were also informed that the quality of the actions were not robust, and no one had ownership of these actions.

There were 219 incidents investigations which were waiting to be completed and was an increase from the previous month. We reviewed the clinical governance minutes for August 2022 which evidenced there were 35 open actions from SI's.

Staff we spoke did not have to time to complete these due to working clinically. Senior leaders acknowledged the quality of the actions were not robust, and no one had ownership of these actions.

We were not assured that learning and action was taken immediately following a serious incident reported to HSIB.

We were not assured that senior leaders had robust oversight of investigating incidents which were graded as low or no harm. For example, the maternity dashboard which confirmed that post-partum haemorrhage (PPH) incidents for blood loss of 1500mls were being graded as low or minor harm (8 in August 2022).

We received information to confirm incidents graded as being moderate harm or above would have a patient safety incident review (PSIR) (previously a 72 hour report) which would identify any immediate learning or safety actions. In addition, they did not report PPH below 1500ml blood loss. This was not in line with RCOG guidance.

We reviewed evidence from the National Reporting and Learning System (NRLS) which evidenced there was a lack of recognition, management, and appropriate response to risk. For example, in September 2022 there were 108 incidents recorded as no harm and 52 as minor/low. In October 2022 there were 107 incidents which were recorded as no harm and 50 as minor/low harm.

In addition, between 31 August 2021 and 16 September 2022 we found 31 incidents relating to CTG's which were graded as no harm and 18 as low harm.

There had been four intrauterine deaths / intrapartum still births reported in the last 12 months. These had been reported to HSIB for further investigations. At the November 2022 inspection we noted there had been a further two intrapartum still births.

The care group reported eight serious incidents (SI) to the NHS Strategic Executive Information System (StEIS) from March 2022 to August 2022 which were investigated.

Managers shared the learning from the recent never event of a retained swab and a retained tampon with their staff and across site. Staff confirmed they were aware of these incidents. We requested audits for swab counts following procedures however, the care group informed us these had been paused due to patient activity and low staffing levels. This meant we were not assured that this learning was being measured effectively to ensure safe outcomes for patients.

Consultants shared immediate clinical learning from incident reports to medical staff. However, senior leaders told us they needed to improve on the sharing of learning from incidents and safety messages of the week and proposed these were to be introduced during staff handovers.

Senior leaders confirmed they needed to engage more with midwives during investigation reports and had plans for a band 6 midwife to check reported incidents to disseminate immediate learning.

We reviewed the compliance rates for the role and specific midwifery training for the rolling time period ending September 2022. This evidenced that 55% of midwives and 36% junior and senior medical doctors had attended learning from incidents, complaints, and claims training.

We saw evidence that the care group issued a newsletter to disseminate information following incidents. Learning was also shared using emails, and governance boards.

Women and their families were involved in these investigations.

Is the service effective?

Requires Improvement ↓

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

Policies were not always updated with national guidance and evidence-based practice in a timely manner. However, staff consistently protected the rights of women subject to the Mental Health Act 1983.

All policies were in place and available on the intranet for staff to follow. Senior leaders acknowledged staff were unclear which policy version to use because not all policies had been reviewed in line with the planned review date. We reviewed the clinical governance meeting minutes from October 2022 which evidenced there were 14 guidelines which needed review and ratification. There were 12 overdue patient information leaflets, and three antenatal screening guidelines were significantly overdue.

The service did not always demonstrate full compliance with all elements of the saving babies lives care bundle (version 2). We identified cases where they did not meet the element for reducing preterm birth. For example, staff reviewed carbon monoxide at booking and again at 36 weeks to measure if women were smoking during their pregnancy. We were advised the care group had ceased the gap audit in according to this guidance. They currently do not complete audits which would give assurance that fetal growth restricted babies were being identified. In addition, they did not have a current saving babies lives lead.

We reviewed the maternity dashboard which showed the care group only reported on primary post-partum haemorrhage (PPH) which was equal to or greater than 1.5 litres (1500 mls). This was not in line with the green top guidance no 52 for the prevention and management of postpartum haemorrhage.

Senior leaders told us that practice had been updated to reflect changes to the fresh eyes approach to fetal monitoring. However, we did not see this during the inspection which meant this had not been embedded. There was low compliance with fresh eyes, and this was displayed on governance boards in the clinical areas.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives, and carers. We received information from two women who said they had been asked about their general health and wellbeing at every antenatal. This demonstrated this complied with best practice and national guidance.

Community midwives followed best practice and guidance for postnatal home visits to check baby's weight and feeding, and also the woman's health and wellbeing.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. However, the environment meant there were no safe rooms available for women who presented with mental health concerns.

The monthly newsletter contained information related to best practice and latest guidance updates.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural, and other needs.

Staff made sure women had enough to eat and drink, including those with specialist nutrition such as diabetes. There was a wide array of food available to accommodate different cultural choices. We observed women receiving adequate nutrition and hydration during our inspection.

Women and families were able to access the patient kitchen area.

Staff fully and accurately completed women's fluid and nutrition charts where needed.

The service had a specialist infant feeding lead midwives. We saw that leaflets were available on promoting healthy pregnancy, post-natal exercise, infant feeding plans for parents as well as breastfeeding and formula feeding guidance.

Diabetes and pregnancy cards were available which provide guidance on managing diabetes when planning pregnancy and actions to take when pregnant for example liaising with the diabetic antenatal clinic.

All woman we spoke with who had given birth had said they were offered food during or after their labour and said it was good.

Water machines were not readily available. The senior leadership team advised that this was currently under review to provide access to water machines in each area.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way. They gave additional pain relief to ease pain when requested.

Staff prescribed, administered, and recorded pain relief accurately.

We requested data to see if the trust audited pain management however they did not complete audits relating to pain management.

Maternity

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment. They did not always use the findings to make improvements and did not always achieve good outcomes for women.

The service carried out clinical and environmental audits. However, these audits had not been completed for July and August 2022 due to staffing shortages and patient acuity. Senior leaders told us that the care group did not have permanent band 7 midwives available to undertake tendable audits as they were required to work clinically. The onsite Allied Health Professional (AHP) manager had agreed to instigate some tendable audits in September and October 2022 until permanent band 7 matrons were in post.

The care group did not consistently audit all aspects of care. For example, they did not complete regular intrapartum fetal monitoring audits. They did not complete recovery care audits, World Health Organisation (WHO) safety check lists, assessments of risk during labour and swab and needle count. This meant there was no oversight of potential risks surrounding unsafe clinical practice.

The service had a maternity dashboard to monitor clinical performance and governance. This displayed a visual chart to monitor performance over the previous six months.

The care group followed the national guidance from Royal College of Obstetricians and Gynaecologists (RCOG) by using a visual traffic colour code system to use for benchmarking performance. However, the dashboard did not always show the comparison data for the trust, regional or similar sized services for all metrics. For example, senior leaders were unable to compare the metrics for the number of babies born before arrival.

The service participated in some national clinical audits. There was an audit data plan for 2022/2023. However, this did not include start dates, expected completion date, committee group responsible for review, actions agreed or re-audit dates.

Following a recent HSIB review from May 2022 there were recommendations which had not been fulfilled. The trust's plan included guidance to support the telephone triage process. Senior leaders informed us the process was currently under review and no changes had been instigated to date.

We reviewed data which confirmed the trust was an outlier for still births. At the October 2022 inspection visit we identified there had been four intrauterine deaths / intrapartum still births reported in the last 12 months. At the November 2022 inspection we noted there had been a further two intrapartum still births. These had been reported to HSIB for further investigations.

We found there was a slightly higher than average percentage of primary post-partum haemorrhage (PPH) for women who lost at least 1500ml of blood. We reviewed the maternity data from January 2022 to September 2022 which showed an average of 3.9% for all births. This was above the Yorkshire and Humber regional average of 3.8%. However, there was still work to be done to improve compliance with the embedding of the risk assessment and proforma to aid the awareness of the woman who may be at high risk to bleed and assist in the management of PPH.

Following the inspection, the trust shared information that there has been ongoing work around the PPH rate at the Trust since October 2022. The PPH scrutiny panel meet monthly to discuss ongoing themes, action plans and regional and national guidance. The trust confirmed the main theme was on the identification of risk factors such as antenatal risk assessments.

Maternity

The maternity data from January 2022 to September 2022 showed there had been 15 babies born before arrival (BBA). There was no regional or national average to use as a comparison.

Senior leaders recognised the correlation between intermittent suspension of the homebirth service and the rate of BBA. They had created a working group to review the triage processes. The care group had appointed a lead for triage and intended to adopt the Birmingham symptom specific obstetric triage (BSOTS) framework by January 2023. They told us they would be working closely with the recruitment and retention team and focusing on community staffing levels and escalation on calls for the unit, to ensure a consistent and well-resourced homebirth team.

Senior leaders told us there was no formal audits undertaken recently for BBA data. However, following our second inspection they had completed a review which they intended to discuss at the next specialty governance meeting.

We reviewed the peer review audit completed for modified early obstetric warning scores (MEOWs) to show if observations had been taken within four hours, were frequency based and uploaded onto the trust's electronic platform or daily. The results were submitted as a rolling 30 days; however, no time period was provided. These showed that staff did not always comply with the recording of MEOWS observations every four hours, set frequency or daily checks and these results did not meet the trust target of 90%. Post inspection senior leaders told us they had successfully embedded improvements on the Scarborough site with MEOWS audits, priority was now working in collaboration cross site to ensure ongoing improvement.

This trust did not always demonstrate full compliance with all elements of the saving babies lives care bundle (version 2) which aims to provide detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. The second version of the care bundle brings together five elements of care that are widely recognised as evidence-based and/or best practice.

We were not assured that the care group were adhering to the saving babies lives bundle version 2. Although the care group undertook carbon monoxide testing for all women at the antenatal booking appointment, and as appropriate throughout pregnancy, we did not see evidence that all women were offered a referral for support from a trained stop smoking advisor. We reviewed the Perinatal Quality, Safety and Assurance Group (PQSAG) report (July to September 2022) which evidenced smoking cessation was not being offered. The care group actions included, reminders sent to all staff regarding offering of smoking cessation, inclusion in the monthly newsletter and to discuss potential of having an 'in house' smoking cessation lead.

We reviewed the maternity dashboard which evidenced low compliance rates with regard smoking cessation. For example:

- Smoking cessation compliance at booking evidenced a compliance rate of 17.1% against a regional average for the last quarter at 13%
- Smoking cessation compliance at 36 weeks evidenced a compliance rate of 12.8% against a regional average for the last quarter at 8%
- Smoking cessation compliance at time of delivery evidenced a compliance rate of 15.4% against a regional average for the last quarter at 12%

Competent staff

The care group did not make sure staff were competent for their roles. Senior leaders did not always appraise staff's work performance and did not always hold supervision meetings with them to provide support and development.

Maternity

We were not assured all staff were experienced, qualified, and had the right skills and knowledge to meet the needs of women.

We had significant concerns that midwives were undertaking both the scrub and recovery roles for caesarean sections on the labour unit. This was not in line with best practice guidance surrounding the staffing of obstetric theatres (College of Operating Department Practitioners 2009 (CODP).

We saw evidence to support the scrub practitioner (midwife) supporting a dual role when handling the new-born baby. There was no dedicated theatre team assigned for this role other than the consultant anaesthetist and operating department practitioner. Midwives we spoke with confirmed they had not received training to support the recovery of women following a general anaesthetic.

We escalated this at the time of the inspection. The care group provided immediate assurance by offering shifts with enhanced rates of pay to bank and agency staff who had scrub competencies. The care group planned to develop a substantive workforce plan and operational model for the dedicated team. The trust had agreed funding to recruit a band 7 team leader for the maternity scrub team.

Senior leaders did not always support midwifery staff to develop through regular, constructive clinical supervision of their work.

At the last inspection in 2018, the trust was told they should ensure that all staff had their annual appraisals. At this inspection we found similar concerns. The appraisal rates was 15% for midwifery staff and 42% for midwifery care assistants both of which did not meet the trust target of 90%. The trust did not provide compliance rates for medical staff. This meant staff did not always have the opportunity to discuss ongoing training needs in order to develop their skills and knowledge. Senior leaders told us that the staff appraisal process required a robust review and work was ongoing to rectify this.

The care group did not have clinical educators who supported the learning and development needs of staff. There was a vacancy for this post at the time of our inspection.

We are not assured there were effective systems to ensure that medical and midwifery staff have the competence and skills to safely care for and meet the needs of women and babies. We reviewed the compliance rates for the role and specific training for the rolling time period ending September 2022.

The compliance rates for midwives was;

- practical obstetric multi-professional training (PROMPT) 77%
- for newborn life support (NLS) 68%
- fetal monitoring 89%
- reduced fetal growth (part of SBLV2) 64%
- continuous fetal monitoring (CTG) (part of SBLV2) 51%
- reducing preterm birth training (part of SBLV2) 61%

The compliance rates for student midwives and healthcare workers was;

- PROMPT 83%

The compliance rates for consultants were;

- (PROMPT 100%
- fetal monitoring 57%
- SBLV2 (reduced fetal growth, continuous fetal monitoring (CTG) reducing preterm birth training) 37%

The compliance rates for junior and senior medical doctors was;

PROMPT 50%

The compliance rates for junior and senior medical doctors for the last nine months (January 2022 to September 2022 was;

- fetal monitoring 62%
- reduced fetal growth 66%
- continuous fetal monitoring 64%
- reducing preterm birth training 26%

This meant midwifery and medical staff did not always meet the care group target rate of 85%.

This evidenced that registered midwives were 27% compliant for mentorship training. This was a concern given the number of recently recruited newly qualified midwives requiring mentorship and guidance during the preceptorship period.

Staff told us they had not received a full induction tailored to their role. They confirmed that team meetings were not always undertaken due to staffing shortages.

The trust had employed two retention midwives to support the career development of new midwifery staff which included overseas midwives. There was a new maternity preceptorship package with a 12-18 month transition period with structured support to enhance the skills, knowledge, competence, and confidence of our newly qualified staff. This included a one-week trust induction followed by two weeks of maternity specific induction/training (off ward), one week of orientation shifts as supernumerary, then two weeks working alongside a band six midwife.

The care group recruited a practice learning facilitator midwife in September 2022. A learning environmental manager (LEM) had been appointed in each clinical area as a point of contact for student midwives. This supported the allocation of the roster, ensuring students were placed with a practice supervisor on each shift to ensure the facilitation of learning. There were plans to organise student professional midwifery advocate sessions to ensure student midwives had the opportunity for confidential reflection sessions if and when required.

There were specialist midwives which included infant feeding, fetal monitoring, perinatal mental health, and bereavement.

There was consultant support in all clinical areas within and out of normal hours for the middle and junior grade doctors and this was provided on an individually assessed basis, in line with the Royal College of Obstetrician and

Gynaecologists (RCOG). All middle grade doctors have allocated educational and clinical supervisors. The general medical council (GMC) national trainees survey 2022 evidenced that out of hours clinical supervision was rated as good or excellent showing a compliance rate of 84% and they had received supervision. All trainees also had an allocated educational and clinical supervisor with whom they meet regularly. This was monitored by the college tutors informally and through the GMC National Survey.

We were informed that the care group continued to employ a senior consultant on a retire and return contract specifically to provide supernumerary general and clinical support and supervision in theatre for new consultants.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed both the medical and midwifery handovers which had good MDT presence. They had clear, structured, and detailed MDT communications in situation, background, action, and result (SBAR) style. They discussed maternity personalised plans and high-risk patients.

We observed safety daily huddle meetings at different times of the day.

However, one of the recommendations from the Ockenden review was that the care group should ensure consistency with the timeliness of the ward rounds and accessibility of medical staff on antenatal and postnatal wards.

Seven-day services

Key services were available seven days a week to support timely care.

Consultants led daily ward rounds on all wards, including weekends. There was always a consultant obstetrician and consultant anaesthetist on call for any obstetric emergencies.

Staff were supported by other hospital services such as mental health services, diagnostic screening and pharmaceutical help and advice 24 hours a day, seven days a week.

The service had a midwife on call who could provide support to women 24 hours a day.

Health Promotion

Staff gave women practical support and advice to lead healthier lives.

Women had access to information from using own maternity electronic notes via a PC, tablet device or mobile phone. There were posters and leaflets on how to keep healthy and keep babies safe and well. For example, we saw an easy read poster encouraging women to stop smoking and the importance of healthy eating.

Resource sheets were emailed which included information on telephone help lines, websites, and apps.

Staff assessed each woman's health at every appointment and supported any individual needs.

Maternity

Staff were trained to support women with newborn infant feeding. Mothers requiring additional support were identified through routine post-natal care and documented in the post-natal notes and safety net contact details provide to mothers outside of this appointment.

Breastfeeding women were signposted to local breastfeeding charities and leaflets were available.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health. However, midwifery and medical staff did not meet the trust target for training compliance.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. They gained consent from women for their care and treatment in line with legislation and guidance.

Staff made sure women consented to treatment based on all the information available and clearly recorded consent in the woman's records.

Midwifery staff received training in the mental capacity act and deprivation of liberty safeguard (DOLS) however, this did not meet the trust target of 85%. This was 65.8% for DOLS and of 75.8% for mental capacity act training.

Medical staff received training in the mental capacity act and deprivation of liberty safeguard (DOLS) however, this did not meet the trust target of 85%. This was 63.6% for DOLS and of 72% for mental capacity act training.

Midwifery care assistants received training in the mental capacity act and deprivation of liberty safeguard (DOLS) however, this did not meet the trust target of 85%. This was 81.2% for DOLS and of 75% for mental capacity act training.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. They were welcoming and introduced themselves to women and their visitors.

We received positive feedback from two women who said the midwifery staff treated them well and with kindness.

Feedback from social media and friends and family tests (FFT) were all positive and confirmed that staff were caring. The care group had received 353 written compliments between October 2021 to September 2022. We saw examples of thank you compliment cards in the staff room.

We observed staff delivering personalised care to women and their family. We saw them complete appropriate baby checks and observations and also well-being checks for women.

We received information from two women who confirmed staff respected their privacy and dignity and said staff "ensured curtains were closed" for examinations.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs.

Emotional support

Staff provided emotional support to women, families, and carers to minimise their distress. They understood women's personal, cultural, and religious needs.

Staff provided positive examples of when they provided emotional support and care to women and their families. Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. For example, staff discussed the emotional care of women during multidisciplinary team handovers and safety briefs. We received information from two women who said their emotional wellbeing was checked and re-assessed by staff at every antenatal appointment. We observed a midwife comforting a newborn baby and mother when medical doctors had to complete a heel prick procedure to take bloods.

Staff shared positive examples of how they understood and respected the personal, cultural, social, and religious needs of women and how they may relate to care needs.

The chaplaincy team were available 24 hours a day seven days a week. The team was made up of chaplaincy staff and volunteers of all different faiths. They would visit the maternity unit when required to offer religious and non-faith blessings for mothers and babies. They felt it was important to offer some continuity to the family and meet them in hospital if they were also providing additional services. The chaplain lead said they would also visit special care baby unit (SCBU) once a week to check on women, their families, and staff well-being.

The chaplaincy team showed us pairs of knitted hearts which had been knitted by volunteers and explained one went into the baby's coffin and one remained with the family.

The specialist bereavement midwife was available to provide additional support and bereavement follow up support to family members.

We reviewed the compliance rates for the role and specific midwifery training for the rolling time period ending September 2022. This evidenced that **52%** of midwives had attended bereavement training.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity. There was a dedicated bereavement side room which was appropriately decorated and sensitive to meet the

needs of women and their families. Inside there was a sofa, TV, fridge and had hot drinking making facilities. It had an en suite bathroom. There was access to a cold cot which meant families more time could be spent with babies following a bereavement. Staff reported women could stay for as long as they needed, and some women had gone home the same day whilst others stayed for longer.

Staff said they also used this room as a quiet room to support women who became distressed in an open environment and helped them maintain their privacy and dignity.

They demonstrated the need for sensitivity, individualised communication, and good listening skills. Community midwives would continue to care for bereaved women and families at postnatal home appointments. Staff were able to signpost them to various charities and support groups. The service had a care pathway for women who were expecting twins or multiple births.

As part of baby loss awareness week, the trust took part in a "light a candle" in memory of baby or babies.

Understanding and involvement of women and those close to them

Staff supported and involved women, families, and carers to understand their condition and make decisions about their care and treatment.

Staff made sure women and those close to them understood their pregnancy care and treatment with clear information at every appointment.

Women could access their own maternity electronic notes via a PC, tablet device or mobile phone.

Women were supported to make informed decisions about their own care and treatment depending on the stage of their pregnancy. We received information from two women who said they felt they had been provided with enough information to decide on their pregnancy care and treatment decisions.

In the CQC maternity services survey published in September 2022 the service scored in the top 20% when compared with others trusts for eight questions. They scored high for the question "Did a midwife or health visitor ask you about your mental health" and two women we received information from also told us they were asked about their mental health at every appointment. They also scored high for involving women in the decision-making process and getting help during labour when they needed it.

The care group offered two breastfeeding clinics and had seven volunteers to provide breastfeeding peer support to woman.

Is the service responsive?

Requires Improvement ● ↓

Our rating of responsive went down. We rated it as requires improvement.

Maternity

Service delivery to meet the needs of local people

The service did not always plan or provide care in a way that met the needs of local people and the communities served.

For the reporting period January 2022 to October 2022, there were 24 intermittent and temporary closures of the obstetric unit. This impacted on 17 women who had made a birthing care plan and had chosen their preferred birth location site. For the same reporting period there were 0.3% of planned home births achieved which was below the regional average of 1.2%.

We reviewed the June 2022 maternity voices partnership (MVP) meeting minutes which confirmed the service was "fragile" and had ongoing staffing challenges and they aimed to have honest communication about what facilities are available on site if a home birth cannot go ahead.

Staff could access emergency mental health support 24 hours a day 7 days a week for women with mental health problems, learning disabilities and dementia.

Senior leaders monitored and took action to minimise missed appointments. They ensured women who did not attend their appointments were sent a further appointment. There was a flowchart process for staff to follow which included further investigation if there was a potential safeguarding concern.

