Scarborough Hospital

Quality Report

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Date of inspection visit: 13 and 14 January 2020
Date of publication: 24/03/2020

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Overall summary

We carried out an unannounced focused inspection of the emergency department at Scarborough Hospital on the 13 and 14 January 2020, in response to concerning information we had received in relation to care of patients in this department. At the time of our inspection the department was under adverse pressure.

We also inspected elements of the medical care core service including wards at this hospital. This included visting the admissions areas to discuss patient flow from the emergency department. During this inspection we inspected using our focused inspection methodology.

We did not cover all key lines of enquiry. We looked at the safe domain for both core services and aspects of both the responsive and well led domains for the emergency department.

Our key findings were:

- Patients who presented to the emergency department with mental health needs were not being cared for safely in line with national guidance (RCEM guidance and Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services).
- The department was not meeting the standards from The Royal College of Paediatric and Child Health Facing the future: standards for children in emergency settings.
- Access and flow of patients was creating significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment exposing them to the risk of harm.
- Systems for recording clinical information, risk assessments and care plans were not used in a consistent way to ensure safe care and treatment for patients.

Summary of findings

- We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients.
- Opportunities for staff to identify and quickly act upon patients at risk of deterioration on the medical wards were potentially missed or actions not always documented.
- Not all incidents were being reported and investigated to identify mitigating actions to prevent reoccurrence and reduce the risks to patients.
- The ward environment on one ward we visited did not support staff in keeping patients safe.

However,

- Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction
- The emergency department had suitable equipment which was easy to access and ready for use. The department was clean and tidy despite being extremely busy during the inspection period.
- Deteriorating patients were identified quickly in the emergency department and treatments were started in a timely manner.
- Staff and managers in the emergency department promoted a culture that supported and valued one another.

We found areas for improvement including breaches of legal requirements that the trust must put right. These can be found in the 'Areas for improvement' section of this report.

Following the inspection given the concerns identified a Section 31 notice of decision and 29A warning notice of the Health and Social Care Act 2008 was issued to the trust requiring them to make significant improvements in the quality of healthcare provided.

We also found several things that the trust should improve that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality. These can be found under the 'Areas for improvement' section of the report.

Ann Ford

Deputy Chief Inspector (North)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Urgent and emergency services	Inadequate 	We carried out an unannounced focused inspection of the emergency department in response to concerning information we had received in relation to care of patients in this department. At the time of our inspection the department was under adverse pressure. During this inspection we inspected using our focused inspection methodology, focusing on the concerns we had. We did not cover all key lines of enquiry. We found breaches of regulations from previous inspections had not been effectively acted upon. The quality of health care provided by York Teaching Hospital NHS Foundation Trust required significant improvement.
Medical care (including older people's care)		We carried out an unannounced focused inspection of the medical care services in response to concerning information we had received in relation to care of patients in this department. We inspected using our focused inspection methodology, focusing on the concerns we had. We did not cover all key lines of enquiry. We did not change the rating of the service at this inspection. We found breaches of regulations from previous inspections had not been effectively acted upon. The quality of health care provided by York Teaching Hospital NHS Foundation Trust required significant improvement.

Summary of findings

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Scarborough Hospital

Services we looked at
Urgent and emergency services; Medical care (including older people's care);

Summary of this inspection

Background to Scarborough Hospital

York Teaching Hospital NHS Foundation Trust provides a comprehensive range of acute hospital and specialist healthcare services for approximately 800,000 people living in and around York, North Yorkshire, North East Yorkshire and Ryedale - an area covering 3,400 square miles.

The trust's annual turnover is over £0.5bn. The trust manages three acute hospital sites and five community hospitals.

There is a workforce of over 9,000 staff working across the hospitals and in the community.

Each year the trust carries out the following activity:

- 127,000 A&E attendances
- 390,000 outpatient appointments
- 119,000 inpatients
- 61,000 operations and procedures
- 5,000 babies delivered

In total the trust has 46 acute inpatient wards across the three hospital sites at York, Scarborough and Bridlington; 1,006 inpatient beds, 58 day-case beds, 47 maternity beds and 33 children's beds.

The trust also provides outpatient and adult community services providing 1632 outpatient clinics a week from the hospital sites and additional community clinics. The trust operates community inpatient hospital services from four community sites:

- The New Selby War Memorial Hospital
- St Monica's Hospital Easingwold
- White Cross Rehabilitation Hospital
- St Helens Rehabilitation Hospital

Community services for adults including end of life care services are also provided in people's own homes and a range of community clinics across the geography of the trust.

Our inspection team

The team that inspected the service comprised of a CQC inspection manager, three CQC inspectors, three specialist professional advisors with expertise in urgent and emergency care and medical care. The inspection was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Why we carried out this inspection

We carried out an unannounced focused inspection of the emergency department at Scarborough hospital in response to concerning information we had received in relation to care of patients in this department. At the time of our inspection the department was under adverse pressure.

We also inspected elements of the Medical Care core service at this hospital and discussed patient flow from the emergency department. During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry.

We previously inspected the emergency department and medical care at Scarborough hospital in June and July 2019. We rated both services as requires improvement overall with both rated as inadequate for the safe domain. Following this inspection, we issued requirement notices for both core services. These were:

- The trust must ensure it has a robust process for identifying learning from deaths and serious incidents and ensure this is systematically shared across the organisation.

For Urgent and Emergency Care;

Summary of this inspection

- The service must ensure all medical staff in its urgent and emergency care service at Scarborough hospital are compliant with all aspects of mandatory training.
- The service 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.
- The service must ensure it has enough, suitably qualified, competent and experienced medical and nursing staff in its urgent and emergency care service at Scarborough Hospital, to meet the RCEM recommendations, including enough staff who are able