Specialist midwives provided additional care and support to women. For example, there were clinics for diabetes, fetal medicine, and preterm birth.

Meeting people's individual needs

The care group was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

The labour ward allowed visitors between 8am and 8pm.

Staff told us that beds were not available for the women's birthing partner to stay on the ward / unit. However, two birth partners were allowed when women were in labour.

The service had information leaflets available to print off in differing languages spoken by women and local community. These could also be ordered. Information could also be accessed in braille, large print, and electronic and audio versions.

Managers made sure staff, women, loved ones and carers could get help from interpreters or signers when needed. Interpretation services and sign language was available to help support women and their families if required. The care group had a tablet at both sites that could be used to access these services and be used as a visual guide when needed.

We were informed of a recent audit to evaluate if women's communication requirements had been met and this was an ongoing quality improvement project.

Maternity

We reviewed results from the National maternity survey (September 2022) which is required by the Care Quality Commission for all NHS trusts providing maternity services. The survey was completed in February 2022. The service scored in the top 20% when compared with other trusts on eight questions. These themes related to checking on women's mental health in antenatal and postnatal care, being involved in the decision making and also involving partners.

Access and flow

Women could not always access the service when they needed it to receive the right care promptly.

On the first day of the inspection the labour unit at York site was closed. The reason for these closures was unfilled staffing rotas. This impacted on a patient who was booked for an elective caesarean section on 11 October 2022 at York Hospital; however, due to insufficient staffing the labour unit had to be closed. The patient was transferred to Scarborough hospital for a planned procedure on 12 October 2022 however due to urgent activity this had to be cancelled. The patient was then transferred back to York Hospital for an elective caesarean on the 13 October 2022.

On the last day of the inspection the labour unit at the Scarborough site was closed to admissions.

In addition, we were informed that both sites were closed on 14 October 2022. However, women could not be diverted elsewhere so the unit had to continue to accept admissions including labouring women.

For the reporting period January 2022 to September 2022, there were 19 intermittent and temporary closures of the obstetric unit to avoid serious incidents and suboptimal care. The labour ward manager and the consultant on call made the decision to close or divert women elsewhere. This was due to an increased demand for bed capacity, or in the event of reduced staffing levels. Staff informed us they did not have an escalation process to follow.

It was unclear how senior leadership had oversight and management of this risk because it was not recorded on the risk register. There was no clear process for the recording of unit closures or reporting to the local maternity neonatal system (LMNS).

We raised this at the time of the inspection and were informed an escalation policy had been drafted and was awaiting sign off by the senior leadership team. They had also implemented a new on-call staffing model to support escalation. We were informed this policy would be relevant across both sites to provide consistency. It would enhance decision-making processes, communication and multidisciplinary working relationships and escalated to senior management and board members. It would also include a standard operating procedure (SOP) when the unit was on divert to include contacting the women to ensure there was no harm caused and/or to provide duty of candour. This work was also being completed in collaboration with the LMNS.

The minutes from the clinical governance meeting from August 2022 confirmed the care group did not have enough capacity for inductions of labour or elective caesarean sections. Staff informed us they had recently commenced audits relating to delayed caesarean sections. However, we did not see evidence of this.

The elective lists for caesarean sections were planned every Monday, Wednesday, and Friday. However, these were not always fulfilled due to staffing shortages and emergency caesarean sections.

Senior leaders and staff worked to make sure women did not stay longer than they needed to.

Maternity

Women who had reached full term or whose waters had broken were encouraged to attend the antenatal induction clinic to have a balloon catheter dilator fitted. This was to promote labour contractions with an expected delivery within 24 hours. This meant the delivery coordinator could plan admissions and deliveries more effectively and improve patient experience. We were not assured regarding the decision making surrounding the length of time required balloon catheter remained insitu as this was not in line with manufacturers recommended guidance of 12 hours.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

Women, relatives, and carers knew how to complain or raise concerns.

Staff understood the policy on complaints and knew how to handle them. The care group shared their complaint response data for the period of April 2022 to June 2022 which showed the average time taken to respond was 33 days for 25 complaints with 44% had been resolved within target of 30 working days.

The care group shared their patient and liaison service (PALS) complaint response data for the period of April 2022 to June 2022 which showed the average time taken to respond was 12 days with 64% being resolved within target of 10 working days.

The care group had received 12 complaints from October 2021 to October 2022. We reviewed the quality and patient safety committee complaints annual report 2021-2022 which identified themes and trends. For example, the attitude of midwifery staff. The care group had developed action plans which included values training, staff listening events and band 7 staff were being supported with writing complaint responses.

Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. We also saw feedback being shared on newsletters and governance whiteboards. For example, we read safety recommendations to help identify and recognise the signs of post-partum haemorrhage (PPH) and the use of correct episiotomy scissors.

Is the service well-led?

Inadequate ● ↓↓

Our rating of well-led went down. We rated it as inadequate.

Leadership

The care group had recently restructured the leadership team. This meant roles and responsibilities had changed and were in their infancy and had not yet been embedded. They were sighted on the priorities; however, we were concerned that they were not effective in implementing immediate changes according to risk to improve safety. They were not always visible and did not always support staff to develop their skills and take on more senior roles.

Maternity

The care group had recently made changes to their senior leadership team and structure. The senior leadership team included four new roles, which included a director of midwifery (DoM), associate director of midwifery (ADoM), lead matron intrapartum / deputy head of midwifery (DHoM) and inpatient services matron.

There were future plans to recruit an outpatient's services matron, community matron and a transformation lead midwife which was funded by the local maternity and neonatal system (LMNS).

These senior leadership roles were in their infancy and needed time to embed within the structure. This meant there were challenges to progress key themes and respond to concerns.

The maternity care group did not have a specific continuity plan regarding succession planning; however senior leaders informed us this would be aligned to the long-term recruitment plan and was high priority within maternity services.

Staff we spoke with reported senior leaders had not fully recognised the challenges they faced on a day-to-day basis, and we saw evidence to support this on inspection.

They said they would appreciate a more visible presence from the senior leadership team. The newly appointed ADoM had completed some clinical shifts and staff informed us that she was supportive. Leaders were aware of their lack of visibility and gave us assurance that this would be addressed. We were informed of plans to organise a daily presence across both sites.

The service had a non-executive director who reported to the board. They met with other maternity safety champions at bimonthly meetings and completed walkarounds.

The trust safety champions which consisted of midwifery, obstetrician and neonatal staff met bimonthly with board level safety champions to escalate concerns, issues, and blockers to improvement work.

When the new Humber and north Yorkshire health and care Partnership, LMNS and maternity voices partnership (MVP) lead commences in post in November 2022 the plan was for them to lead a full MVP review around capacity, roles and workplans with a plan for implementation April 2023.

We reviewed action plan from the most recent staff survey in 2021 which highlighted the following.

- leadership and management development for all leaders
- values ambassador training for all leaders
- Human resources team to provide additional appraisal training for all managers. Work had also been undertaken to review appraisal allocation amongst managers.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. However, leaders and staff could not fully articulate or know how to apply them to monitor progress.

The care group had a vision and strategy in place which supported:

- Personalised care and support plan: care that is individualised and meets cultural needs.
- Local integrated care: developing services with partners across LMNS and co-produced with women and families underpinned by cultural awareness training.
- Maternal mental health service: to meet the needs of women with birth trauma.
- Transitional care: strengthen model as additional staff join the team.
- Bereavement care: purpose-built bereavement suite is developed to meet the recommendations of the National Bereavement Care Pathway.
- Continuity of care: increased ability to provide named midwife throughout women's pregnancies.
- Pelvic health: access to post-natal specialist physiotherapy for pelvic dysfunction.

The strategy had a purpose, ambition, and highlighted the care groups key challenges. In the next 12 months the care group intended to:

- Build a more sustainable model of delivery on and across our sites building on our extended obstetric workforce.
- Develop our midwifery workforce to support the delivery of enhanced safety and continuity of care in line with Saving Babies Lives.

The trust had an overlying strategy which included maternity services highlighting a commitment to outstanding care for women, children and young people enabling them to live their healthiest lives. However, there was not an effective approach to monitoring, reviewing, or providing evidence of progress against delivery of the strategy or plans. The strategy was in its infancy and had not been translated into action in maternity services at the point of our inspection.

Culture

Staff did not always feel respected, valued, and supported. The service did not have a culture where staff could raise concerns without fear as they were not always managed appropriately. However, staff were focused on the needs of patients receiving care.

Staff informed us the recent changes in senior leadership, visibility and oversight had impacted on the care group as a whole. Staff felt disillusioned, unsupported, and lacked clarity with regard the clear vision and strategy of the care group. Due to staffing shortages and patient acuity staff informed us they often missed regular breaks which impacted on staff wellbeing.

We were informed by staff of the toxic culture which was historical surrounding the lack of leadership support, lack of equipment and the impact of staffing shortages. We received mixed information surrounding historical bullying and harassment concerns. Staff did not feel confident in reporting concerns as they felt they were not managed appropriately.

We reviewed the staff survey results (2021) which highlighted a completion rate of 38.3%. Responses to 87% of the questions were below the national benchmark. Responses corroborated what staff told us on inspection. The care group had commenced an action plan to address concerns highlighted; however, this was in its infancy and results were not yet visible.

It was evident during the inspection that midwifery and medical staff made every effort, under difficult circumstances, to meet the needs and care for women and babies.

Maternity

Governance

The current governance systems and processes were not always effective. The care group had recently proposed a new governance structure. This meant staff were not always clear about their roles, responsibilities, and accountabilities. Staff did not always have regular opportunities to meet, discuss and learn from the performance of the service.

The maternity service was part of the women's health care group which included Gynaecology.

The care group recognised the need to formalise the governance framework and processes to support the safe and effective delivery of care.

Most staff we spoke with informed us they were not clear of how governance addressed current challenges and risks. Although these had been recognised by senior leaders this was not reflected in immediate action planning. There was no clear leadership of how this was going to be addressed. There were no regular meetings for staff to receive updates surrounding governance and action planning.

However, we were informed there was a newly proposed governance structure. This included senior midwife leads assigned to each key line of enquiry including safe, effective, caring, responsive and well led. They had reporting responsibilities to the newly appointed quality and governance lead.

Staff informed us there were newly recruited quality governance band 7 managers at each site with a band 5 coordinator.

The care group were embedding a new team meeting cascade and action tracker including a fortnightly specialist midwives forum with a cross site approach.

The quality and governance lead attended clinical governance meetings. We saw evidence of meeting minutes from October 2022 which demonstrated quorate attendance and covered relevant aspects of governance. For example, this included discussions surrounding the maternity dashboard, audit, risk register and infection control. There were appropriate methods of escalation up to the quality, performance, and safety (QPAS) meeting.

We reviewed a shared learning presentation embedded in the October 2022 clinical governance meeting minutes. This evidenced the review of a reported serious incident, inclusion criteria, learning points and referencing to national guidance.

We saw evidence this information was disseminated on the governance information white boards on each area. This included challenges, risks, and training information.

Senior leaders informed us they were unsure of the outcome of the Ockenden proposed recommendations of the birth rate plus assessment which was presented to the board in July 2022. This meant the birth rate plus assessment would need to be recommissioned.

We found several policies which were out of date and some that required ratifications following amendments. For example, the waterbirth policy was changed to reflect recent RCOG guidance in March 2022 and was still awaiting sign off at governance meetings.

The care group produced governance newsletters.

Maternity

Management of risk, issues, and performance

Senior leaders did not always use systems to manage performance effectively. They did not have clear oversight of the key risks highlighted on inspection as plans/processes in place to address these had not mitigated immediate risk.

Divert / closure

During inspection we highlighted concerns regarding significant risks surrounding the closure of the labour units at both sites. This meant some women who were in labour were diverted elsewhere. The reason for these closures was unfilled staffing rotas. This decision to close / divert units was made by the midwifery coordinator and consultant. However, there was no senior leadership oversight of this. Staff informed us this was not always reported on datix as an incident and no follow up was in place to check diverted women.

Staff informed us closure and diverts had not been escalated with the local maternity neonatal system (LMNS). This impacted on local hospital infrastructure within the region.

The care group gave assurance that recruitment of midwives had been implemented. However, we were not assured the risks had been mitigated in the short term due to the skill set of the new recruits, the length of the induction required (18 months), and the mentorship/support required by new registrants / students. This impacted on women's individualised preferences of delivery location and also on the health and wellbeing of staff.

Scrub / recovery

During inspection we highlighted concerns regarding significant risks surrounding the midwives undertaking both the scrub and recovery roles for caesarean sections on the labour unit. There was no dedicated theatre team which was not in line with best practice guidance. Midwives we spoke with confirmed they had not received training to support the recovery of patients following a general anaesthetic.

Senior leadership acknowledged there was a poor staff compliance rate of 10% for scrub competency training. In addition, there was no evidence to support that bank staff had completed scrub competency training. They acknowledged there was no recovery competency training package.

Management of medication risks

During inspection we highlighted concerns regarding significant risks surrounding the management and safe storage of medications. We found medicines unsecured on different areas of the labour department. We escalated this with senior leaders who confirmed that additional support is being provided by pharmacy with regards to safe and secure handling on the maternity areas and a pharmacy technician role was being recruited to focus on high risk patients.

Midwifery staff we spoke with confirmed they had received no clinical pharmacy team support since our first inspection and were not aware of the recruitment of a dedicated pharmacy technician for the maternity service.

We received audit data from the trust which showed medicine management remained a concern and therefore was an ongoing risk.

Environmental risk factors within the theatre setting

Maternity

During inspection we highlighted concerns regarding theatre ventilation. We escalated this at the time and were given assurance by the estates team that ventilation was appropriate. Post inspection we reviewed the annual inspection reports undertaken in October 2022.

The report stated there was several maintenance related issues requiring attention.

The external company stated 'due to the bespoke design away from the recommended standard lay-outs of HTM 03-01, they would consider 'maternity theatres' were more of a delivery room rather than an operating theatre. There is no separate anaesthetic or recovery area as seen in most other maternity theatres and no prep area.

We escalated concerns with senior leaders. We did not receive action plans to address the concerns raised at the time of receiving the annual inspection reports. The remedial works required were not listed on the care groups risk register.

The care group returned data which showed the estates team was currently working through the remedial actions.

Fire risk factors on Hawthorn ward

During our first inspection we highlighted concerns regarding significant risks surrounding the fire safety. There was unsafe practice surrounding fire risks, unclear and unsafe evacuation controls, and the lack of recent fire drills. We observed poor storage of equipment which were left in the corridor and blocked fire exits. Senior leadership acknowledged immediate review. They provided an action plan which stated they had completed a full review of the departmental risk assessment and they were fully compliance with the fire evacuation plan.

Following the inspection, the senior leadership team confirmed that fire drills had also been conducted and the tape had been removed from the door on Hawthorn ward.

We found there was a lack of robust governance systems and processes to assess, monitor and manage risks within maternity services. Staff, including senior leaders, could not clearly articulate how risks were being managed, the actions put in place to mitigate risks and reduce the reoccurrence of incidents.

Appraisal

We had significant concerns regarding senior leadership oversight of poor mentorship training, competency training and appraisal compliance rates which did not always meet the trust target.

Senior leadership acknowledged the appraisal rates were low and had extended the time for appraisals to be completed. They informed us the increase in the numbers of senior leaders would help to expediate the appraisal process. We found there was a lack of robust governance systems and processes to assess and monitor staff performance.

Audit

We had significant concerns regarding senior leadership oversight of the audit process. The care group had not been able to complete weekly and monthly environmental and clinical audits in July and August 2022 due to band 7 staff

having to work clinically. We noted there had been no swab and needle count safety audits completed despite having reported one never event (from April to July 2022). We were therefore not assured of ongoing improvement and senior oversight of safe effective practice within the theatre environment. Senior leadership acknowledged these audits will recommence in October 2022.

We did not have assurance how learning and action planning was disseminated following the audits which had been completed. For example, there was poor compliance of the most recent fresh eyes audit. This meant women's observations were not always being monitored every 15 minutes during labour. We did not see any formal action planning to address this although the senior leadership acknowledged there were specific areas for improvement.

We reviewed the care group's risk register. This highlighted that not all risks found in inspection had been acknowledged by senior leaders. Some risks that were recorded high with a potential for severe harm such as the lack of CTG machines did not have appropriate mitigations in place and for example there were gaps in control and assurance.

We reviewed the most recent audit for swab and needle count safety in February 2022. This showed that compliance for this was low showing a compliance rate of 60% of 20 sets of medical records. This showed a deterioration from the previous audit in November 2021. We reviewed the action plan which did not show assigned leads or dates to confirm completion. There had been no further swab and needle count safety audits completed.

From April to July 2022 there had been one never event which related to poor compliance surrounding swab and needle count. We were therefore not assured of ongoing improvement and senior oversight of safe effective practice within the theatre environment. Senior leadership acknowledged these audits will recommence in October 2022.

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Post-partum haemorrhage (PPH)

We had significant concerns regarding senior leadership oversight of the management of PPH risk. From 16 October 2022 to 24 November 2022 there had been 21% of women who had a PPH.

The care group were not reporting post-partum haemorrhage (PPH) below 1500mls despite trust's guidance of obstetric haemorrhage recognising primary haemorrhage is 500ml, minor 500-1000ml and major (moderate) 1001- 2000ml and major as 2000ml. It was clarified they were not reporting PPH of 1500ml following a serious incident review which was not in line with RCOG guidance.

We reviewed the service's incidents from September 2022 and found 32 incidents graded as low harm and 63 incidents as no harm. 17 of these incidents were related to post-partum haemorrhage (PPH) and of these 16 incidents described an estimated blood loss (EBL) exceeding 1500 millilitres. This amount of EBL met and, in many cases, far exceeded the national guidance threshold for categorising these incidents as serious (SIs). This meant these incidents level of harm did not reflect the level of risk to women.

Maternity

We reviewed trust data of the numbers of PPH from 16 October 2022 to the second inspection date which showed the care group had not reported 80 cases. This is not in line with RCOG national guidance.

We reviewed the trust's compliance with the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme. This showed the care group were only compliant with three elements. This meant there were seven safety actions which had not been achieved to improve the delivery of best practice.

Information Management

The care group collected data however they did not always analyse this to understand performance, make decisions and improvements. The information systems were not always secure. However, staff could find the data they needed, in easily accessible formats.

Staff informed us there were not enough computers and could not use them in every area because of the lack of data points and bedside space.

Staff did not always meet the trust target of 85% for information governance training which was included in mandatory training.

We reviewed the maternity dashboard. This did not always show comparisons with the regional, national, or similar size services. In addition, not all performance metrics were RAG rated against this.

The care group had a digital midwife and they had invested in the digital care record system which was expected to go live in February 2023. This will also give other hospitals within the LMS access to maternity records if women were diverted into their care.

The care group had launched electronic software system in Summer 2021 for medicines management.

Staff could easily access the electronic patient record systems and care records and women had access to their own patient records.

Notifications were submitted to external organisations as required.

Engagement

Senior leaders actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

Leaders we spoke with acknowledged the impact of system wide issues such as recruitment, retention, sickness, and shift fill on staff experience.

They were aware of themes and trends escalating from incidents raised and staff survey results.

The main themes emerging were that staff felt unsupported of staffing issues and also being asked to work on different areas.

Senior leaders informed us they were going to offer various engagement opportunities for staff. We reviewed a list of these which included work streams for retention rates, working with a clinical psychologist and looking at different kinds of flexible working models.

Maternity

There was a culture, communication, and leadership workstream for the maternity improvement plan who met monthly. This was a multidisciplinary meeting, with members including consultants, union representatives, midwives, ward managers, matrons, organisational development, and improvement learning team, human resources, quality improvement and the recruitment and retention midwives.

The care group had piloted an approach with a dedicated occupational health link who provided a monthly overview of any concerns identified through occupational health. This had resulted in some initial work looking into the rosters, where it had been identified some staff were not being given appropriate rest between shifts. They were also going to review the rotation of midwives.

The care group also intended to commence staff engagement with community road shows and listening events.

We reviewed a newsletter which encouraged staff to seek additional support if they had been involved in intrapartum stillbirths. The purpose of the newsletter was to highlight ways to improve the service and also included staff recognition and employee of the month award.

The care group were going to commence a workstream for reviewing the NHS England "we can talk project" in response to poor communication with patients. This was highlighted as a trust wide theme and trend following a recent patient survey.

Senior leaders were going to collaborate with another trust to benchmark and learn about baby abduction drills and related audits to help improve services.

Following recommendations from the Ockenden review the care group regularly attended LMNS meetings and also to work with them more closely in the future.

The maternity voice partnership (MVP) meetings had recommended as face to face meetings in June 2022. The MVP was a multi-disciplinary group of women and their families, commissioners and professionals from local maternity services who are working together to review and contribute to the development of local maternity care.

We reviewed the minutes from the June 2022 meeting which highlighted themes around negative feedback which included communication and attitude of staff. We also read the specialist maternal mental health practitioner was engaging with a wide range of communities across the area to understand their different needs. This included the traveller community and ethnic minority group.

Learning, continuous improvement and innovation

Senior leaders needed time to embed the vision and strategy for the care group. This meant learning and innovation was in its infancy.

We heard positive examples at ward level where staff recognised the need to make improvements. However, it was difficult to progress with new ideas or innovations due to the current staffing issues. In addition, the low compliance rates for appraisals meant there was limited opportunity for staff to learn and develop.

Staff participated in a fundraising event for new bereavement suite.

Urgent and emergency services

Requires Improvement ↑

Is the service safe?

Requires Improvement ↑

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff. However, not all medical staff had completed it.

Nursing staff received and kept up to date with their mandatory training. ED nursing staff had an overall completion rate of 87.4%. Of the 15 statutory training courses, 12 had a completion rate of over 85%. The three remaining modules had completion rate of over 75%. The completion rate for sepsis awareness was 81%. Of the seven required learning courses, four were above 85%, two were above 84% and one had a completion rate of 19.1%.

We reviewed all emergency medicine staff's latest mandatory training compliance rates. Nursing staff achieved an overall compliance rate of 91.7% which met the trust target of 85%. All the service's modules were above 75% compliance for nursing staff.

However, compliance was not achieved in three modules; these were adult advanced life support (ALS) (4 years), deprivation of liberty safeguards (DoLs) level 2 (3 years) and adult life support (1 year). Less staff overall were eligible for the two adult life support modules.

Medical staff received mandatory training but did not keep this up-to-date. On our last inspection in October 2019, we told the service it must ensure all their medical staff at the hospital are compliant with all aspects of mandatory training.

On this inspection we found limited improvement and a repeat breach. At Scarborough hospital medical staff had an overall training completion rate of 70.1%. This was lower than the trust target of 85%. Of the 16 statutory training courses, only four had more than 85% of staff complete the module. None of the additional learning or required learning modules achieved the 85% target.

We also reviewed role or core specific training compliance rates for the service's medical staff. This was only 43.9% overall which fell well short of the trust target. The required learning module with the lowest compliance was aseptic non-touch technique (ANTT) practical with 20%. However, only five staff were eligible to complete this.

Additional clinical staff had an overall completion rate of 85.5%. Of the 18 statutory training courses, 13 had completion rates of over 85%. Four of the seven required training modules achieved the 85% trust target.

The mandatory training was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training. However, they did not always alert staff when they needed to update their training. We heard the department's clinical educator resulted in a sustained positive impact on nursing staff's mandatory training compliance which had improved significantly and achieved trust target overall.

Urgent and emergency services

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. We reviewed safeguarding adults level 2 training compliance for all ED staff by role. All roles achieved the trust target of 85% except for two medical staff roles.

All nursing staff roles exceeded trust target for this training, with staff nurses achieving 100%.

Safeguarding children's level 3 training showed a similar picture where the two roles with the lowest compliance were medical staff. Again, all nursing staff roles met or exceeded trust target.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Nursing staff we asked could tell us how they raised safeguarding alerts or concerns using the trust intranet's referral form. This had separate tabs for children and adults. The department displayed a large safeguarding information board. We saw posters on display in the department promoting staff's awareness of adult and children's safeguarding.

We reviewed the care group's latest risk register and found a risk relating to children's safeguarding scored 8 out of a possible 25. This was added after our last inspection in February 2019 and last reviewed by leads in August 2022. This described the risk of harm to patients with child safeguarding needs resulting from poor compliance with the trust's mandatory training and children's safeguarding documentation, as a result of the high levels of locum and agency staff covering shifts in the ED. The service had introduced an electronic child safeguarding referral system in response, but at the time of our inspection had not evaluated this.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff knew their safeguarding lead point of contact and their contact number was on the intranet page. Nurses discussed different local authorities and were aware they needed to check when raising a safeguarding which authority patients and others fell under.

Senior nursing staff on the emergency assessment unit (EAU) could reiterate the safeguarding procedure discussed in ED and provide examples. We asked if the department had a protocol in the event of needing to declare a major incident and how staff would respond. These staff told us they would remove as many patients as they could from the department. We heard ED staff had recently held a tabletop role play exercise for armed forces day.

Staff followed safe procedures for children visiting the ward. The department had cover provision in place during the absence of a named lead doctor for safeguarding children onsite. A child safeguarding liaison nurse was in post and ED also had a nominated lead sister for children's safeguarding.

The department waiting area had a separate children's room. However other child patient areas were mixed with adults as their streaming pathway overlapped with other patients and visitors to the department. This meant we could not always ensure staff retained oversight to keep them safe.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures. They kept equipment and the premises visibly clean. However, staff did not always protect patients, themselves, and others from infection.

All areas were clean and had suitable furnishings which were clean and well-maintained. The department appeared visibly clean. Waiting area furnishings did not appear to have breaks in their surface. We saw domestic staff proactively maintaining the cleanliness of the environment and saw 'I am clean' stickers on equipment in the dirty utility. Domestic staff completed the department's cleaning roster including the mental health assessment (MHA) room.

The national patient led assessments of the care environment (PLACE) inspections had not taken place since 2019. However, at the time of our inspection the hospital's PLACE audit for ED was planned for 19 October 2022. Leads told us the challenge to maintain the department's cleanliness remained, due to their significant footfall pressures. To mitigate these pressures, staff in each area had the responsibility to ensure their environment was clean and tidy. Each ED area used daily cleaning checklists reviewed and monitored by the NIC or matron.

The trust's working group continued to meet to provide oversight of outstanding actions, most of which were resolved except several estates issues, also featuring within accessibility and dementia-friendly audits. The compliance lead maintained regular contact with the national team and services were awaiting confirmation this year's assessments would go ahead in the autumn.

Training plans had been refreshed and training dates for both patient and staff assessors were circulated in August 2022.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. Healthcare assistants (HCAs) completed all blood spill/bodily fluid cleaning in the department then called domestic staff who came and carried out a second clean. ED domestic staff were always on shift. One domestic services assistant was on duty 24 hours a day and two more assistants worked in the afternoon. A domestic supervisor performed checks three times daily to ensure cleanliness in the department. Cleaning schedules were taken to the department lead or cleaning manager the day after completion for audit purposes over a six month period.

However, we found staff's legionella water testing schedule was incomplete as they only checked this three times weekly on alternative days instead of daily as required. This meant there was a potential risk of staff not responding to contaminated water outbreaks in the department promptly. We were unsure how the new ED build would address this issue.

Staff followed infection control principles including the use of personal protective equipment (PPE). ED staff followed the appendices attached to the trustwide infection prevention and control (IPC) guidelines policy regularly, due to the varying types of patients. This provided a step by step guide for the domestic team and any staff working in ED on the relevant cleaning required for different circumstances.

Environment and equipment

The design, maintenance and use of facilities and premises kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, staff checks and use of equipment did not always keep people safe.

Patients could reach call bells and staff responded quickly when called. The department had access to 24 hours a day security support. We heard staff only had brief delays with security coming when called.

The design of the environment followed national guidance. The department had a designated separate paediatric waiting room for child patients and their parents or carers. This contained staff names on the door, was well lit and appropriate for children with some provision of toys, games and books. Other department areas for children were the paediatric room and flexible paediatric resuscitation room.

However, staff were concerned the new ED build's paediatric unit would have the same number of child patient beds when they needed more bed spaces.

The department capped the number of patients on trolleys awaiting review along the ambulatory corridor at six. We attended a hospital bed meeting where leads confirmed ED were struggling with space for these patients and their discharge lounge was full. ED staff used the back of the neighbouring outpatients department to cohort.

We tested the mental health assessment (MHA) room's strip alarm and found it was in working order. There was a specialised key fob which ensured the room's doors swung open both ways. The room's furniture was in good working condition and had seating for up to three people.

The mental health liaison service was based in ED during out of hours. ED also had two mental health support workers to manage and support patients with mental health issues. Staff escorted these patients to the main bathrooms in the department in which we found no ligature risks.

After our inspection service leads sent us a workplace risk assessment for the care and treatment of patients whilst in an ambulance. Staff followed a hazard rating system using an overall hazard risk rating number qualified by a risk level of low, medium or high to confirm control measures would be effective. However, we did not see ED staff or ambulance crew using this risk assessment during our inspection.

Staff did not always carry out daily safety checks of specialist equipment. We checked the main ED's resuscitation trolley and found no out of date items. However, we reviewed staff's trolley equipment checks for April, September and October 2022 and found several missing dates and signatures. This meant it was unclear who had checked or maintained the trolley. Staff or patients could potentially take stock as needed so in the event of an emergency life-saving equipment was unavailable.

On our follow up inspection, we again found staff left gaps in their recording of resuscitation trolley checks. ED had implemented a new checklist to try and combat this.

The service had suitable facilities to meet the needs of patients' families. We saw a relatives room opposite the resuscitation area which was quiet and private. We heard after consultation with nursing staff, the new ED model build would incorporate a family and relatives room as well as bigger cubicle areas to accommodate patient visitors.

The service had enough suitable equipment to help them to safely care for patients. However, we checked three pieces of medical equipment for portable appliance testing (PAT) and found only one had this displayed.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. However, staff did not always identify and quickly respond to patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The department used the national early warning score (NEWS2) which staff managed well. During our time in the department, paediatric nursing staff's resuscitation and ventilation of a child patient overdosing with heart arrhythmia was well managed involving a transfer by a specialised regional transport service for critically ill children.

ED staff worked to manage all presenting patients as safely and effectively as possible. However, internal and external issues within key stakeholder service provision often resulted in the department becoming overcrowded. For example,

the department had issues around their streaming service due to the urgent treatment centre (UTC) being contracted to an external provider. There was risk of a delay in unwell patients being referred to the appropriate clinical service promptly as the UTC streaming nurse was unable to fulfil their responsibility of streaming all presenting patients within 15 minutes of arrival. There were also risks of delays in patients being streamed to UTC minor injury and illness services due to ongoing staff gaps. These could often result in there being no UTC service available ED staff can refer patients onto. We saw this risk on the care group's latest risk register scored 12 out of a possible 25 with mitigating actions in place.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

ED senior nursing staff had introduced an extra healthcare assistant (HCA) in the waiting room at all times as well as a waiting area assurance document to better monitor and inform longer wait patients. This document was a patient identifier with criteria asking them to let staff know if they deteriorated or felt worse. All patients we saw holding this paper slip were wearing wristbands.

Nursing staff we asked showed a good understanding and awareness of how to monitor and respond to the deteriorating patient. The department had standard operating procedures (SOPs) for their different pathways so staff knew which patients should be placed in each area. We saw escalation policy posters on the main department walls. Receptionists in the main waiting area could access emergency call buttons for an urgent response in the event a patient or member of the public deteriorated. However, they had no criteria checklist for early signs or recognition of patient deterioration.

Staff described the process for ambulances admitting patients into the department. Patients arrived by a designated ambulance arrival entrance. They were then supported through to triage and after initial assessment were relocated into the main corridor.

We saw structured and timely reviews of six patients on beds along the corridor and in ambulances. ED's main corridor allowed up to a maximum of six ambulance stretchers. These patients were checked frequently by staff members. During busy periods where the maximum six stretcher limit was breached, patients stayed on the back of ambulances until capacity became available. ED staff maintained a designated clipboard within the ambulance triage area. This contained patient details, arrival time, ambulance call sign and presentation. This enabled a degree of oversight of the situation with ambulances and assists in monitoring and prioritising patients. On 12 October 2022 upon our arrival into the department at 10.30am there were three ambulances queuing outside. By the afternoon, there was approximately six/seven ambulances.

However, ambulance crews gave us inconsistent messages about ED staff's monitoring of patients. Some crews indicated ED staff would make efforts to consistently check patients on the back of the ambulance and take their bloods and baseline observations. Other crew members told us this did not happen. One ambulance indicated they had been waiting over an hour and had no ED staff onboard to check their patient. ED staff said they felt confident escalating any deteriorating patients to senior staff members.

Staff did not always know about and deal with any specific risk issues. ED's SOPs for ambulance care, risk assessment and waiting room observation paperwork were only at the draft stage. This meant they were not well embedded or always known and followed by staff.

Urgent and emergency services

We reviewed the service's latest sepsis training compliance for nursing, medical staff. Medical staff's latest compliance was 75%, although only eight staff were eligible for this training. Nursing staff's latest compliance was 81%. These rates did not meet the trust target of 85%. This meant service staff were not always trained to recognise or respond to the warning signs of sepsis in patients.

The trust used the sepsis six care bundle. This was the latest adult sepsis screening and immediate action tool (version 21) approved by the deteriorating patient group. The new tool was then rolled out to ED staff through training and support from sepsis link nurses. We heard the children's ED had sepsis tools specifically for child patients. The department completed quarterly advanced clinical practitioner (ACP) audits and reported their results and findings back to the sepsis delivery group who in turn reported to the deteriorating patient group.

Staff followed a flow chart to determine if patients were at low, possible or high risk of sepsis. If patients had any one red flag for sepsis present staff should commence the sepsis 6 care bundle immediately. However, we saw instances where staff had ticked a red flag but recorded no follow up actions, name, signature, date or time.

On our follow up inspection, we reviewed the records of two patients with sepsis. One patient's treatment was delayed by over 2.5 hours; their sepsis was identified at 10:06am but staff did not administer them time-critical medication until 12:45pm. There was no documentation of what time this medication was prescribed. Nursing staff had left paperwork blank for the second patient with sepsis who had no follow up actions. Staff gave the patient antibiotics, but we could not assess timelines from their records.

The service's sepsis audit considered time to antibiotic treatment. We reviewed excerpts from these audits in quarter 3 and 4 of 2021-22. They showed ten of the 12 patients had antibiotics before or within an hour of them having a NEWS2 score of 5 or greater (83%). 11 of the 12 patients had two antibiotics (91.6%) prescribed.

However, four of the 25 patients (16%) in this audit were either given antibiotics before staff completed their screening or recorded no time these were given in their notes. 20 of the remaining 21 patients were given antibiotics after screening (95%) and one had an unknown administrative time. 13 of the 25 patients (56.5%) were given antibiotics based on other valid features requiring antibiotics aside from a NEWS2 of 5 or greater.

Of the 10 patients scoring NEWS2 5 or greater when they arrived or in the department 3 (30%) of the patients scoring within 1 hour of arrival of these received antibiotics within 1 hour of their score; one reason could be an administrative issue rather than a recognition and prescribing one due to stressors in the Covid wave. Another patient was given antibiotics before their NEWS2 of 5 or greater.

22 of the 25 patients had two antibiotics (88%) prescribed. A common theme in this audit found that despite clear sources of infection being suggested in the plan a generic plan of Tazocin and Gentamicin was commonly used, with an astounding 18/25 patients having this plan (72%).

ED staff used the pressure ulcer risk primary or secondary evaluation tool (PURPOSE-T) for patients. This was an evidence-based pressure ulcer risk assessment instrument used to identify adults at risk of developing a pressure ulcer and supported nurse decision-making to reduce that risk.

However, we saw staff failed to recognise or make reasonable adjustments to meet the needs of one patient with mental health issues and anxiety who had a crisis. Nursing staff did not administer pain relief when or after the patient requested. They could also not offer this patient a preferred room with more privacy, so they were treated in the main waiting area.

After our inspection service leads sent us a waiting area assurance document for use with all patients streamed to ED. Staff could record hourly observations of patient's NEWS2 and pain scores, nutrition and hydration needs as well as elimination once they were streamed and given a wristband. However, we did not see these in use during our inspection.

The care group undertook a quality audit which used a sample of the ten longest wait patients above 12 hours in a seven-day period. The audit chart metric which scored lowest was for ED staff completing pressure ulcer risk assessments. This only scored 40% for the 26 September to 2 October 2022 audit week. We also saw this metric scored 0% on 18 September and 20% on 24 July 2022.

Leads told us all pressure ulcer assessments would transfer onto their new clinical records system. This should improve staff compliance and completion as well as data accuracy around pressure damage sustained in ED. The care group's weekly quality audit also monitored how often ED staff had completed a falls risk assessment. This scored 80% for the 26 September to 2 October 2022 audit week. However, it fell to only 20% completion on 18 September 2022.

The department planned ongoing work to further embed staff completion of the risk assessments for falls and pressure ulcers. This included the development of a new documentation booklet of all assessments together, so staff did not have to look for extra documentation. The clinical educator worked with staff continually, so they were aware of the requirements.

After any patient falls in ED, nursing and healthcare staff ensured they completed step two of the falls risk assessment. They ensured safe mobilisation and transfer of the patient using the hoverjack. Nursing staff should also complete lying and standing blood pressure checks for patients presenting with a previous fall. They used a post-fall sticker to document actions taken following a fall. Medical staff completed a four A's test (4AT) delirium screen. This was a short, four-item tool designed for use in clinical practice to assess patient's delirium.

An allocated lead consultant from same day emergency care (SDEC) attended the venous thromboembolism (VTE) committee and discussed any issues with teams and within the care group quality committee under the medicines optimisation section.

The service had 24-hour access to mental health liaison and specialist mental health support. However, ED staff we asked were concerned care provision for patients with mental health (MH) needs could be delayed. We reviewed the care group's latest risk register and found a risk scored 12 out of a possible 25. This related to patients presenting at ED with MH needs were not being cared for safely in line with national guidance such as the royal college of emergency medicine (RCEM) and psychiatric liaison accreditation network (PLAN) quality standards for liaison psychiatry services. As a result, some of these patients had to wait significant lengths of time to receive support from the mental health trust.

We reviewed the service's audits and action plans for mental health risk assessment. This was an ongoing piece of work to improve compliance. The barriers to completion were around the length of the risk assessment documentation but the audit did not allow for information recorded elsewhere in the records. Leads had a plan in place to urgently move to a more user-friendly intuitive risk assessment tool on their new clinical records system.

Staff shared key information to keep patients safe when handing over their care to others. The department's adults only emergency assessment unit (EAU) had an assessment criteria for admitting patient which included observations, full bloods and echocardiograms (ECGs). For example, patients should have a NEWS2 score of 4 or less. We reviewed this

proforma which highlighted DNAR, advanced care planning and any required discussion information for staff upon handover. The unit also had an EAU short stay patient assessment document for those staying overnight. This included intentional rounding, a manual handling assessment, a multifactorial falls risk assessment and care plan for adult inpatients including bed rails and a falls prevention plan.

Nurse staffing

The service did not have enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers could not always regularly review staffing levels and skill mix. However, they gave bank and agency staff a full induction.

The service did not have enough nursing and support staff to keep patients safe. We reviewed all 558 ED shifts from September 2022, the latest month will complete data. 77 of these shifts were understaffed, and 61 were mixed. This meant that 13.8% of the month's total number of ED shifts were understaffed.

During our inspection on 12 October 2022, we observed two staff nurses in the adults resuscitation area. However, staff told us this was not normal. They usually only had one adult nurse posted to resuscitation who often did not always feel particularly safe. They regularly escalated staffing issues to seek additional support, particularly during busy periods.

The service did not always meet the required level of paediatric nurses. Some paediatric staff in ED were concerned as the service had no other paediatric nurses to complement or cover when they were unavailable. They felt isolated with no supervision as they completed training and clinical competencies on the children's wards.

Since the service's original staff design, children's ED attendance patterns and numbers had significantly increased. As a result, leads had submitted a business case to support an increase to this paediatric ED staff model, to update the staff modelling reflecting the service demand changes. If paediatric ED staffing shortfalls for cover occurred, every effort to mitigate the risk was made, accessing in-reach support from the children's ward, as well as urgent requests to bank and agency staff. Paediatric ED staff would do additional shifts to support the service when requested and if able. Occasionally we heard a paediatric trained RN was not available. In this event the department would ensure a paediatric immediate life support (PILS) trained staff member could cover that shift.

Managers could not always accurately calculate and review the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Senior nursing staff told us they used the safecare app to determine appropriate staffing models on the unit. However, they reported this app was not fit for purpose for their type of department as they were not a ward but leads requested, they had to complete it regardless.

The department manager could adjust staffing levels daily. The matron of the day reviewed the skill mix's suitability for each shift and would adjust ED staffing from the wider hospital staffing as needed. Each shift total included a swabbing shift repurposed to provide a staff member for the waiting room.

Nurse staffing mitigations in ED included a daily staffing matron for the day (MOD) who supported staff to ensure safe levels. The MOD role was to review and mitigate any staffing concerns, addressing the planned staffing versus actual staffing and balancing against the acuity. Managers moved staff from across the hospital wards and department to mitigate staffing risks.

Service leads had a plan to trial and roll out the safer nursing tool in the emergency department.

The number of nurses and healthcare assistants did not always match the planned numbers. We heard examples of EAU nursing staff shortages which meant they felt unsafe when dealing with challenging patients from ED. For example, one hallucinating patient displaying violent and challenging behaviour needed a deprivation of liberty safeguard (DoLS) and sedation. Three staff members were needed to ensure they did not fall. They rang the matron to escalate.

The service did not have low and/or reducing vacancy rates. We reviewed ED nursing staff's overall vacancy rate at the hospital from July to September 2022. This had slightly increased by 1.3% from 12.88% to 14.18% full-time equivalent (FTE) vacancies. ED's band 4 position had also slightly increased by 3% from -3.68% FTE to -0.68% but still met establishment.

However, for band 5-7 registered nursing staff this had reduced by 5% from a FTE rate of 14.42% to 9.42%.

The service had low but not reducing turnover rates. We reviewed ED nursing staff's turnover rate headcount from the year September 2021 to August 2022. This was 2.33% which was a FTE rate of 2.56%. However, the turnover rate was much higher for additional clinical services which was 12.37%.

The service had quite low but not reducing sickness rates. We reviewed ED nursing staff's absence or sickness rate from September 2021 to August 2022. During these 12 months their FTE rate was 4.26%. The absence rate for additional clinical services was slightly higher at 4.99% for the same period. Both monthly rates fluctuated and saw no consistent reduction.

The service did not have low and/or reducing rates of bank and agency nurses. Managers did not limit their use of bank and agency staff. We reviewed the service's latest total number of bank shifts requested and filled for the six months up to our inspection. They had been unable to fill 402 bank shifts during this period. This was a rate of 19.2% of the total shifts.

We also reviewed the service's latest total number of agency shifts requested and filled from 22 April to 21 October 2022. They were unable to fill 152 shifts in total during these six months, or 13.5% of the total.

We reviewed the service's latest total number of agency nursing shifts requested and filled from 22 May to 22 September 2022. They were unable to fill ten shifts during these five months. This was a total rate of 37% or more than one out of every three shifts.

For the three months from August to October 2022 total A&E bank and agency staff usage saw little variation. Bank usage for August 2022 was 27.14% of total hours worked. This was the second highest figure of all areas across the care group. Agency usage was also the highest or second highest figure of all care group areas during this period.

We heard EAU nursing staff sometimes had to orientate agency nurses from ED who had not previously worked on the unit when they were understaffed or at times of higer patient acuity.

However, managers requested staff familiar with the service. They made sure all bank and agency staff had a full induction and understood the service. The nurse bank office provided daily support and sent out urgent immediate requests to cover any unfilled shifts to the hospital bank and agency.

Urgent and emergency services

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction. However, they could not always access locums to cover extra shifts.

The service had enough medical staff to keep patients safe. We reviewed the department's medical staffing rotas. Their tier one and two mitigation level were dependent on several factors; the number of gaps, shift time, if the shift was core and skill mix on the day. Leads individually reviewed and scrutinised each shift against all the rotas to ensure as a team they provided a safe and effective level of cover 24/7, not just to patients but for supervision of their junior tiers.

The service's core shifts for tier three consultants were achieved daily. This consisted of one EPIC from 8am to 4pm weekdays and another from 2pm to 10pm daily before switching to on-call. These shifts were covered 100% of the time as this was a mandatory requirement when running an ED, with either substantive or locum consultant cover.

The medical staff matched the planned number. We reviewed the emergency medicine consultancy and junior doctor planned cover for the month before our inspection. The ED's consultant rota met the 100 PA's or 10 clinicians equivalent as per RCEM recommendations. The clinician figure factored in the department's average annual attendance rate of between 35-40,000 patients. However, this staffing establishment did not account for the patient complexity and lack of clinical support services faced by a small rural and remote hospital. With this in mind, the Director and Associate Chief Operating Officer for ED's care group agreed to consider a business case which brought their consultant rota up to 12 clinicians (120 PA's). The proposed staffing model addressed key issues faced both nationally and locally through senior workforce development. For example, the model considered timely investment in succession planning through training and development of the tier 2 team.

The service had low and reducing vacancy and sickness rates for medical staff. We reviewed the service's number of unfilled shifts for medical staff in the three months before our inspection. 15 shifts were unfilled due to vacancy; this comprised 8.24% of the total. Ten shifts were unfilled due to sickness. This comprised 11.76% of the unfilled total.

The service found short notice absences much harder to fill, as reflected in their unfilled shift statistics we reviewed. As a result their increased medical staffing from August 2022 had been beneficial.

The service's latest total emergency medicine vacancies were minus 17.87 wte. This meant the department was over established for the number of full-time equivalent (FTE) medical staff it needed.

The service had low and/or reducing turnover rates for medical staff. ED's appointment process of temporary medical staff was overseen by the trust's medical bank and agency team (MBAT). They worked closely with the care group when employing these staff at all clinical levels. This included suitable vetting of agency workers. Where appropriate all ED requests for temporary medical staff went to bank before agency. The trust's medical deployment team could email requirements to a medical staff recruitment company.

The service had low and reducing rates of bank and locum staff. We reviewed the service's use of bank agency and locum staff for tier 3 medical staff in the three months before our inspection. 100% of core shifts were filled for both (as stated above). One of these two posts was covered ad-hoc by agency when needed to cover staff's study or annual leave for example.

Managers made sure locums had a full induction to the service before they started work. All ED requests for agency locums went to the trust's master vendor provider with a protected response time before the relevant care group. ED always asked one of their consultants to review the locum CV and checklist for any clinician's suitability to cover the vacant shift's requirements. ED's care group also had a departmental checklist in place used when reviewing CVs.

However, managers could not always access locums when they needed additional medical staff. Bank locums could only support 54% of additional shifts in the three months before our inspection.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service had a good quality skill mix across all their four tiers.

From August 2023 the service planned to increase out their tier one rota to 18 doctors. This was an increase of five doctors since February 2021, allowing them to create a rota with additional support shifts throughout the day.

However, we heard medical staffing on EAU was not always adequately covered, yet operational areas remained open.

The service always had a consultant on call during evenings and weekends. The service had a senior clinical available 24/7 which had onsite presence from 8am to 10pm seven days a week. After 10pm until 8am they were on-call daily. The 8am to 2pm shift on Saturdays and Sundays was not a mandatory requirement. However, the service included this as a core shift in the business case for two additional ED consultants.

Records

Staff kept detailed records of patients' care and treatment. Records were clear and up to date. However, they were not always stored securely or easily available to all staff providing care.

Patient notes we checked were comprehensive, up to date and all staff could access them easily.

We reviewed ten sets of patient notes. This included one patient who had bee in the department for over 30 hours. Staff had maintained detailed record keeping with timely baseline observations.

ED staff used a new situation, background, assessment, recommendation (SBAR) handover tool. This was a mix of the old ED handover form with a pressure area safety checklist of timed prompts. The clinical educator told us they had completed some training on the new tool with nursing staff.

When patients transferred to a new team, there were occasional delays in staff accessing their records. EAU nursing staff told us there were times they had to highlight to ED staff the need for patients to have notes or documentation when they arrived on the unit overnight in case of an emergency. We heard the EAU nurse in charge (NIC) had to review ED documentation to ensure it was to a high standard for patient safety and ongoing care especially if their unit saw consistent delays overnight. The NIC had to raise questions regarding patients for transfer after rapid assessment team (RATS) review, some with conflicting stories and lack of awareness about patient mobility or medication. In one case RATS had documented a patient was bed bound and required a full hoist but the responsible nurse stated they were mobile with a walking stick.

We reviewed a set of notes for the longest admitted patient on EAU. We found some inconsistencies but not from the EAU staff.

The department had a lead advanced clinical practitioner (ACP) allocated to attend antimicrobial stewardship team meetings and promote improvement work.

Records were not always stored securely. On our last inspection in October 2019, we told the service it must ensure computer screens showing patient identifiable information are not left unlocked when not in use, in the urgent and emergency care service at Scarborough hospital.

On this inspection we found records for patients waiting in the ambulance arrival corridor were placed on the back of their beds and easily accessible. However, as we found no unlocked computer screens when staff were away from their desk this was not a repeat breach.

ED frailty service staff used a comprehensive geriatric assessment document which used the Rockwood clinical frailty scale scores for patients, from vulnerable to terminally ill. Due to their patient cohort, alerts, allergies, DNAR, advanced care planning and any discussions needed were highlighted yellow under observations staff recorded which served as prompts.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, staff did not always follow them.

Staff did not always follow systems and processes to prescribe and administer medicines safely. On our last inspection in October 2019, we told the service it must ensure medicines are managed safely in the urgent and emergency care service at Scarborough hospital.

During our last inspection multiple drug cupboards across the department meant compliance maintaining security of locked cupboards was highlighted as suboptimal.

On this inspection we found service improvements to ensure staff managed and prescribed medicines safely. For example, ED's stock medicine storage areas had been condensed with swipe access control on the main medication room door. This meant only registered ED staff had access as well as individual cupboard locks.

However, on our follow up inspection staff did not always administer patient medications accurately. We observed a nurse measuring the incorrect volume of a liquid medicine. We saw a nurse sister queried this who explained they should only give the amount prescribed.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. ED's stock list was reviewed, and the department now had a drug trolley due to patient's increased waiting times for admission. This increased the range of commonly used drugs and prevented missed or delayed doses of critical and other medications. Service leads planned a business case to introduce an automated drug dispensing cupboard in the new development build.

Staff completed medicines records accurately and kept them up to date. ED used electronic prescribing and medicines administration (EPMA) once staff completed the medication section on the ED card. This was shortly after the hospital rolled out EPMA to their acute wards in 2018. This allowed clinicians and nursing staff easy access to decision support and other supporting information such as the British national formulary (BNF), electronic medicines compendium, the

intravenous (IV) guide medusa and links to relevant trust policies and national guidance. EPMA allowed a clear, legible prescription with a clear audit trial of prescribing and medicines administration. EPMA also enabled electronic prompt ordering and supply of time critical medicines which minimised nursing staff's workload. Medicines leads had a plan in place to facilitate the full transfer to EPMA and remove handwritten prescriptions in the department.

Staff stored and managed all medicines and prescribing documents safely. Since our last inspection in October 2019 the ED had made improvements around medicines management. For example, by increasing pharmacy presence in both EDs, increasing the range of medicines stocked, introducing a drug trolley and staff's use of EPMA for critical medicines for patients staying in ED for prolonged periods.

The service had also implemented an updated temperature monitoring policy for ambient and fridge medicine storage areas in line with the royal pharmaceutical society (RPS) safe and secure handling of medicines guidance. All clinical areas storing medicines had a calibrated dual thermometer. Staff documented maximum, minimum, and current fridge temperatures and current ambient temperatures on a trust form daily.

The ED had a new purpose-built drug room with increased security which included the fridge. Previously the drug room was too small, and the fridge was kept at the main nurses station. Out of pharmacy hours supplies of fridge medicines were now kept in a dedicated emergency cupboard rather than the ED fridge; this reduced unnecessary footfall.

However, the department operated two systems in relation to prescribing. Patients were initially clerked in on a paper prescribing document known as a 'CAS' card where immediate medications were prescribed and administered. Once patients were seen by medical staff, any prescribing was then completed on the EPMA system. A manager we spoke with raised concerns around using two prescribing systems concurrently. This meant staff ran the risk of missed or duplicate prescribing and administration.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Staff told us there was no clinical pharmacy service into the department. Following our last inspection an ED pharmacist role was created. The band 8a pharmacist was based in the department, primarily to carry out medicines reconciliation and initial pharmacy review for patients on critical medicines such as insulin, Parkinson's medication, and anticoagulants. They ensured critical medicines were appropriately prescribed and prioritised ordering from pharmacy. In addition, they were a source of advice for prescribing and nursing staff on clinical and medicines management issues.

The ED team highly valued this role and service leads had plans in place for a stepwise introduction of medicines management technicians within ED to support the pharmacist and enable more patients to be seen. The long-term plan was for ED to have a pharmacy service 16 hours per day everyday.

Staff learned from incidents to improve practice. However, they did not review national patient safety alerts for relevant learning. The trust's two EDs were the joint most common locations for medication incidents, comprising 9% of the total. We reviewed the service's medicines incidents for August 2022; three of which resulted in minor or low harm. Two of these involved staff missing doses of patient's medication. Staff involved had taken action including apologies to patients and family showing their understanding around duty of candour.

One ED advanced clinical practitioner (ACP) was a trust medication safety group member and shared learning within the department. Pharmacy and the medication safety team shared monthly learning bulletins trustwide with any learning

from medication incidents. We reviewed September 2022's bulletin which outlined learning from two ED incidents around staff prescribing patients with delirium excessive doses of sedative drugs. The team reminded staff their delirium guideline provided advice on non-pharmacological methods to support these patients and advised avoiding the use of sedatives if possible, which themselves may precipitate delirium symptoms.

Medication safety and quality was included in the monthly medicines optimisation reports presented by the lead pharmacist and discussed at monthly care group quality meetings. This learning was shared within the department via the governance lead. Medication incidents learning was also covered during medical, nursing and pharmacy staff inductions.

However, the trust's latest medication safety strategy 2021-23 stated many measures put in place around their 69 historic national patient safety alerts (NPSAs) relating to medicines were no longer relevant and needed review. One of the trust's priorities for 2021-22 was to establish an audit programme to ensure ongoing compliance with historic alerts.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. The service carried out quarterly controlled drug (CD) inspections. After we raised concerns about the management of patient's own CDs on our last inspection, pharmacy leads purchased a separate CD cupboard, and the pharmacy governance team contacted the ED weekly to remove any unwanted CDs. The results were shared with the local team for learning and improvement.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team. Managers ensured actions from patient safety alerts were implemented and monitored. However, managers did not always support staff to raise incidents. When things went wrong, staff did not know how to apologise and give patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust/provider policy. A&E reported 12 STEIS incidents from 1 August 2021 to 1 September 2022 which averaged one per month. The most common incident type was slips, trips or falls (meeting SI criteria) which accounted for 4 STEIS or 33.33% of the total. All four resulted inpatient fractures. Three of these were unwitnessed falls (one from a patient leaning into bed railings) in the hospital's ED during January, June, and July 2022.

However, staff did not understand the duty of candour. Staff we asked had no knowledge, training, or visible procedure for the duty of candour process.

Staff received feedback from investigation of incidents, both internal and external to the service. On our last inspection in October 2019, we told the trust it must ensure it has a robust process for identifying learning from deaths and serious incidents and ensure this is systematically shared across the organisation.

On this inspection we found the service had made significant improvement around learning from incidents. For example, ED's clinical governance forum agenda included reviews of all reported, serious, and safeguarding incidents to identify any areas for shared learning. We saw the minutes from September 2022 focused on staff's poor discharge instructions and inappropriate tablets to take home (TTOs) for a patient with learning disabilities. The clinical governance team also shared structured judgement case reviews (SJCRs) and related good practice. We saw examples in governance reports of 72-hour reports awaiting and post-senior review along with those completed and taken to the quality and safety committee for learning.

However, staff we asked was unaware of any learning following recent incidents. They said they attended a daily morning debrief where any important learning updates were mentioned and reiterated for a few weeks so absent staff could catch up.

Staff met to discuss the feedback and look at improvements to patient care. Staff held safety briefs and debriefs after any incident to address the most common incident types. Clinical leads feedback any new learning from reported incidents to all staff on safety briefs.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We reviewed the learning summary for a patient who fell and sustained a fracture. This patient was immediately assessed by a doctor; two nurses were present and had witnessed the patient fall. In response leads took actions such as educating staff in completing step 2 risk assessments, carrying out lying and standing blood pressure and increasing use of and understanding delirium screening for patients in ED. This was added to the daily safety brief for six weeks. They also commenced a long wait weekly audit to identify improvements and disseminated learning through the care group newsletter.

The associate chief nurse and governance team reviewed all incidents raised by department staff weekly to identify themes and trend, cases requiring more in-depth investigation and any learning.

Managers did not always debrief and support staff after any serious incident. Emergency assessment unit (EAU) nursing staff told us they were not always supported after escalating concerns about unsafe staffing which could result in a serious incident. As such they were discouraged from raising staffing incidents or taking further action as per their duty of care to patients for fear of being interpreted as causing trouble.

Is the service effective?

Requires Improvement ● ➔ 🡐

Our rating of effective stayed the same. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983. However, managers did not always check to ensure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. However, we could not always evidence how managers checked to ensure that staff followed guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We observed effective conversations between staff regarding the mental health act which demonstrated a good level of understanding.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers. We observed nurses and medics included consideration of patient's mental health and wellbeing in their conversations.

Urgent and emergency services

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Trust staff used the malnutrition universal screening tool (MUST) to monitor patients. This was a five-step nationally recognised and validated tool to identify adults at risk of malnutrition.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. ED staff we observed ensured patients were supported at meal times. The department had a ward nutrition board which the nurse in charge updated regularly. This contained 30 minutes before mealtime, during and post mealtime guidance including documentation prompts.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. ED staff had completed MUST scores in patient's notes we reviewed to manage or modify their diet in aiding recovery.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We heard the Abbey Pain Scale was being rolled our across the care group. This tool was an instrument designed to assist in the assessment of pain in patients unable to clearly articulate their needs, for example, patients with dementia, cognition, or communication issues.

Patients received pain relief soon after it was identified they needed it or they requested it.

At the time of our inspection no ED audits had been undertaken regarding timely pain relief administered. We reviewed the service's medicines incidents from August 2022. In one incident resulting in minor or low harm a patient was transferred from another provider. ED staff were concerned the patient had not received adequate pain relief from the other provider.

The care group had introduced different staffing systems to ensure the waiting area was covered and all patients waiting to undergo observations had a pain score so analgesia could then be given quickly. The patient assurance document also prompted the responsible nurse to ask patients about pain hourly. The care group planned to undertake an audit in the months after our inspection to assess the effectiveness of department systems and pain relief.

At the time of our inspection the department had relaunched their first assessment. This had previously improved staff's administration times of pain relief. However, times were being adversely impacted by service demand and the number of ambulance arrivals and patients blocked in the department. ED had introduced another measure still being developed which was the SOP regarding assessment and treatment in ambulances. Leads had planned a meeting with the local ambulance trust to finalise detail around treatment being given.

Staff prescribed, administered, and recorded pain relief accurately. We were told staff recorded pain scores on the system from the main doctor's records.

Urgent and emergency services

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. The hospital reported similar rates of survival after trauma to those expected for 2020/21.

Outcomes for patients were not always positive and consistent and did not always meet expectations or national standards. The service admitted 27 patients with a severe head injury directly from the scene of the injury who had a computerised tomography (CT) scan between January 2019 and December 2021. Their median time for patients receiving a CT scan was 1.05 hours. This narrowly missed the NICE guidelines national standard of under 60 minutes.

The service participated in a paediatric ED audit with monthly observations using five sets of notes. In the eight months before our inspection from January to August 2022 the hospital's compliance of undertaking observations in the initial 15 minutes of attendance as per the royal college of paediatrics and child health (RCPCH) standard was 100%. Audit compliance was affected by skill mix, agency staff or vacancies and level of activity or demand in the department. Results were shared with the team every month and monitored through the monthly paediatric emergency department operational delivery group.

We reviewed the most recent sepsis audit completed in April 2022. This showed the hospital's ED had a sepsis screening compliance rate of 100% with 20% of patients receiving antibiotics within one hour of recognition. We were informed sepsis audits had paused after this date and in September 2022 a new sepsis pathway was relaunched with updated audit questions.

On our last inspection in October 2019, we told the service it must ensure it takes action to improve its performance in the royal college of emergency medicine (RCEM) standards in the urgent and emergency care service at Scarborough hospital

On this inspection we found the service could not evidence sufficient improvement in its performance and this was a repeat breach.

The service had developed and progressed RCEM action plans for 2019-20. For example, around care of children and mental health care in EDs. These action plans showed evidence of completion, but service leads had stated several actions' completion dates were not applicable. RCEM had only launched the results and reports for 2020-21 on 13 October 2022. This meant at the time of our inspection leads had only just begun developing the action plans for 2020-21.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They used the results to improve patients' outcomes. This audit work helped to develop their single improvement programme (SIP) section 2.1 ED and EAU operating model. Leads planned to repeat the audit and were collating data from June to September 2022. The audit's outcomes would help update and develop the SIP's workstream in future to reduce incidence of missed opportunities and improve care for patients. Audit leads planned to align this work with the GIRFT work elsewhere in ED.

The hospital's tissue viability team had developed an audit relating to pressure ulcers (PUs) originating in ED. Data was pulled about any patient who did not have a skin assessment documented within six hours as per national standards. Staff subsequently raised a backdated incident for any identified pressure ulcers.

We reviewed the matron's monthly assurance inspection summary of the trust's tendable audit. The ED's care group matron and senior nursing team monitored their compliance with these audits, quality scores and actions through the app and website. They discussed issues at daily meetings and escalated to ward sisters for action as required. The overview document was also reviewed by the patient safety team.

Improvement was checked and monitored. The hospital's paediatric ED matron's tendable monthly assurance report achieved 94% for September 2022. This was their second highest score during the previous 12 months from October 2021. The ED overall scored 81.3% under 11 key themes. This was an improvement on August's score of 73% but the third lowest of 13 areas that month. The department was ranked 79 out of 90 areas participating in the audit trustwide. Several of ED's average scores for questions in the August and September 2022 monthly audits were themes we found on this inspection. For example, no evidence to show staff had completed resuscitation trolley equipment checks for the last calendar month, no evidence staff had individualised or evaluated pressure ulcer prevention (PUP) care plans for patients or no evidence staff repeated patient's PUP assessments in line with trust policy. Managers used information from the audits to improve care and treatment. The ED's care group recently undertook a specific audit of long wait ED patients who had subsequently died to assess the impact. Two of these patients were referred to the structured judgement case note review (SJCR) process for further investigation. The service undertook a weekly audit of the longest waiting patients in the department.

Managers shared and made sure staff understood information from the audits. The reviewing deaths process revolved around the medical examiner (ME) process and the ME assessments outcomes were presented and discussed at the care group's weekly MDT quad governance meeting. This meeting had senior medical, nursing AHP and management representation and acted as their MDT 'clearing house' for immediate clinical governance actions including ME assessments, serious incident (SI) actions and allocations.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. However, the care group medical staff's additional learning compliance did not meet trust target.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. On our last inspection in October 2019, we told the service it must ensure all medical and nursing staff in urgent and emergency care services at Scarborough hospital complete the required specialist paediatric life support training to enable them to safely care for children in the department. We also told the service it must ensure it has enough, suitably qualified, competent, and experienced medical and nursing staff in the urgent and emergency care service at Scarborough hospital, to meet the RCEM recommendations, including enough staff able to treat children in an emergency care setting (We also issued a requirement notice about this breach on our previous to last inspection.

On this inspection we found ED nursing and medical staff's compliance with paediatric life support training had improved significantly and exceeded the trust target of 85%, achieving over 90% overall. Staff's compliance in this module was monitored at the resource committee and care group board as well as being reported by exception to the operational performance assurance meeting (OPAM). Work around this training was also part of the service's single improvement programme projects. The department ensured they had at least one band 6 paediatric trained nurse on every shift.

Junior doctors we spoke to were very complementary about their two hours' protected weekly rota time working in ED.

However, medical staff's additional learning compliance in dementia and learning disabilities (LD) awareness did not meet trust target across the care group. This was only 33% for LD and 42% for dementia awareness.

We reviewed the care group's latest risk register and found a risk relating to staff competencies. This described a risk to patient safety due to a shortage of adequately trained staff in trauma in the ED setting caused by a lack of training provision. This module was not part of the trust's statutory and mandatory assurance process. Training leads were awaiting details of an online module and when face to face training could recommence. As a result, the ED team were working through trauma objective, structured clinical information (OSCI) booklets.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. One nursing staff member told us they had good professional development and had completed a masters degree course through the trust. Another nurse had upskilled their competencies to work in urgent care. Both were grateful for these opportunities and told us six other nurses were now undertaking this continuous professional development (CPD).

The clinical educators supported the learning and development needs of staff. We saw provision of clinical information and guidance for staff throughout the department.

Nursing staff we asked were happy with their CPD. We spoke to one nurse who started as a domestic, then progressed until they completed nurse training. They explained without the trust's support they would not have been able to afford a degree qualification.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. On our last inspection in October 2019, we told the service it must ensure all nursing staff have an up to date appraisal each year in the urgent and emergency care service at Scarborough hospital

On this inspection nursing staff told us they received annual appraisals with their line managers. However, these could occasionally be postponed or rescheduled.

Managers did not always ensure staff received any specialist training for their role. We reviewed ED's triage training compliance rates for nursing staff in the urgent treatment centre. Overall compliance was 75% but the team did not directly triage due to the private contractor's role. 46% of band 6 nurses (six out of 13) still had to complete this training. As this service was separately contracted, ED training leads sent the UTC a reminder to complete their training on 30 September 2022 as the service staff used a different system for patient documentation.

All ED's HCAs had completed their paediatric observation competency assessment booklets with dates booked for final training in January 2023 to complete this. The adult nurse educator managed the training and compliance records for paediatric observations and fed this into the paediatric ED operational delivery group.

The royal college of nursing (RCN) competency booklets were stopped during the COVID-19 pandemic; the service decided to reintroduce the RCN booklets in March 2022 whilst starting the back to basics campaign.

Managers recruited, trained and supported volunteers to support patients in the service. We heard the care group were increasing their number of volunteers to help communicate with relatives. The care group had also increased the number of ward clerks and found patient's communication concerns had reduced since visiting rules were relaxed.

Urgent and emergency services

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. However, ED staff did not always follow the SDEC/EAU admission criteria.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. ED staff worked closely with the SDEC/EAU areas.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. However, they did not always complete risk assessments. We reviewed the service's audits and action plans for mental health risk assessment as part of an ongoing workpiece to improve compliance. From August 2021 to September 2022 staff compliance had inconsistently improved in completion of most risk assessment pages. However, compliance of pages 6-7; their review of changes and consideration to maintain safety completion had declined 22% over this 14-month period. Staff's barriers to completion were around the length of the risk assessment documentation and the audit did not allow for information recorded elsewhere in the records.

Leads had a plan in place to urgently move to a more user-friendly intuitive risk assessment tool on their new clinical records system. This was being prioritised for implementation as soon as ward rollout was completed. At the time of our inspection the team were working on the format ready for the developers to use.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. The service's SDEC unit was open 24/7 with a full complement of clinical staff seven days a week from 08:00 – 22:00. Overnight the unit was nurse-led and supported by both the clinical team from ED and the inpatient medical team.

Dedicated ED frailty service capability was not yet in place for the hospital in location and workforce terms. Acute frailty services were provided in EAU and ED. In ED the Dales unit provided six trolley or chair spaces from Monday to Friday 12 hours a day for frailty services.

A private contractor was commissioned to run the department's screening and urgent care centre. The contractor followed the Manchester triage system for trust patients. This was a clinical risk management tool used by clinicians to enable them to safely manage patient flow when clinical need far exceeded capacity.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. We saw patient information leaflets on display promoting healthy lifestyles and providing information and support on a range of physical health conditions.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Urgent and emergency services

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). However, they did not always keep this up to date. Nursing staff compliance for MCA training was 93.6% which met the 85% trust target.

However nursing staff compliance for DoLS was 76.2% which did not meet the target.

Medical staff also received training in the MCA and DoLS. Their compliance for both MCA and DoLS was 83.3%. This narrowly did not meet the 85% trust target.

Staff we asked could describe and knew how to access policy and get accurate advice on both MCA and DoLS. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. All patients attending the ED had a brief capacity assessment undertaken regarding their willingness to be in the ED or wait for further assessment. If a patient who had presented to the ED after an episode of self-harm or mental health illness subsequently wished to leave the department of their own volition (self discharge), staff completed a further capacity assessment where possible. If staff had any concerns the patient lacked capacity, they were rapidly escalated to the nurse in charge, EPIC, liaison team or the child and adolescent mental health services (CAMHS) if the patient was under 18.

Staff gained consent from patients for their care and treatment in line with legislation and guidance and clearly recorded this in the patients records we reviewed. Staff made sure patients consented to treatment based on all the information available.

However, at the time of our inspection the care group undertook no identified consent audits onsite. This was being reviewed as part of their work plan.

ED had a referral pathway to the liaison service for patients 16 years old or older. ED and liaison assessments could take place, when appropriate and when the patient was able to engage in a psychiatric assessment, concurrently where possible. Staff did not need to wait until the patient was medically fit for discharge.

All paediatric staff we asked understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

If the hospital's liaison team assessed a patient in ED who required a MHA assessment, it was the responsibility of this team to facilitate this and make the referral to the local authority AMHP in hours or the emergency duty team (EDT) out of hours. This often resulted in a delay in the patient being assessed and if necessary, transferred to a psychiatric bed.

Urgent and emergency services

The liaison team would liaise with the NIC and ensure they were kept up to date about the assessment's timing. The team would also work with the ED staff to consider potential risk management in the meantime to agree medication options, observation levels, and a suitable environment such as a cubicle beside the nursing station. If there were concerns about a patient's condition deteriorating, ED staff could contact the team at any time to request further review and support.

We saw evidence managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. We also saw evidence managers monitored how well the service followed the Mental Capacity Act and how they would make changes to practice when necessary. For example, care group leads undertook MCA spot check audits.

Is the service caring?

Good ● ➔ ➔

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff tried to mitigate the ED environment's limited ability to offer patients privacy and dignity. For example, they limited the number of patient beds on wheels to six along the ambulance corridor.

Patients told us staff treated them well and with kindness. Most staff showed a genuine compassionate professional behaviour and care towards the patients. We observed staff supporting patients on the ambulance corridor, in cubicles and waiting areas.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We reviewed ED's enhanced supervision policy which provided clear instructions on how this should be implemented. The service also had guidelines for risk assessment to identify the level of supervision patients required. Staff followed the policy and escalated all risks to the matron of the day or ED matron.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff emotionally supporting the family relatives of an overdosing child patient appropriately and attentively. Staff provided emotional support to patients by giving them time to talk which gave them reassurance.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. Staff could access a relatives room in a quiet corner of the department in which they could hold private and sensitive conversations.

Staff told us they had completed training on breaking bad news and demonstrated empathy when having difficult conversations. However, these training rates were not formally captured within any mandatory or role specific data we received. This meant we were unable to review any documentation which supported staff's comments.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We observed staff in many areas of the department explaining to patients their plan of care and answering any questions they asked. The family of a patient in resuscitation told us staff kept them updated and explained what was happening.

Staff talked to patients in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. ED staff gave patients and relatives the 'your experience matters' booklet with information on compliments, comments, answering concerns or making formal complaints. The trust used the NHS friends and family test for patient feedback on their GP out of hours service experience and how likely they were to recommend the service.

The feedback from the emergency department friends and family survey test for November 2022 was 72% positive. This was slightly below the monthly national average of 75%.

Is the service responsive?

Requires Improvement ↑

Our rating of responsive stayed the same. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system. However, ED staff could not always work well with local partner organisations to plan care.

Managers planned and organised services so they met the needs of the local population. The acute frailty service considered future provision. For example, the care of the elderly team were under remit to develop a sustainable plan for how they would support frailty within the new urgent and emergency care (UEC) facility under construction and due for completion by April 2024. Leads would factor this resource into their overall frailty workforce plan.

Urgent and emergency services

We reviewed the service's missed opportunities audit from October 2021. The recommendations for system partners found a review of the UTC operating model could support joined up escalation so patients were pulled to reduce the pressure in ED. However, the service could not always work well with partners. For example, clinical information and communication was not always shared between the ED trust staff and private provider who ran the service's UTC to best meet patient needs. This created more silo and fragmented work in an already challenged system.

Facilities and premises were not always appropriate for the services being delivered. At the time of our inspection the department's estate did not meet demand. The department lacked the capacity to meet the needs of the numbers and acuity of patients accessing the service. Overcrowding at peak times was an issue with significant waits for patients to be seen by medical and nursing staff. Care group leads were aware of these issues and had actions in place to address such as the building of a new expanded department. Overcrowding was one of the highest scored risks on the care group risk register. In response ED leads explained the business case for their new build had lots of attendances modelling. Staff would work differently to better utilise space with more bed change functions around patients.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia.We reviewed the mental health in the ED standard operating procedure (SOP) ratified by the ED mental health steering group. This policy applied to all trustwide patients who attended the EDs with possible mental health related illness or disorder. The policy's standards were in line with national recommendations from royal college of emergency medicine (RCEM) guidance and psychiatric liaison accreditation network (PLAN) quality standards for liaison psychiatry services.

ED staff had access to a learning disabilities lead nurse.

The service had systems to help care for patients in need of additional support or specialist intervention. The acute frailty assessment service had front of house plans underway but at the time of our inspection these were not very developed or ready to share. For example, a direct pathway with the local ambulance trust to SDEC and close links with their community frailty provider on delivering a virtual ward to patients and avoid ED attendance. Frailty leads were also developing the use of an urgent crisis response (UCR) to support rapid turnaround and discharge from ED.

The service relieved pressure on other departments when they could treat patients in a day.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. They coordinated care with other services and providers. However, staff did not always make reasonable adjustments to help patients access services.

Department areas were designed to meet the needs of patients living with dementia. For example, the department displayed a large dementia information board. We saw a bus stop to Scarborough town centre in the corner of the department. This served as a visual aid to help orientate local patients and familiarise their environment.

We heard the care group had commenced training for ED nursing staff on patient discharge from frailty wards, including the completion of trusted assessor forms. The care group was also piloting the John's campaign and a carer passport to encourage and support carers to visit openly to support care delivery.

Staff supported patients living with dementia and learning disabilities by using 'what matters to me' documents and patient passports. The trust utilised this form for any patients with dementia or delirium as a useful tool which their family, the patient or staff members could complete for more insight. ED staff found this information could be invaluable especially if a patient became distressed, agitated or unable to communicate with them.

We heard staff stuck "dementia daisy" pictures onto trolleys of patients with dementia for easier identification and recognition of their needs.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff ensured recorded and written information was provided to patients in different formats as required such as letters in large print.

The service and care group complied with the accessible information standard (AIS). This is a legal requirement for all NHS organisations and sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. ED staff could book interpreters for patients to meet their needs. This was done through an automated DA languages phone line service where linguists were available 24 hours a day seven days a week.

Staff had access to communication aids to help patients become partners in their care and treatment. ED staff were made aware of patients preferred communication methods. The trust's digital patient records system CPD could prompt users and display alerts when staff selected any letter for printing, for example text message or email. Staff could access tablets and communication aid boards for patients who needed extra support.

Access and flow

People could not always access the service when they needed it and receive the right care promptly. Not all waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

The service did not make sure patients could access emergency services when needed or receive treatment within agreed timeframes and national targets. However, managers monitored waiting times. On our last inspection in October 2019 we told the service they must ensure they continue to work to improve the following performance standards for the urgent and emergency care service at Scarborough hospital

- the median time from arrival to treatment.
- the percentage of patients admitted, transferred or discharged within four hours.
- the monthly percentage of patients that left before being seen.

On this inspection we found these performance standards had not improved. This was partly due to the COVID-19 pandemic which had impacted on the standards.

The trust's percentage of patients waiting more than four hours from the decision to admit to admission was consistently considerably higher than the England and North East and Yorkshire regional averages from December 2021 onwards.

As of August 2022, the trust percentage was 43.4% compared to the England average of 36.5% and regional average of 32.2%.

We saw this ongoing risk of ED not delivering the four-hour emergency care standard (ECS) was included on the care group's latest risk register. This could result in patient harm and poor outcomes due to very long waits in ED for patients who were clinically ready to proceed. This risk was scored 15 out of a possible 25 and was very likely with a grading of moderate harm. Leads had mitigating actions in place such as a developed trustwide agreed four-hour pathway that identified its critical components.

The trust's median time from arrival to initial assessment deteriorated considerably during the winter for 2021/22. From 11 minutes in June 2021, this deteriorated to 26 minutes in December 2021.

However, this was followed by a considerable improvement to 16 minutes in July 2022.

(Source: NHS Digital - A&E quality indicators)

In August 2022, 924 of the trust's patients waited more than 12 hours from the decision to admit to admission. This was the fourth highest number in England, and the highest in the North East and Yorkshire region.

The trust reported the highest figure in the North East and Yorkshire region for this metric every month from December 2021 to August 2022.

(Source: NHS England - A&E SitReps)

Managers and staff could not always work to make sure patients did not stay longer than they needed to. The trust's median time from arrival to treatment was consistently worse than the England average from summer 2021 onwards. There was a considerable increase from one hour 20 minutes in January 2022 to one hour 44 minutes in July 2022.

(Source: NHS Digital - A&E quality indicators)

The trust's median total time in A&E was consistently considerably longer than the England average from August 2021 onwards. As of July 2022, the trust median was three hours and 40 minutes, compared to the England average of three hours and 10 minutes.

(Source: NHS Digital - A&E quality indicators)

The ED was challenged as the privately contracted urgent treatment centre (UTC) service also impacted upon people's waiting times to be seen for treatment, patient flow through the department and patient safety as a result.

Two medical staff members told us they had difficulties and constraints with their see and treat patients at peak times. For example, if there were more than six patients on the ambulance arrival corridor these staff took patient's observations such as blood pressure onboard ambulances. However, they could not offer ambulance patients personal care or examinations.

Medical staff told us patient flow through the department was a significant issue as they did not physically have the bed or room space to examine and treat patients due to longer stay patients bed blocking. This results in more patients waiting in corridors and being unnecessarily delayed.

Urgent and emergency services

Staff told us about ED's significant issues with waiting times, both for ambulance arrivals and people self-presenting to the department.

We found patient streaming was more coherent and functional (than other trust sites). However, the private contractor's system not being linked to the NHS system caused issues, as well as triage documentation not replicating the NHS version. Reception and streaming staff already short on time had to input the same duplicated information onto different systems.

ED had a streaming nurse stationed in the waiting area. We saw they completed regular patient checks to monitor them for any potential signs of deterioration. The same streaming nurse also handed patients paper slips stating their nurse or clinician and observations or review stage to ensure they knew what they were waiting for.

The department saw significant delays with ambulance handovers due to patient demand and lack of flow in the overall hospital. We spoke with paramedics who advised us they could often spend up to a full shift at the ED supporting patients waiting for a space to be allocated to them.

We were not consistently assured ED staff were regularly checking patients waiting in the back of ambulances. This contravened the service's SOP for care and treatment of patients whilst in an ambulance which stated 'a clinician will be allocated to assess the patients on the ambulance if they have been held for over 30 minutes'.

However, we did see evidence of ED staff regularly checking on the welfare of patients placed in the ambulance waiting corridor. This corridor was often full and during the day shift staff were under more pressure to admit patients waiting on the back of ambulances. For example, by 3pm on the day of our inspection, the average turnaround time for ambulances was 76 minutes and the 'notify to handover' average was 120 minutes.

We found direct streaming and treatment pathways and standard operating procedures (SOPs) were in place. The service had pathways for stroke, SDEC, ED frailty service and integrated acute assessment unit (IAAU). Their SOPs in place were for patients waiting in ambulances, paediatric fast track and patient self-handover. We reviewed these SOPs which at the time of our inspection included a draft version of the former with the local NHS ambulance trust for comment ahead of the two trust's next meeting.

The ED nurse in charge told us their average waiting times for paediatric (child) patients was nearly always under an hour.

Staff told us EAU was not always utilised to its full capacity which impacted upon ED flow. This was due to a lack of ED staff understanding about their unit. We heard ED colleagues did not always realise the unit were a front door service accepting admissions from streaming as well as from the main department.

We reviewed an overview report of the service's missed opportunities audit from June 2022. The audit period covered January to May 2022 from a random sample of 100 patients covering all ED attendances. The audit's key findings and recommendations were used by the care group to inform current and future pieces of work. One headline was 66% of patients streamed to ED were inappropriate, and alternative options for delivering appropriate care should have been utilised within community services or the hospital. As a result service leads planned to improve streaming practices to encourage early transfer to peripheral units, and appropriate utilisation of the urgent care centre (UCC).

Managers and staff did not always start planning each patient's discharge as early as possible. We reviewed a serious incident investigation concerning an inappropriate discharge for one patient in ED from April 2022. Irrespective of the

department being busy, fundamental standards of care were not delivered to this patient. The investigation's root causes found no beds were available so the patient had an extended stay in ED of 24 hours which impacted on the care provided. Staff's decision to discharge this patient was unclear and highlighted several issues including poor documentation in the ED medical and nursing notes.

In the care group newsletter for September 2022 the cover update read 'we remain consistently under pressure across the site with long waits in ED, primarily as a result of the excessive number of medically fit patients we are unable to discharge. This meant wider system issues also impacted upon the service's ability to plan timely patient discharge.

Staff did not always plan patients' discharge carefully, particularly for those with complex mental health and social care needs. We heard from the discharge suite staff sometimes booked inappropriate transport and ambulance crews for patients before transferring them across which caused further delays. For example, one patient with advanced dementia returning to their care home had a one-person ambulance booked. This meant their daughter or a crew member could not accompany them in the back of the vehicle.

Staff did not always ensure or check patients could transfer from trolleys into wheelchairs before booking them wheelchair transport for discharge.

Staff supported patients when they were referred or transferred between services. The service saw enormous increases in the percentage of ambulance handovers taking over 60 minutes from the summer of 2021 onwards. Their performance reached a peak of 21.3% in December 2021. There was an even greater deterioration to 32.2% in April 2022. As of August 2022, the figure was 31.3%.

The trust's performance was considerably worse than the overall performance for ambulance handovers from their regional NHS ambulance service. This saw a deterioration to 12.1% in October 2021, followed by broadly similar performance until August 2022 (12.7%).

Managers did not always ensure patient moves for treatment between wards/services were kept to a minimum. We saw the consultant and senior nurses from SDEC arrive in ED to potentially enable patient transfer from the department. However, staff told us ED did not always follow the SDEC/EAU admission criteria and there were occasions where patients with higher acuity were transferred upstairs inappropriately.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Staff understood the policy on complaints and knew how to handle them. We reviewed the number of complaints received by the service. From 17 September 2021 to 16 September 2022 the hospital's emergency medicine received 30 complaints. This was more than any other speciality during the same period.

Managers investigated complaints and identified themes. The hospital's ED service's top theme was 'communication with relatives or carers' for which they received seven complaints in the 12 months of 2021/22. The service had six complaints each under the themes of 'care needs not being adequately met', 'attitude of nursing staff' and 'delay or failure in treatment or procedure' in the same period. Under the 'care needs not adequately met' theme; personal care was the most common area of concern, including toileting, oral hygiene and delays answering buzzers.

Urgent and emergency services

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Service leads acknowledged all complaints within three working days and care groups had 30 working days to investigate a complaint and send a final response. The care group had the highest compliance with closing complaints within the required trust target. For example, in the 12 months from September 2021 to September 2022 they met the target of closing 80% of their complaints within the 30 day timeline every month except two. We heard their care group consistently maintained the highest performance on closing complaints as band 7 staff were more involved in formulating complaint responses.

Managers shared feedback from complaints with staff and learning was used to improve the service. The care group shared monthly staff bulletins which included information about complaint themes and trends.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Requires Improvement ↑

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. However, staff sometimes felt pressured or threatened by senior nursing staff.

The care group leadership structure consisted of a care group director who oversaw an associate chief operating officer, associate chief nurse and associate chief AHP. We interviewed the care group quad leads. They met with senior leaders frequently to review operational oversight of risk, issues and performance. The service's leaders and senior leaders were passionate about the department. Staff told us they were visible and they represented and supported the department and issues staff faced.

Leads had oversight of all the service's challenges, successes and ongoing work since our last inspection including the recruitment of ten more ED consultants. They were seeking wider solutions to increase discharges and alleviate their huge gridlock of patients. They worked to mitigate patient's long waiting times to be admitted onto wards, for example by stepping up their ambulatory unit into SDEC.

We heard allegations about a bullying from senior staff in the department. They explained conversations around staff moves from the unit to cover ED shortfalls could be ad-hoc, with little notice and in public areas such as the nursing station. Staff sometimes felt pressured or threatened if they did not agree to extra ED shifts when they already felt ill or understaffed on their own unit.

Urgent and emergency services

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The care group had a clear plan of how they wanted to improve patient care at the front door in order to consistently meet fundamental standards. Leads cascaded their strategic workplans down to frontline staff to address the ED's main risks. Staff we asked understood how leads were addressing the challenges in the department and the impact of system delays.

At the time of our inspection leads had utilised external partners to develop a structured planning process to ensure quality care to meet some local needs. They planned to further develop and expand their front door capacity to patients with deep vein thrombosis and were trialling a cellulitis pilot with a local surgery.

However, they faced challenges from partnership working with a private contractor. This limited their ability to plan and provide a sustainable UTC service.

EAU senior staff showed us their unit had a very clear plan for the next five years.

Culture

Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. Patients, their families and staff could raise concerns without fear. However, staff did not always describe an open culture where they felt respected, supported and valued.

Nursing staff described an unsupportive culture from their matrons where it was regular practice to leave EAU with unsafe staffing numbers. They explained on two occasions they were left with only one registered nurse on the unit. These staff felt vulnerable, isolated and unsafe.

We heard registrar staff sickness on the EAU impacted upon decision making for those shifts. As a result the Covid-19 registrar covered the unit to review and discuss all existing patients for support with discharge.

We heard some doctors in ED showed EAU nursing staff and how the unit worked a lack of respect and understanding. Nurses were made to feel obstructive for declining patients from ED who would become 'bed blockers'. They were asked to justify why patients were unsuitable for the unit when already clearly documented in their notes.

Staff in other areas told us that due to ED's lack of patient flow and space to medically review patients, they were pressured to accept inappropriate and unsafe patients by ED registrars. Their strict admission criteria could be overruled by bed managers. Patients awaiting review were sent onto the EAU at times when no medic was available. Unit staff felt ED registrars did not always listen to their concerns or rationale and were happy to let patients wait a day or two for review. EAU staff also felt ED registrars could be derogatory towards their own unit staff.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Quad leads attended weekly governance meetings. They explained these meetings helped them cover various issues which did not fall under one category. Leads felt since our last inspection their revised governance and management structure was well embedded and better organised to facilitate service improvement and oversight.

The hospital's governance lead issued governance newsletters every four to six weeks for ED and AMU front of house staff. These covered a range of topics including new policies and procedures, and ongoing audits.

On the care group's single improvement plan there was a dedicated workstream for embedded assessment and triage.

The service's missed opportunities audit from October 2021 demonstrated poor communication between their UTC contract provider and ED.

Emergency medicine risks on the risk register were reviewed at ED governance meetings to confirm scores were correct. Risks scored 12 or above were taken through the quality committee.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. However, the service had no clinical quality and safety dashboard or oversight of patients before they were streamed to ED.

On our last inspection in October 2019 we told the service it must ensure the processes for the management of risks, issues and performance, and the governance and oversight of these processes are fully embedded within the urgent and emergency care service at Scarborough hospital

On this inspection we found the service had made significant improvement in managing risks. We saw from the actions in emergency medicine's latest governance report leads planned to review their 12 risks on the risk register and provide an update. Six of these 12 were scored as a significant risk level and three were high. Any service risks scored 16 or over were added to the risk application template and taken to the risk and oversight committee. Four risks had a score above 16; three of which scored 20. These related to overcrowding in the department, ambulance handover within 15 minutes and ED temporary risks during the new build.

Service leads had developed several assurance tools and assessments to support management of patients through ED which helped to ensure they received safe and sustainable care whilst in the department. Leads monitored patient complaints and incidents via their incidents reporting dashboard and they reviewed these at weekly care group meetings.

At the time of our inspection service leads confirmed they had no clinical quality and safety dashboard. However, plans were in place to develop a single dashboard for services, but no timescales as yet.

We reviewed the service's performance metrics for the four weeks before our inspection (18 September to 9 October 2022). During this time the hospital was on operational pressure escalation level (OPEL) 4. OPEL 4 or a black alert is the most severe of the levels, which is a method for the NHS to measure stress, demand and pressure. NHS England classes a black alert as a "serious incident", which means the system is under severe pressure. This showed a mixed picture as ambulance arrivals had declined and so handover times over 60 minutes had fallen. However, their number of attendances, breaches and admissions overall had hardly changed along with performance. The department's number of patients waiting on trolleys or waiting to be admitted over 12 hours increased during this month.

Urgent and emergency services

The service's front of house performance meetings considered their time to assessment and time to treatment metrics. Their signal dashboard data was also embedded around performance; after our inspection leads noted a slightly worsening picture.

Leads confirmed ED's performance was being adversely impacted by patient numbers attending the service and inpatient beds lack of flow due to lack of social care packages and placements. On average the service had 70-100 medically fit patients who did not meet the criteria to reside 'blocking' beds. This in turn led to patient queues ready for transfer to a ward still in ED meaning there was no space to promptly assess and treat patients arriving. Leads told us this risk was mitigated by dynamic front door assessment and getting the sickest patients off ambulances first.

However, the service had no patient oversight before they were streamed to ED as this service was provided by an external contractor who utilised a separate computer system. We heard this lack of department oversight could lead to unknown/hidden risks to patients and a lack of quality assurance.

The trust's winter resilience plan 2022-23 sought to explore opportunities for increasing extra capacity in their hospitals and wherever possible prevent avoidable admissions. Some of their planned mitigation measures included 'hot' outpatient services, consultant connect or ALERTIV, out of hospital home based pathways and virtual wards. Where admission was required the plan sought to protect EDs by improving flow, reinforcing alternative treatment pathways and facilitating timely ambulance handovers through robust ED escalation plans.

ED's escalation plan for the hospital was well established. An ambulance handover SOP was in place and the fracture clinic and outpatient area (overnight and weekends) were recognised cohorting areas. The local NHS ambulance trust had agreed to implement a secondment for a cohorting team to operate in ED seven days a week overnight; recruitment was underway to the scheme. Delayed ambulance handover times well over 15 minutes from arrival and the local NHS ambulance trust's need to undertake regular cohorting were included on the care group's latest risk register. This risk was scored 15 out of a possible 25 due to being very likely and causing moderate patient harm. Leads had taken action in response by drafting an SOP to clearly describe the handover process. This SOP would include a safe system of assessing patients on ambulances and recording this on the trust's clinical patient records system.

First assessment had been re-established for ambulances and ED (Type 1) walk in attendances and ongoing streaming improvement continued albeit very slowly, in collaboration with their private contracted urgent treatment centre (UTC). Mitigation plans to back fill the UTC services when they were unable to provide a staffed service was in place but put significantly more demand on the ED team to cover, particularly when the private contractor rescinded at short notice. This back fill of workforce also added in type 1 activity which should be recorded as type 3. To further enhance the escalation plan, leads considered reviewing the boarding protocol within the full hospital capacity protocol to determine if the "Bristol Model" of boarding would have utility this winter.

Information Management

The service collected data and analysed it. Data was in easily accessible formats, for staff to understand performance. Data or notifications were consistently submitted to external organisations as required. The information systems were secure. However, they were not integrated. Staff could not always find the data they needed to make decisions to best care and treat patients.

The trust's in-house clinical patient records system was incompatible with that of their external contractor for streaming patients. This led to a lack of shared information oversight in ED staff's ability to make the best clinical decisions to patients.

Service leads told us all ED staff's risk assessments would transfer into their new clinical digital documentation system. This should then have a positive benefit on compliance and completion and help improve data accuracy around pressure damage sustained in ED. The department would be one of the last areas of the hospital this was rolled out.

The trust's EPMA rollout had reduced some medication related risk for ED staff by ensuring clear prescribing and access to decision support. However, at the time of our inspection this was not rolled out universally and required IT support to manage outstanding risks on the action log.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust performed within the expected range for all nine sections in the CQC Urgent and Emergency Care Survey 2020.

There was one question where the trust performed significantly better than other trusts:

- Before you left the hospital, did a member of staff discuss your transport arrangements for leaving A&E? The trust scored 6.4 out of 10. Other trusts' scores for this metric ranged from 2.9 to 6.9 out of 10.

There were no questions where the trust performed significantly worse than other trusts.

ED's care group had set up a new staff voice working group looking at what staff were telling leads they needed to improve their working lives, and what solutions may help. Leads invited representatives from each staff group to attend and contribute thoughts and ideas at staff voice monthly one-hour meetings.

The department had several staff qualified as mental health first aiders (MHFAs). Staff could contact a team member for support and signposting.

We saw for two weeks in November 2022 trust staff could take part in a charity online auction to raise funds for the hospital's urgent and emergency care appeal.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

We heard numerous examples of quality improvement (QI) and multidisciplinary team (MDT) work from the department sepsis lead. This included lessons learnt; the lead had organised a MDT escape day where staff had 30 minutes to follow septic triggers for unwell patients. The lead completed actions minuted and agreed in the sepsis delivery group. The lead and link nurses worked with a neighbour trust interprofessional to develop a sepsis network with new patient safety tools.

The service's governance lead had multiple workstreams, quality improvement projects (QIPs) and audits underway, such as the missed opportunities audit. For example they had registered and were undertaking three different royal

college of emergency medicine(RCEM) QIPs around infection, prevention and control, pain in children and consultant sign-off. At the time of our inspection the lead was reviewing all the service's processes, policies and SOPs to compare clinical summaries from the national institute for health and care excellence (NICE). They also performed clinical lead checks against a health toolbox application as the clinical champion.

At the time of our inspection the care group had commenced a single improvement programme across their ED operating model. We reviewed an extract from the 2022-23 programme with 15 actions opened and monthly updates due. Areas of work included initial assessment, pathway mapping, implementation plans for a direct referral to speciality audit and a refer/admit process on the trust's patient system.

Medical care (including older people's care)

Requires Improvement ● ➔ ➔

Is the service safe?

Requires Improvement ● ↑

Our rating of safe improved. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff, however, not all staff completed it.

Mandatory training was comprehensive and met the needs of patients and staff. However, we observed shortfalls in training completion for all staff groups.

Staff said the learning hub contained the mandatory training information and they were emailed by the learning hub when mandatory training updates were due. Mandatory training subjects was monitored monthly by both the ward sister and matron.

At Scarborough hospital medical and dental staff had an overall training completion rate of 64.5%. This was lower than the trust target of 85%. Of the 19 statutory training courses, only four had a completion rate of more than 85%. None of the additional learning or required learning modules achieved the 85% target. Training statistics confirmed that only 24.4% of medical staff had completed sepsis awareness training.

Nursing and midwifery staff had an overall completion rate of 88.3%. Of the 18 statutory training courses, only one was not meeting the trust target of 85% completion. Completion rate for sepsis awareness was 71%. Of the role specific courses, four of the seven modules had completion rates higher than 85%.

Additional clinical staff had an overall completion rate of 82.6%. Of the 20 statutory training courses, 13 had completion rates of over 85%. Sepsis training had a 61.4% completion rate and three of the seven required training modules achieved the 85% trust target.

Corporate led sepsis audits were paused in April 2022 to focus resource to the re-launch of the sepsis screening tool. A re-launch of the sepsis pathway took place on World Sepsis Day (13 September) which included additions based on learning from incidents and serious incidents. The associated policy was due to be updated.

On Lilac ward staff confirmed that all band 5 and band 6 nursing staff had completed immediate life support training and three nursing staff had completed adult advanced life support.

Annual and four-yearly adult life support training sessions were undertaken by medical and nursing staff. Training statistics confirmed 100% of designated medical and nursing staff had completed the adult advanced life support four-year training. Annual adult life support training was completed by 85.8% (188 of 219 staff) of nursing staff and 73% (73 of 100) of medical staff.

Dementia awareness and learning disabilities awareness online training sessions were completed by staff; however, we noted some completion rates did not meet the trust baseline of 85%. For dementia awareness training medical and dental staff training completion rate was 41% to 69%; Nursing and midwifery staff training completion rate was between 74% to 93%, whilst allied health professional's completion rate was from 73% to 85%.

Learning disabilities training compliance for medical and dental staff was between 33% to 71%; Nursing and midwifery staff training completion rates were from 80% to 95%, whilst allied health professionals had a completion rate between 59% to 82%.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff could access training on how to recognise and report abuse and they knew how to apply it, however, not all medical staff were up to date with this training.

Safeguarding training and PREVENT awareness training sessions were completed by all staff groups. However, we observed some shortfalls in completion of these training sessions for medical staff compliance levels overall in safeguarding and PREVENT awareness training completion. Medical staff training statistics confirmed 75.2% had completed safeguarding adult's training – level 2 and 69.7% PREVENT awareness level 3.

Nursing staff training statistics confirmed compliance ranged from 94.7% (Prevent awareness level 3) to 100% compliance for safeguarding children level 3 core training.

Staff could approach safeguarding support through the hospital and local safeguarding authority safeguarding team. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff confirmed that should there be a safeguarding incident these incidents were reported on the trust incident reporting system and the safeguarding team alerted.

Staff said they accessed and stored information about patients with safeguarding concern's through the core patient database. Alerts specific to the patient were in the alerts section of the patients record.

Safeguarding updates were provided by the safeguarding team on the nurse handover information.

Safeguarding policies which included female genital mutilation guidance and procedures were in place. The current guidance was due for review in April 2022 and remained fit for purpose. The guidance had been reviewed and the updated guidance was out for comment and scheduled for ratification on the 10 November 2022. The short delay in updating the guidance was due to the safeguarding partnerships updating their own multi agency guidance. The hospital safeguarding teams contact details which included contact details for the local safeguarding authority were located on each clinical area.

The trust confirmed that disclosure and baring checks statistics had been completed for all staff prior to working at the trust.

Cancer patients had alert cards which meant they were kept safe and isolated during their stay.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Medical care (including older people's care)

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

A ward refurbishment programme was underway on Chestnut ward with plans to follow with Cherry ward to help address environmental factors. There were no areas which used ventilators in Care Group 2.

Water checks and legionella checks were completed monthly throughout the year. We saw most checks had passed, where a fail was identified on the 7 June 2022 for one area there was not a supporting action plan confirming what actions the trust should take to ensure safety.

The trust had accreditation to provide decontamination, packing and moist heat sterilisation services. The date of accreditation expiry was the 18 May 2023.

Cleaning teams were sub-contracted to the hospital and allocated to ward areas.

Cleaning schedules were displayed, cleaning rotas were completed, and staff said the cleaning manager had completed weekly cleaning audits.

From 1 September 2022 to 31 October 2022 cleaning synbiotix audits compliance levels ranged from 90.3% to 99.87% throughout the medical wards and clinical departments at Scarborough Hospital. The tendable fundamentals matron monthly report identified actions against any shortfalls noted in clinical areas.

Annual deep cleaning of clinical areas took place, proposed start and completion dates were identified for each clinical area.

Weekly tendable audit reports confirmed that checks on the environment and infection control took place.

The infection prevention and control team completed weekly audits on cleaning and hand hygiene. Weekly update emails were received by wards which highlighted any required actions which the ward manager monitored and provided updates against the actions. The April to November 2022 hand hygiene audit results confirmed overall compliance between 56% to 100%, however, we observed compliance had improved as the year progressed.

The trust confirmed that significant focus was placed on infection prevention and control (IPC) and the reduction of infection rates. An infection prevention nurse attended the Care Group 2 (CG2) The Quality committee included a standing agenda item for IPC updates and discussion. The IPC documents linked to the IPC dashboard which was viewed during the meeting. The trust shared exerts from minutes of IPC discussions which took place monthly throughout the year until September 2022. Some examples of the topics discussed at the monthly IPC meetings included the following:

Progress against areas such as staff compliance in the aseptic non-touch technique (ANTT) which was used to prevent microorganisms from hands, surfaces or equipment being introduced into a susceptible site such as an intravenous site. ANTT training was now on the hospital required learning programme and to improve training attendance the IPC Conference on the 12 October 2022 included ANTT workshops for staff to attend.

Ongoing conversations related to the monitoring of infections such as those caused by the Clostridioides difficile (C-Diff) infection had taken place. Concerns were identified in June 2022 about levels of C-Diff infections, however, by July 2022 there was a recognition of the improving picture of C-Diff infections at the Trust.

Discussions confirmed good levels of compliance against the February and July 2022 hand hygiene audits.

From July to September 2022 the trust confirmed zero MRSA bacteraemia cases. The remaining statistics confirmed: nine Escherichia coli, three Klebsiella, nine Clostridioides difficile and five Methicillin-resistant Staphylococcus infections. Ongoing work continued to reduce the infections and a focused IPC week and relaunch of champions took place earlier in the year. NHS England had supported the trust with site visits and additional training.

In endoscopy settings when people were seen with suspected communicable diseases elective patients had an alert on their electronic record. Inpatient bookings, the ward informed the endoscopy team when they called them to confirm a date and time for procedure. Endoscopy staff also checked to see if an alert was identified and noted this information in the recovery area diary.

In radiology settings guidance was in place to support staff when people were seen with suspected communicable diseases.

Environment and equipment

The environmental design in some clinical areas meant there was limited space around the bedside due to additional bed placement in bays. Oxygen and suction in one clinical area was not present at each bed space. Equipment checks and servicing had taken place on most of the equipment and staff had received training in how to use this equipment. Staff managed clinical waste well.

Following the inspection, on 17 January 2020, we served the following requirement notice. The service must ensure that substances hazardous to health are stored securely and used in a safe way to avoid potential or actual harm to patients.

At this inspection we found that controlled substances hazardous to health were locked away in all areas except for Chestnut ward and COSHH guidance was available.

Senior staff said since the last inspection the service had reviewed clinical areas, so the main ward areas were now at the 'back of the house'. This allowed the elderly care areas, Cherry ward and Chestnut ward to be in one area. The acute medical unit had been consolidated and was now located on Lilac ward. On Beech ward the bottom two bays were allocated to Covid-19 patients whilst the other bays and beds accommodated overnight patients.

Entry to clinical areas were secure, patients and visitors had to identify themselves before gaining entry to clinical areas.

Over one day we visited six clinical areas. Beds on some medical wards did not all have oxygen and suction which meant that patients were often moved dependent on who was being admitted. One patient and one relative from Oak ward confirmed they / their relative was moved due to a lack of oxygen at the bedside. Whilst on Chestnut ward, bay one we saw three beds to the left of the door had no oxygen or suction per bed. We discussed the lack of oxygen and suction by some beds to the ward sister who said she had already escalated this issue.

Chestnut ward had recently had some areas renovated; two more bays were due to be renovated. Staff said the bays should accommodate four beds, however, in bay one we saw five beds were in place. Staff expressed concern's around the lack of space around the beds should an emergency occur and were unsure that this risk had been escalated.

We observed patients could reach call bells and staff responded quickly when called.

Completion of the risk assessment for the mammography room was planned for December 2022.

Staff were trained on devices in accordance with their band, area of responsibility, and what they were expected to maintain.

All reusable medical devices were assessed and recorded on the trust Backtraq database. They were maintained in accordance with MHRA Managing Medical Devices (2021) and we saw some examples of the records of planned and reactive maintenance recorded.

Electrical safety testing was performed to IEC 62353 standard for the in-service and post repair testing of electromedical devices. All calibrated test devices were recorded when used in the test and verification of a device. Portable appliance testing checks had taken place and equipment passed these checks. We undertook random checks of equipment which confirmed they were checked in 2022 by the presence of dated stickers.

The trust equipment service schedules were monitored to ensure services were completed, for example at Scarborough Hospital that 97.42% of high assurance devices where no more than one month overdue their service date and 100% of urgent and emergency requests had been actioned.

During the inspection we observed some equipment which had been due to be serviced in February 2022 which included the standing hoist on Cherry ward and Chestnut ward.

Lilac, Cherry and Chestnut wards check of medicines and equipment in the resuscitation trolley were all to be in-date. The resuscitation trolley was tamper evident. Resuscitation equipment records check lists confirmed daily, and weekly checks took place in most instances. We reviewed random checklists and noted that minimal checks were missed, for example on Lilac ward one resuscitation trolley had three daily checks missed in July and four checks missed in August. On Oak ward, resuscitation trolley checks were missing, otherwise the other checks were seen.

Daily medicines fridge checks had mostly been completed across the medical ward areas.

Staff disposed of clinical waste safely. Protocols were in place for the safe disposal and spillages of cytotoxic waste.

Business continuity plans were in place.

Assessing and responding to patient risk

Staff completed and updated risk assessments for some patients which removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Following the inspection, on 17 January 2020, we served the following requirement notice. Systems for recording clinical information, risk assessments and care plans were not used in a consistent way on the medical wards at Scarborough Hospital to ensure safe care and treatment for patients.

At this inspection we found that not all risk assessments and screening tools were completed. Further detail is documented within the records section of the report.

Staff completed venous thrombosis (VTE) risk assessments for patients, using a recognised tool, and reviewed this regularly. The current protocol was to document the patients risk assessment within 14 hours. Reassessment within 24 hours was not captured electronically.

Medical care (including older people's care)

The 2021/22 VTE audit across medicine in Scarborough Hospital confirmed 54% of patients were aged above 85 years compared to 37% in the previous year's audit. The VTE assessment was completed in 50% of patients by the time of post take in 2022, and 51% in 2021. VTE prophylaxis commenced within 14 hours in 46% of patients in both studies. Recommendations and actions resulted from this audit to increase the completion of VTE risk assessments.

The service confirmed all patients admitted to the trust over the age of 65 were required to have a falls assessment as national guidance and per trust policy.

Patients at risk of falls were identified through the presence of yellow bands. We observed that staff followed the falls assessment policy on Lilac ward when we reviewed one patients' medical records. Falls and bed rails risk assessments were completed which identified reassessment in seven days unless the patient deteriorated or improved. Staff from Chestnut ward confirmed patients falls assessments were completed by nursing staff on admission, then reviewed weekly.

We reviewed two patients records to ascertain whether the trust sepsis pathway had been followed and saw initial treatment for sepsis commenced in the emergency department within 30 minutes of admission to the emergency department. The electronic prescribing and medicines administration (EPMA) charts confirmed the antibiotic therapy continued on the inpatient ward.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

The deteriorating adult patients monitoring and escalation policy (v5) included clear direction on patient monitoring, what to do should a patient deteriorate, staff duties and responsibilities, completion of training and competency assessments and the escalation pathways for each hospital location.

National early warning score (NEWS) tools monitored patients at risk of deterioration. Nursing staff were informed of patients clinical deterioration at the 7.45am safety brief and when the consultant arrived at 9am to ensure these patients were prioritised on the consultant's ward round. Staff said immediate contact with the critical care outreach doctor took place should the patient score five and above and this support was usually requested out of hours as during the day there was a consultant presence on Chestnut ward.

The electronic NEWS tool confirmed calculations were made against the Glasgow Coma scale and pain assessments were included. The electronic NEWS process was used correctly, and staff were responsive to the outcome of the news scores.

The 'NEWS2 Observation Frequency' report dated 29 September 2022 confirmed that average NEWS2 compliance for York Teaching Hospitals NHS Foundation Trust was between 80-85% month on month.

Staff said monthly NEWS2 audits took place. We saw the outcome of this audit for Lilac ward which confirmed NEWS2 96.2% compliance. (report dated 2 October 2022). The remaining NEWS2 audits from October 2021 to March 2022 showed compliance from approximately 40% to 100% across the medical service at Scarborough Hospital.

Staff shared key information to keep patients safe when handing over their care to others. Daily safety huddles took place on each ward and department to share key and essential information across the ward staff groups. These safety huddles were not officially documented, but we saw that each area recorded each safety brief in different formats. The priority was to ensure key messages were disseminated widely. The trust said discussions had been held in the monthly sister meeting to formalise safety huddle documentation.

Medical care (including older people's care)

The trust confirmed in the last 12-month period the percentage of urgent or unplanned medical admissions patients seen within the 14-hour post take consultant review average was 84%.

Daily, the post-take of patients sat with the acute physician team in the acute medical unit (AMU). Patients for admission were clerked in the AMU. Due to ongoing flow issues the clerking team and acute physician post take in the emergency department regularly until 5pm. At 5pm, the on-call consultant undertakes post take until they leave the site at 2000 (Mon – Fri). At weekends, post take is carried out by the on-call consultant.

From January, additional acute physician resource was to be deployed at weekends to provide additional support. From January, a cardiology on call rota will commence to improve the current 14-hour post take performance. Daily monitoring was established to ensure all patients marked "For Post Take" prior to 2000 were seen that day.

Mental health support was provided 24/7. The daytime mental health team were based in the on-site office and the overnight team member based in the emergency department or the on-site office where they took referrals via telephone/mobile phone.

Local safety standard for invasive procedures (LocSSIPs) endoscopy and five radiology audits (undated) were shared by the trust. The endoscopy audit outcome confirmed approximately 97% were correctly completed. We observed that gaps were identified in the radiology checklist audits, however, no further information was provided to confirm what follow-up took place.

Monthly LocSSIPs meetings which involved departmental representatives took place on the third Friday. Findings were discussed to promote and share good practice and address any learning points or areas of improvement arising. Chest drain documentation which related to guidance and the necessary checks were also shared to confirm LocSSIPs systems where in place.

Staffing

The service did not have enough allied health professional staff in all areas with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

Trust staffing information dated 18 October 2022 confirmed shortfalls in allied health professional staff. These shortfalls have been demonstrated through the planned versus actual AHP staffing levels for the past month. The actual shortfalls had increased from August 2022 to 51.08 whole time equivalent (WTE) an additional shortfall of 10.29 whole time equivalent (WTE) staff.

The last AHP staffing paper was discussed at the trust executive committee on the 21 September 2022 which confirmed that AHPs were autonomous professionals and were assigned operationally to care groups but were not assigned to a ward rota. They were managed as speciality teams to cover across wards to support annual leave, sickness, vacancies, and gaps in establishment. The staffing report also confirmed as of August 2022 there were 40.79 AHP vacancies within the acute emergency and elderly medicine at Scarborough. Cancer and support services had 1.45 vacancies.

The trust confirmed they had not met the AHP staffing recommendations for stroke services which had impacted on their ability to deliver high quality care.

The trust confirmed AHP professional leads had undertaken a review of recruitment and retention work programs such as attending the universities and recruitment events. Engagement with regional workstreams through the AHP faculty ensured the trust benefited from regional programs of support, and new roles.

In addition, the following initiatives were and will be introduced:

- Apprenticeship routes
- International registered AHP recruitment
- Changes to the preceptorship programme to commence November 2022 to offer further support to the newly qualified AHPs and international recruits
- Return to practice

We asked the trust to confirm whether all bank and agency AHP staff had a full induction and competencies assessed prior to them working in the medical service but did not receive information these processes were in place.

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

Following the inspection, on 17 January 2020, we sent the trust a notice to impose conditions under section 31 of the Health and Social Care Act 2008, stating that the trust must immediately ensure there are sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff at all times to meet the needs of patients within all medical wards at Scarborough Hospital.

At this inspection we found shortfalls in nursing staff continued. Discussions with senior staff confirmed a shortfall of 25 registered nurses and 33 healthcare assistants across Care Group 2. The management team said they used staffing tools to plan staff need and skill mix for the clinical areas. The tools in use were the 'Safer Nursing Care Tool (SNCT) – adult inpatient design' (2013 version) and the 'Safe Care' patient acuity tool to plan staff need and skill mix requirements for clinical areas. The first establishment review was completed in the summer (2022). Senior staff and some staff from wards we visited confirmed that staffing had improved since the March 2022 CQC inspection at York Hospital.

SafeCare is an accredited tool used within the trust to review patient acuity against real-time staffing levels, enabling staff to raise 'red flags' to identify areas of concern and identify any potential risk to matrons within the care group. Each morning the matron team, head of nursing and associate chief nurse met to review the day and staffing for the next 24 hours plus weekend staffing on a Friday.

Matrons contacted the wards each morning to confirm the real-time staffing levels and redeploy staff to areas unable to meet the fundamental care needs of their patients. Wards were red, amber, green rated (RAG) rated based on staffing levels and acuity and escalations were taken to morning and afternoon staffing meetings.

If staffing shortfalls existed the team looked to see whether other areas could provide staffing support, urgent repeated requests for bank and agency took place and individual wards would request additional staff. When all these areas were exhausted, staffing requests from the York site were made and those areas which constituted a higher risk the team tried to address their acuity and flow.

Medical care (including older people's care)

Areas where red flags risks were not mitigated and closed were recorded monthly and data including datix reports were collated to identify any harm that occurred as a result of reduced staffing levels and high patient acuity.

The trust confirmed the standard operating procedure entitled 'Daily Nursing and AHP Workforce and Escalation Meetings. Adult Inpatients Wards' was embedded across both sites. This helped identify where wards required additional support through a RAG rated system, the impact of this on the fundamental basic cares for patients and where support could be deployed from other areas.

Safer staffing reports from July to November 2022 confirmed the average nursing day and night fill rates for Care Group 2. The statistics showed the percentage of staffing shortfalls for qualified and unqualified staff were mostly observed during the day when compliance levels ranged from 82% to 93%. Qualified staff shortfalls were also observed over night with compliance levels from 91% to 96%.

Staffing shortfalls were reported via the trust incident reporting system; discussed in safety huddles and at the larger operational meetings. The trust confirmed that any unmitigated staffing actions highlighted at the end of each month were reviewed and discussed at Care Group quality committee, alongside any reported nurse sensitive indicators to establish if harm came to patients or staff due to unmitigated staffing concerns. The results were triangulated to include ward to board feedback to reduce incidence and promote safer staffing.

The nursing workforce report (20 October 2022) was presented to the trust resource committee. Current workforce pressures and concerns were identified one of which related to the fill rates since July 2021. Fill rates above 80% were achieved for the night shifts since June 2021 but there continued to be a concern in relation to the day shift for the registered workforce.

The nursing workforce report confirmed that the trust continued to report a significant unmet need in relation to temporary staffing requests for registered and unregistered nurses. In August 2022, 39% of all shift requests were unfilled a deterioration of 1% equating to 403 shifts.

Staff felt there were occasions at night despite staffing rotas being fully established when staffing levels were unsafe. Staff completed incident reports when staffing levels were felt to be unsafe, for example on the cardiac unit staff said there were approximately two incidents reported weekly; particularly, incidents which related to night shifts.

Staff from Chestnut ward identified some concerns which related to staff being stressed and said they had raised concerns about staffing on the ward to the ward manager. Staff described staffing skill mix and training as not adequate but gave no further details as to why they thought this.

Staff from four areas said they would benefit from additional staffing, despite, some of these areas having a full complement of staff. Over the last two months there had been less staff on shifts and staff had been moved to work night duty in another speciality not their own at York Hospital. Staffing on three wards was not a reflection of individual wards planned staffing numbers.

Initiatives to improve nursing uptake, included: the creation of a pool of staff to work part shifts, financial incentives which included enhancements for bank staff over the winter months and ward staff received a financial enhancement if they moved wards. Concern's raised by some staff related to staff frequently being moved to other areas and the bed office pressures exerted on staff.

If the head of nursing and associate chief nurse struggled to mitigate the shortfall, double time was offered to staff as an incentive to work additional hours.

Care Group nursing sickness rates ranged from 3.56% to 7.31% from September 2021 to the September 2022.

Registered nurse vacancies as of the 6 November 2022 had been 35.06 wte across medical and emergency services. This improved to a vacancy rate of 25.06 wte for the same period which took into account the in post and recruitment stage.

We asked the trust to confirm whether all bank and agency nursing staff had a full induction and competencies assessed prior to them working in the medical service but did not receive information these processes were in place.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The medical establishment review was articulated to the executive committee on the 17 March 2021 with the recommended level of medical staffing and allied health professional uplift required. The full recommendations were not taken forward. The Care Group looked at ways to expand the workforce through a combination of recycling some of the high agency spend, extending some winter funding schemes and some new investment. Another option was to expand resource deployed out of hours across all three tiers of the medical team. The recommendation from this report asked the executive committee to consider the implications of the workforce deficit as described, on the quality and safety of provision of services within Care Group 2 at Scarborough and Bridlington Hospitals and discuss potential solutions.

Discussions with senior staff confirmed concerns regarding middle grade medical cover as the hospital was short of approximately 16 middle grade doctors. Another group of middle grade doctors was required for the tier two rota. Concern's related to insufficient middle grade out of hours cover and safety overnight so from January 2023 a second consultant would be on-call at weekends to improve patient flow.

A consultant trained in general and / or acute internal medicine was always on call at Scarborough Hospital. Those consultants who were off site were able to reach the hospital within 30 minutes of being called. Their responsibility was to post take new patients in both the emergency department and acute medical unit and support deteriorating patients as identified by the ward and on call teams.

At weekends and bank holidays one on-call geriatric medicine (G(I)M) consultant's priority was post-taking new patients and responding to escalations from the medical on call team. A discharge consultant worked from 9am until 5pm whose priority was to conduct a review of possible ready for home patients as well as supporting post takes and medical reviews as required. Medical staff said weekends could be short staffed, although, senior support can be accessed.

As of January 2023, weekend cover would move to a three-person rota consisting of: one G(I)M consultant; one acute physician on call and one cardiologist on call. They are all responsible for post-taking, reviewing and being available for the escalation of patients. The G(I)M consultant will be based in the emergency department and downstream wards and the acute physician is based on the acute medical unit and medical same day emergency care. The cardiologist was based in coronary care unit and attended to cardiology patients across the site.

Medical care (including older people's care)

During the working week all medical wards had a senior morning ward round with a multi-disciplinary team board round. Consultants were expected to attend an afternoon "huddle" at 2.30pm prior to the 3pm operations meeting where ward escalations were made to the patient flow team for resolution. These were the priorities for the Care Group job planning process but due to limited staff in some areas the afternoon board rounds were planned, but not always possible. The ambition was to move all medical in-patient specialties onto a "Consultant of the Week" model. Currently, this was only achievable within cardiology.

Medical staff confirmed they had completed inductions and e-learning when they first joined the service.

We asked the trust to confirm whether all bank and agency locum staff had a full induction and competencies assessed prior to them working in the medical service but did not receive information these processes were in place.

Records

Staff kept records of patients' care and treatment, however, they were not always complete. Records were clear, up to date, however, not always stored securely and easily available to all staff providing care.

Following the inspection, on 17 January 2020, we served the following requirement notice. 'The must ensure staff are maintaining securely an accurate, complete, and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.'

Our findings from this inspection confirmed some shortfalls remained in records storage and completed records.

Records were not always stored securely in clinical areas. Records were stored in open trolleys on Lilac ward. Records were stored securely on Mulberry ward.

Whilst at Scarborough hospital we reviewed a total of 24 records. These records included a selection of completed risk assessments, intentional rounding records, capacity and do not attempt cardiopulmonary resuscitation records for individual patients. The risk assessments included venous thromboembolism risk, falls, sepsis and bed rail assessments.

We reviewed patients records across Lilac, Cherry, Chestnut and Oak wards. On Lilac ward patients risk assessments were up to date and evidence seen that the patient's treatment had progressed along the identified pathway.

On Oak ward, one patients' records confirmed they were not prescribed anti-coagulants or stockings despite the patient requiring them, this was actioned by staff immediately following escalation by the inspector.

On Chestnut and Cherry wards we reviewed nine patients intentional rounding records which were regular checks with patients using a standardised protocol to address issues of positioning, pain, personal needs and placement of items. The intentional rounding documentation confirmed two hourly checks were completed with the exception of one rounding session for two patients on Chestnut ward.

Three patients' medical records were reviewed which confirmed some shortfalls in information collection. For example, patients' cognitive screens and abbreviated mental tests were not completed.

The service currently used paper records which all staff could access easily. When patients transferred to a new team, there were no delays in staff accessing their records.

Medical care (including older people's care)

The trust was currently in the process of transferring patients records onto an electronic patient's records system which was being introduced across the medical wards. The new system would identify patients' personal details, risk assessments and safeguarding information where required.

We saw the introduction of the electronic patient's records system taking place on Lilac ward as staff were being issued with phones and iPads which would be used to capture patient information.

The trust confirmed there was no formalised records audit and that they would add this to the care group audit plan. Informal review of records and feedback had occurred during other processes such as incidents or complaints however this could not be formally evidenced.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. Access to the medicines room on one ward was not secure.

Staff followed systems and processes to prescribe and administer medicines safely.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff completed medicines records accurately and kept them up to date.

Staff stored and managed all medicines and prescribing documents safely, although, we observed on Chestnut ward that the medicines room door was held open by a trolley. Staff from the ward said weekly checks of the drugs took place; however, no checklist was available to confirm this. Following this finding, we checked some medicines with the staff in this area and one other clinical area and found them all to be in date.

We reviewed random controlled drugs and the controlled drug book with a staff member on Lilac ward and found all the controlled drugs to be in date and the controlled drug book fully completed. Staff confirmed the pharmacist completed a three-monthly controlled drug review and weekly medicine stock checks on the ward.

Patients medicines were prescribed, updated and documented once given on the electronic patient medicines administration chart. The EPMA system included a traffic light approach to monitoring patient's medication, for example, when medicines were due, they flagged as red, green if not due and blue for deferred items. Two patients medicine records were reviewed both confirmed medicines were given as prescribed.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents but staff said they had not always shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The incident management policy with the associated governance processes at Care Group and corporate level were used to ensure effective incident management. The trust was preparing to introduce 'Patient Safety Incident Response Frameworks (PSIRF)'. An outline project plan was established, and an interim patient safety specialist ensured additional capacity and expertise to the implementation of PSIRF.

Medical care (including older people's care)

The Care Group and trust governance and assurance committees received reports on incident management, themes, trends and lessons learned to inform action plans and service developments.

Forums were in place such as the monthly clinical medical governance meeting which included shared learning held across care group two (CG2). Shared learning included: learning from incidents, serious incidents, and mortality reviews.

All staff knew what incidents to report and how to report them.

Staff reported serious incidents clearly and in line with trust policy.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

Some staff said they had raised staffing incidents, however, the outcome and follow-up actions which related to these incidents were not fed back to staff.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw an example of a duty of candour event. The verbal apology was given on the same day and the written apology was completed within 12 weeks of the initial incident having taken place.

Is the service effective?

Requires Improvement ● → ←

Our rating of effective stayed the same. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Quality and Patient Safety Group minutes and the Quality Committee Agenda confirmed ongoing monitoring of National Institute for Health and Care Excellence (NICE) guidance, and National and Clinical Audit Updates were shared.

NHS York and Scarborough Hospitals Foundation trust currently worked to the most recent NICE Guidance NG89 which was last updated in August 2019, Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism.

The trust followed NICE pathways for prostate, lung and breast cancer in older patient. Participation in national audits has taken place and data from associated trust audits was reviewed. For example, the prostate cancer data was reviewed quarterly. Action plans were in place for the 2021 breast audit and a urology action plan was in development following the 2022 urology audit.

Medical care (including older people's care)

All patients admitted to the trust over the age of 65 had a falls assessment as national guidance and per trust policy.

The most recent development that involves technology for Care Group 2 was the ongoing expansion of the 'Hospital Out of Hours Tasking App'. The tasking app is used by the wards and on call medical team to create, handle and manage tasks that the medical team are required to perform during the out of hours period.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

The acute medical unit (AMU) operated on a once daily senior review with an outcome of that review being a clear discharge plan with criteria for discharge for that day. Unwell patients had a second senior review. If a senior review enabled discharge, they were seen again. The AMU staff supported in reach to the emergency department where a good proportion of post taking took place due to flow issues that constrained access to AMU for some patients. These patients went direct to the specialty ward once seen by the acute physician.

The trust had applied the 'Dementia Friendly Charter' within the medical service. Each ward used the 'forget me not' symbol in clinical settings to denote that the patient was living with dementia. It was positioned on the bed board and was used across the clinical settings. The 'What matters to me 'document was in use and John's campaign formed part of clinical practice which aimed to involve the family carer from admission to hospital until discharge. The trust was currently participating in the National Dementia Audit 2022. Dementia care was audited monthly and compliance ranged from 44.4% to 100%.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. However, staff from chestnut ward said they often had to ask family members to assist with meals to ensure that patients received them at designated mealtimes.

On Chestnut ward patient's nutritional information was displayed above their beds.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

We undertook a short observation framework for inspection using an inspection tool which allowed the inspector to make a judgement as to what it was like for people using the service. During the observation we saw that patients were interacted with regularly and all patients had fluids adapted for them.

Specialist support from staff such as dietitians were available for patients who needed it.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Malnutrition universal screening tool (MUST) auditing took place. One issue highlighted was a lack of staff awareness that MUST needs completion within 24 hours, so the matron team were raising awareness of this. The November MUST compliance per ward confirmed that improvements were required in this area. The audit tool confirmed compliance within 24 hours of admission to the ward and within seven days of assessment by the ward. Compliance level ranges for the medical wards for both were between 5.6% to 80.9%.

April to October 2022 monthly tendable audits across the medical department showed an improving picture of compliance with scores in September and October 2022 between 78.1% to 100%.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

The trust had implemented most of the 'Faculty of Pain Management's Core Standards for Pain Management'. Work was ongoing to achieve the remaining standards. The service confirmed they met waiting times recommendations for acute pain only.

The Abbey Pain tool has been agreed by the trust as the tool to assess the pain of those people living with dementia. Staff have and will undertake educational e-learning and ward level bite size training during dementia awareness week. In addition, staff competence, learning and effective completion of an Abbey assessment will be audited in the future.

Regular pain assessment was included in the NEWS 2 assessments in the form of a visual analogue scale (VAS); 1-10.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff confirmed that patients were asked whether they had pain when their observations were completed. Confirmation pain levels were assessed was seen documented alongside the patients national early warning score observations.

Monitoring of patients' pain took place through the weekly and monthly tendable audit when individual patients were asked directly if they had had their pain assessed and appropriate actions taken to relieve the distress. The overarching monthly response was 100% that patients had access to pain relief when it was required. The weekly audits identified that Ash and Beech wards scores were 50% and 66.7% respectively; remaining wards were 100% compliant. The trust confirmed a plan was in place with their matron to resolve this. The final weeks all patients asked reported they received pain relief (100%).

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits and information from audits was used to improve care and treatment. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Direct learning was shared, and themes and trends discussed at medicine site governance meetings which the medical staff and ward staff are encouraged to participate and share the learning.

Local nursing themes and trends were highlighted through the weekly, monthly, and quarterly Tendable audits.

Scarborough and Bridlington Hospitals had maintained their JAG accreditation to date and was due a full accreditation visit in November 2023. It was proposed the trust requested to have a full accreditation review to include all three sites, York, Scarborough and Bridlington. This was discussed at the endoscopy operational meeting, the risks and benefits of this approach considered and has been agreed at board level by the trust executive committee.

The trust confirmed all patients admitted to the trust over the age of 65 were required to have a falls assessment as national guidance and per trust policy. Falls assessments and care plans were to be completed within 6 hours of admission. Monthly audits were undertaken from April to October 2022 across the medical service; compliance scores ranged from zero to 100%. We observed that three wards had consistently high scores which ranged from 90% to 100% across the six-month period. Some of the lower scoring ward areas appeared to be those clinical areas which cared for patients who required more care and clinical support. The care group confirmed they had developed an improvement plan which was monitored and held to account through the trust wide improvement plan. The falls improvement plan was not provided as evidence.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. Managers had arrangements for medical staff to review any medical patients on non-medical wards. Staff said medical outliers were kept to a minimum and two wards medical patients outlied were:

• Maple (General Surgery) – Outliers overseen by the Gastro Team

• Holly (Trauma and Orthopaedics) – Outliers overseen by Care of Elderly Team

Following input from the acute physicians on the acute medical unit, downstream specialties were identified, and the patients are “pended” to the specialty wards. Patients who went to downstream wards direct from the emergency department (ED) were coordinated by the patient flow practitioner in conjunction with the ED nurse in charge. Medical ward outliers from July to September 2022 totalled 97 patients.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

Managers gave all new staff a formal induction with competency assessments around area specific skills and some generic skills e.g. medications. The quality and professional practice team supported staff for up to 12 months alongside local mentors as part of the trust preceptorship programme.

Managers identified poor staff performance promptly and supported staff to improve.

Managers made sure staff received any specialist training for their role, for example, four staff had recently completed the electrocardiogram interpretation module.

Staff said they could access assessment of the acutely ill patient, end of life care, breaking bad news and difficult conversation training.

The staff training needs analysis provided the basic training requirements for each band that was required to function in the role. Ward managers oversaw statutory and mandatory training which was recorded centrally on the learning hub.

All staff groups could access the development framework specific to the palliative care team.

Staff completed objective structured clinical examination (OSCE) assessments, for example venepuncture so they and the trust were assured of their competencies in these areas.

There was no formal supervision for the ward nursing teams, however informal supervision occurred across the ward settings. Specific concerns raised at ward level were escalated to the matron and wider support offered. Debrief sessions were available on an ad hoc basis and teams could request more structured trauma related clinical issues via the clinical skills support team.

Clinical nurse specialists linked to cancer and palliative care had access to more formal supervisory sessions.

One trust grade doctor said they did not have a clinical or educational supervisor allocated to support them.

Medical staff confirmed Wednesday weekly teaching sessions took place and an additional hour teaching session took place on Thursdays.

Staff confirmed they had completed annual appraisals. Appraisal statistics dated 18 October 2022 confirmed 92% of nursing and midwifery and 93% of allied health care professionals had received an appraisal.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Care Group 2 completed a weekly programme of scrutiny on discharges to promote flow and reduce length of stay. External partners attended the cross-site discharge improvement group for CG1 and CG2 where discharges complaints, incidents data and improvement plans were shared and discussed. Eighteen discharge related incidents from July to September 2022 were documented in the discharge improvement group minutes at Scarborough Hospital. The main themes for this quarter were discharge with no medication, the incorrect medication or no drug chart so medications are unknown. This was followed by no care support where care package was not in place.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. For example, the 11:30 board round comprised of members of the multi-disciplinary team.

Staff worked across health care disciplines and with other agencies when required to care for patients, for example, urgent community response and social services.

We observed one ward round which included two patients' reviews. The ward rounds appeared medically based and discussions centred around bloods and x-ray for one patient. There was no nurse or therapist input observed.

The trust met monthly and quarterly with other providers as part of the range of meetings hosted by the Humber and North Yorkshire Cancer Alliance. In July 2022 the extraordinary lung clinical delivery group meeting was arranged to discuss the roll out of lung health check programme across the Cancer Alliance and the expectations for the next 5 years. We also noted that further discussion in this area took place at the quarterly meeting on the 8 August 2022 whose discussions also included targeted lung health checks (LHC) – next steps.

Patients had their care pathway reviewed by relevant consultants.

Medical care (including older people's care)

Seven-day services

Key services were mostly available seven days a week to support timely patient care.

Discussions at the trust executive committee on the 19 October 2022 confirmed the trust had reviewed the seven-day hospital services clinical standards in 2021. In summary, there was assurance of partial compliance with the four priority standards, with some further detailed audit work required to inform a comprehensive action plan. The work stream was to be led through the urgent and emergency programme board which will be accountable to the executive transformation committee.

A seven-day discharge service was in place. Senior staff said allocation of social workers was an ongoing issue and it was normal to wait for seven to 10 days for a social worker to be allocated.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

High dependency patients were managed in the coronary care unit (ccu) and respiratory ward (Beech ward). In the CCU the consultant of the week saw patients daily. If CCU patients required a second review, this was identified by the nurse in charge. Two respiratory consultants (a 3rd had joined the team on 22 November 2022) were based on Beech ward, so patients were seen daily. If a further review was required, this was escalated by the nurse in charge.

The acute medical unit (AMU) was staffed by acute physicians Monday to Friday 0800 – 1700. From 1700, the GIM consultant took over the AMU.

At weekends, the geriatric medicine (GIM) consultant undertook the AMU function from 0800 – 1900. Again, the GIM consultant worked either work on AMU or the emergency department. Additional support is provided by a second acute physician on an ad-hoc/availability basis. The second consultant role will be formalised in January 2023 and included on the rota timetable.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Staff said they did not have access to magnetic resonance scanning at weekends and at night.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle.

Patient information leaflets were available on clinical areas which patients, relatives and carers could access.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. However, they did not always support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Medical care (including older people's care)

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act (MCA).

We reviewed a number of patients MCA and DoLS records and noted that some were fully completed, whilst, some patients despite requiring mental capacity assessments these were not completed.

On Mulberry and Chestnut wards completed DoLS and mental capacity assessments were seen for one patient on each ward. On Cherry ward one patients DoLS and DNARCPR were completed.

On Chestnut ward and the acute medical unit, we identified the following three concern's and escalated the concerns identified below to the hospital management team. Initially, the trust did not confirm these concerns had been actioned, however, following the inspection the trust confirmed they had addressed and rectified these concerns at the time of inspection**.** On Chestnut ward and the acute medical unit (Lilac ward) three patients' mental capacity had not been assessed. Staff confirmed these patients should have had capacity assessments completed. We escalated the need for capacity assessments for the three patients to the senior management team on the Scarborough Hospital site. One patient also required a safeguarding referral which was also escalated.

A do not attempt cardiopulmonary resuscitation (DNACPR) order was in place for one patient who had not been assessed as not having capacity. The DNACPR documentation did not confirm whether this was discussed and agreed with the patient.

On the acute medical unit, we reviewed the records for one DNACPR patient who was admitted on the 8 October 2022. The DNACPR record was completed in February 2022 prior to hospital admission. No reviews of the DNACPR record had taken place despite good practice guidance on the certificate which advised this action.

Nursing staff training statistics confirmed 90.8% had completed training in the Mental Capacity Act and 90% Deprivation of Liberty Safeguards.

Medical staff training statistics confirmed shortfalls in training completion as 63.3% (69 of 109) had completed training in the Mental Capacity Act and 48.6% (53 of 109) Deprivation of Liberty Safeguards.

The trust does not currently audit consent at Scarborough Hospital and was going to review this as part of their work plan.

Is the service caring?

Good ➔🡐

Our rating of caring stayed the same. We rated it as good.

Medical care (including older people's care)

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients.

Staff took time to interact with patients and those close to them in a respectful and considerate way.

Three patients said staff treated them well and with kindness and were happy with the care received.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

To ensure patients oral care needs were met a mouthcare trolley had been implemented on Chestnut ward. Patients oral status was reviewed using a red, amber, green (RAG) risk alert system. The trolley was organised into RAG so that staff could quickly access the tools required as identified through the patient's oral care plan.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

On Oak ward a family planning meeting took place in the quiet room on the ward. Staff said they had used this room when speaking with families and also when bad news was discussed.

Medical care (including older people's care)

Two patients in the discharge lounge confirmed they were happy with the support provided through the discharge lounge.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service.

Is the service responsive?

Requires Improvement ➔🡐

Our rating of responsive stayed the same. We rated it as requires improvement.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population.

The service relieved pressure on other departments when they could treat patients in a day.

Facilities and premises were appropriate for the services being delivered.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

The 'Forget Me Not' scheme had been implemented in the trust. The 'Forget Me Not' flower was used to indicate that a patient had either dementia or other cognitive problems. The flower is a magnet that is placed above the patient's bed. The trust also used a booklet titled "What matters to me" to assess specific requirements of the patient with dementia to enable personalised care to be given. This was updated from the previous version and relaunched on the 1 September 2021.

The 'MacMillan Recovery Package' was used in cancer services. This package was referred to as the personalised care agenda within the trust and formed a key part of the trust cancer strategy. The trust has implemented risk stratified follow up in the breast, colorectal, lung surgical, early endometrial, low risk melanoma pathways with plans to roll out to prostate next. The trust monitored performance via a personalised care dashboard.

The completion of equality impact assessments (EIAs) and the process of embedding them into processes for change in terms of policies and services, including transformation was identified as an area of development for the Care Group and the trust. The current equality impact assessment register showed three EIAs related to medical services; Nutrition, Falls and Self-administration of medicine; assessment templates were identified for each EIA.

Medical care (including older people's care)

In 2020, a patient equality and diversity action plan was created. Due to the pandemic, the trust had not focused on developing this plan. The trust said from August 2022, equality and diversity was to be included as a standing agenda at Care Group board to ensure the equality agenda was taken forward.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The trust achieved compliance with the Accessible Information Standard (AIS) as one of three agreed equality objectives 2020-2024. The trust had undertaken a number of initiatives to ensure compliance against the AIS, for example, an on-demand British Sign Language video interpreting was introduced during the pandemic, to support the trusts work on accessible communication in 2021. The roll-out of this facility has now been progressed to other trust sites.

The trust's baseline assessment for the National Institute for Health and Care Excellence clinical health guideline NG27 was completed as "partial compliant" in July 2016. This guideline relates to the transition between inpatient hospital settings and community or care home. The discharge command centre (DCC) was the coordinating cell for all pathway one to three discharges from the site and outlying patient community units into social care placements or home with packages of care. The pathways discharges were administered via a trusted assessor form (TAF) which was the single reference point for the referral to the social care provider or placement. The DCC screened all TAFs to ensure they are accurate and reflective of the care needs of the patient so that transition from hospital to the social care setting is seamless and safe. The DCC run a regular series of escalation calls and daily update as well as contributing to the weekly long length of stay (LLOS) reviews.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had access to communication aids to help patients become partners in their care and treatment.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had information leaflets available in languages spoken by the patients and local community.

Wards were designed to meet the needs of patients living with dementia. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

Access and flow

People could not access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

The trust said their access policy (v8) followed best practice recommendations and was embedded across the organisation.

Medical care (including older people's care)

Over the last 12-months Scarborough Hospital met report turnaround times for medical staff requesting diagnostic imaging and endoscopy. The referring clinician referred to live reports from live systems immediately after the scans are taken.

The trust had not achieved the referral to treatment (RTT) targets and was currently a Tier 2 trust for elective recovery. This involved fortnightly meetings with the Integrated Care System and regional team to monitor progress on the 78-week target and number of patients over 63 days on the cancer pathway. The trust resubmitted the operational plan trajectory to the region for these targets with an anticipated position of 397 78-week waits by March 2023. Please refer to further detail in the well led management of risk, issues and performance section.

The trust remained off plan for the 78 week and Cancer trajectories.

A team of seven RTT pathway trackers (five WTE) worked with the trust's care groups to validate and track patient pathways and held meetings fortnightly at specialty level. Earlier this year the majority of RTT treatment waiting lists were reviewed by an external company with less than 2% of reviewed pathways having their clocks stopped.

Weekly patient tracking meetings took place chaired by the operational planning and performance manager.

Oversight of patient flow across the Scarborough site was provided by the patient flow team headed up by a senior patient flow manager who acted as site BRONZE command during working hours. Patients identified for admission were either admitted through the Acute Medical Unit (AMU) or direct to a specialty ward if the patient had been post-taked in the emergency department. Senior staff said to improve patient flow the following initiatives were in place: daily ward rounds, the afternoon huddle where patients are discussed, and decisions made regarding discharge and a daily operations call. A medical led in-reach service in the emergency department ensured medical patients were seen and admitted or discharged as appropriate.

Daily operations meetings took place at 3pm where hospital activity which included ambulance activity was discussed to identify patient flow issues either into or out of the hospital. Discussions also included staffing needs, bed availability at midnight and referral waits, for example, patients waiting for speech and language therapy and mental health referrals.

For the last three months Scarborough hospital statistics confirmed a total of 358 patients were moved between wards at night; 195 patients originated from Lilac ward the acute medical unit (AMU). The AMU was the primary receiving ward for all acute admissions and operated 24/7.

A standard operating procedure was in place for managing discharges over the weekend and Bank holiday periods. To support patient, flow a discharge liaison officer (DLO) worked over the weekend and/or Bank Holiday period to support the discharging doctors.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to try to prevent them. Delays in some patients' discharges were due to problems with care homes closing in the area and this had increased. In addition, care homes would not take patients due for discharge after 5pm daily or at weekends.

Patients were sent to the discharge lounge prior to discharge where they waited for transport to take them back home or to another provider, for example, care home. A patient flow officer supported the discharge liaison teams across the site to take escalations from ward teams for any delays. The senior patient flow manager held operational meetings

throughout the day. The 9am call was a full site BRONZE meeting identified all site issues, staff and patient escalations. At 3pm a whole site conference call with ward sisters was held to report discharge intentions and escalate issues regarding patient placement. The final site meeting was held at 4.30pm which was the handover meeting for the on-call management team and late shift matrons.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

The service clearly displayed information about how to raise a concern in patient areas.

Patients, relatives and carers knew how to complain or raise concerns.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and complaint turnaround times were audited. Complaints were acknowledged within three working days and care groups had 30 working days to investigate a complaint and send a final response to the complainant. The annual audit (July 2021 to July 2022) confirmed response times had improved in that the majority of Care Group 2 complaints were acknowledged and responded to within 30 days.

The complaints breakdown provided by the trust confirmed there had been 107 complaints in the medical specialities at Scarborough Hospitals from the 17 October 2021 to the 16 October 2022.

The trust chief executive officer received 15 compliment letters for Care Group 2.

Is the service well-led?

Requires Improvement ● ➔🡐

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. Staff mostly were supported to develop their skills and take on more senior roles.

The care group leadership consisted of a director, associate chief nurse, associate chief allied health professional and associate chief operating officer were supported by matron's, a head of nursing, operational and general managers. Four lead clinicians and four speciality focused operational clinical leads also supported the service.

Staff mostly confirmed they had opportunities to progress within their career with the exception of one staff member who said they had not received additional training to support their ongoing development.

Physiotherapy staff confirmed they felt well led their therapy lead who listened to them and was described as 'supportive'.

Medical care (including older people's care)

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, however, had not been developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The Trust Strategy 'Building Better Care Together' set out the clinical care models for the organisation and identified a number of 'high impact interventions' to support the delivery of the strategy and drive the recovery of the Trust following the impact of the COVID-19 pandemic. The scope of the programme was approved in June 2021, with the project team in place by the Autumn. The programme was resourced through a blended model of substantive staff contributing time to 'Building Better Care', external project professionals and fixed term project posts. Responsible owners were identified from care groups and corporate teams with care group directors as clinical leads. The responsible owners lead the programme of work across all care groups.

The care group two (CG2) strategy identified their key challenges and how with partnership working these challenges would be resolved. In year one (2021-22) the areas of focus were identified along with individual speciality focus plans for emergency, cardiology, respiratory, gastroenterology and care of the elderly. Specific development areas were also identified for all specialities, such as establish single clinical leadership, joint business planning and joint clinical governance. The strategy also supported the delivery of clinical care models and integrated care.

A comprehensive implementation plan for year two of the Dementia Strategy (2021-2024) was in place.

'Our cancer strategy – 2020-2025' was developed by the trust and defines its mission, vision, themes, foundations, values and strategic partnerships.

Staff when asked confirmed they had not been involved in the development of the hospital strategy or vision.

Staff described the trust values as 'Openness, Kindness and Excellence'.

Culture

Staff did not always feel respected, supported and valued. They focused on the needs of patients receiving care, although, at times could not complete patients care needs. The service promoted equality and diversity in daily work. The service culture ensured patients, their families and staff could raise concerns without fear, although, feedback following these concerns was not always given.

Staff described feeling unsupported at times on the medical wards and one staff member said they had occasionally gone home crying due to the lack of support in place.

Staff said they had voiced concerns about staffing regularly but had been left unsupported which they felt affected patient safety and attendance to patient care needs which at times were not completed.

Staff could access a freedom to speak up guardian. Freedom to speech up policy guidance (v11) was in place and was past its review date of February 2022. The trust confirmed they had received no whistleblowing events in Care Group 2 for the last three months.

Staff felt confident to escalate any concern's although, the person they escalated the concerns to could not always help, but they always listened.

Staff said the trust had just completed a 'culture week' which was also present on the hospitals twitter account. Staff were involved in the culture week and its aim had been to celebrate differences and culture.

Staff said they felt supported by their medical colleagues.

Some staff described their teams as kind and said good team working existed. For example, physiotherapy team members described positive experiences around support, in-service training and induction processes.

Governance

Leaders operated governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Governance reporting structures reported into the board of directors. Decision making took place at the executive committee, corporate enablers (for example finance), care group boards, oversight and assurance committees. The trust had a wide governance membership which reported into the board of directors and care groups. Examples of these groups included the quality and patient safety group, sustainability committee and quality and safety care group meetings.

Staff said they had been involved and informed of governance and safety at the morning safety brief, through audit feedback and monthly newsletters. Staff said the 'Named Nurse' role was due to be introduced and prior to its introduction staff would receive training around this new role.

Monthly audit reports with information broken down by speciality were shared. Clinical auditing progress was reported through quality accounts meeting minutes from September to November 2022. The quality committee minutes summarised the key information, assurances and escalations from national mandated audit. These reports also confirmed any overdue actions which were then shared with Care Group governance mailboxes for action.

Local nursing themes and trends were highlighted through weekly, monthly and quarterly tendable audits. The tendable audit outcomes from April to October 2022 showed that compliance levels had improved across Care Group 2. In October 2022 compliance ranged from 86.6% (Oak ward) to 96.4% (Johnson ward). Tendable audit outcomes were shared by matrons as part of the monthly assurance process.

The Quality committee had a standing agenda item for infection prevention and control updates and discussion with attendance from one of the team. Monthly updates were given.

The deteriorating patient group was a sub-group of Quality and Patient Safety Group (QPAS) and represented a trust wide approach to sepsis, deteriorating patient and resuscitation.

Monthly clinical medical governance meetings included shared learning were held across care group two (CG2). Shared learning included patient experience, audit, learning from incidents and serious incidents, mortality reviews and specific care group and trust governance issues. Learning and themes from this meeting are planned to be shared at ward meetings.

The trust dementia improvement group met six weekly and medical care groups were represented by the relevant matron.

Medical care (including older people's care)

Board assurance around cancer waiting times was identified through the chief operating officer's report on the 2 November 2022 which was presented to the board of director meeting and confirmed the trust remained off plan for the 78 week and Cancer trajectories and had resubmitted updated trajectories as requested by NHSE Regional Team. Please refer to further detail in the well led management of risk, issues and performance section.

Management of risk, issues and performance

Leaders and teams used systems to manage performance, but these were not always effective. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The risk register was coordinated by the associate chief operating officer (ACOO). Risks were discussed at quality committee and the care group board. All escalations were raised through quality performance assurance and safety (QPAS) and the operational assurance meeting (OAM). All new risks were sent to the ACOO and discussed at care group board to assess the risk and add as required.

The Care Group 2 risk register identified the current risks to the service, accountabilities and mitigation, rated them and next steps. However, we noted that referral to treatment targets, consultant and nursing staffing for the medical areas were not identified as current risks.

Performance delivery was managed through care group operational teams, with regular discussion with the chief operating officer and the deputy director for performance and planning.

Monthly monitoring of Care Group 2's performance was presented to the trust board through performance reports. The October 2022 'Our People Executive Committee Report' updated the executive board on key performance indicators and risks in areas such as vacancies and staffing.

To address the current referral to treatment (RTT) performance position the trust implemented an improvement programme to support the trust strategy delivery 'Building Better Care'. This programme had specific projects which included targeting elective care and cancer – early diagnosis and staging as part of the programme. The trust had accessed elective recovery monies to establish the programme team, run a full validation of the RTT waiting list and accessed capital funds to establish an elective hub off the main site at York. A weekly performance update was sent to corporate directors and care group leaders and business managers. Monthly reports were sent to the Digital, Finance and Performance Committee, and up to Board through the trust Priorities Report.

The trust had engaged with the Integrated Care System to access mutual aid from other Trusts and had commissioned insourcing for theatres and previously for endoscopy. An interim Improvement Director was appointed to support performance recovery. The trust had committed through the Executive Transformation Committee in October 2022 to explore further outsourcing options for additional capacity, a revised approach for pensions to support take up of extra contractual activity and a focus on increasing first outpatient capacity back to planned levels. The trust also agreed to increase administrative resource to support patient bookings and outpatients.

The head of nursing attended the c-difficile cross-site Improvement group where themes from investigations were discussed along with pro-active planning to reduce the trust incidence of c-difficile. This was chaired by the assistant chief nurse and had representation from microbiology, IPC, facilities and each care group. The care group medical director represented the care group from a medical perspective.

Medical care (including older people's care)

A trust-wide monthly local safety standard for invasive procedures (LocSSIPs) improvement group was established in October 2021 to oversee effective implementation of safety checklists and procedures for invasive procedures across the trust. The group reported to the quality and patient safety assurance committee to ensure corporate governance and oversight of its activity. The project plan had largely been delivered to ensure all invasive procedures had appropriate checklists and procedures in place and that these were audited regularly to ensure adherence and identify any gaps or omissions for further actions or learning and improvement.

The 'Emergency Preparedness, Resilience and Response (EPRR) Policy' identified how the trust would prepare for, manage and maintain services during emergency situations.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The electronic patient record was being rolled out within Care Group two (CG2) in October 2022. The service currently used paper records. The trust was currently in the process of transferring patients records onto an electronic patient's records system. The new electronic patients' records system was being introduced across the medical wards. The new system would identify patients' personal details, risk assessments and safeguarding information where required.

We saw the introduction of the electronic patient's records system taking place on Lilac ward as staff were being issued with phones and IPads which would be used to capture patient information.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The 2021 survey sample was taken from adult patients discharged from inpatient care in November 2021. The national response rate was 39%. The York hospitals survey invited 1250 people to take part which gave a response rate of 39% compared with 47% in 2020. The largest number of responses came from people 66yrs and over (64%). Physical or mental health conditions, disabilities or illnesses were declared by 83% of people.

The trusts top five scores were in the areas of leaving hospital and food ratings.

The trust's bottom five scores were in the areas of care and treatment, hospital and ward, leaving hospital, and nurses. The trust confirmed that responses about support given by staff to meet 'fundamental care needs' had deteriorated, including getting enough help to wash or keep clean and to eat meals, as well as being able to get help from staff when needed. Hospital discharge remained a challenge for all. Actions were identified following this patient survey, for example: Care Group two (CG2) were implementing a nutrition and hydration focus for a month starting on 31st October.

The service used the friends and family (F&F) audit to capture patient feedback. Throughout the service we saw friends and family information posters displayed. The top issues identified by F&F respondents in November 2021 were waiting times, communication (including attitude of staff), and low number of staff on duty. The themes of hygiene needs, nutrition and hydration, staff numbers and discharge are already identified as areas for improvement at local level from the combined patient experience data sources.

The 2021 staff survey response rate was 40% (benchmark 46%). An improvement plan was developed by the trust which comprised of nine promise elements which identified the element score, actions, timescales, accountable team members, measures and other comments. The elements included: discrimination, bullying or violence, inclusion, recognition and reward, confident to speak up, safe and healthy. We observed that the trust scores mostly fell just below average scores, although, some areas scored average or just above. Timescales were identified, the majority being the 31 March 2023, although, we observed some areas had been completed in a shorter timescale, for example, the staff brief started in July 2022.

Staff confirmed they attended monthly staff meetings in their clinical areas.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The stroke pathway was an example of a stakeholders working with the quality improvement (Qi) methodology to address quality issues identified by clinicians. The trust six stage QI methodology was based on the model for improvement and the team were working through the stages. There was evidence of using cause and effect methodology, staff discovery interviews, process mapping the pathway in-order to diagnose the problems which will then become part of a project aim and supported driver diagram. The project plan was owned and delivered by the Care Group.

In Scarborough General Hospital, the Care Group had developed a single improvement programme where all individual projects sit. The aim was to ensure they target resource accordingly and provide a framework for all QI work so that it meets the trust and Care Group strategic and immediate priorities. The programme consisted of nine major projects, each with a Care Group senior management team sponsor.

Care Group 2 were developing a “Missed Opportunity” discharge audit to identify any further themes which could be fed into the single improvement programme. The trust is hopeful that this new audit will be rolled out over the winter period.

The tasking app was first rolled out in Scarborough in June 2020 (as a pilot for the Trust). Since then, the app, which is loaded onto trust provided mobile phones, has been used by wards to communicate to on call teams’ tasks that are required to be performed. At the commencement of the night shift, medical staff, outreach nurses and HCAs all log in to the app. The task is raised on the trust information technology system where it appears in a task list within the app. Further work this year has been undertaken to enhance the use of the app and the app itself has enabled further Quality Improvements.

Electronic remote monitoring will come online when the Somerset Cancer Registry software is fully- implemented. This was expected for completion by the end of March 2023; currently, site-specific teams kept individual spreadsheets to track patients on remote monitoring.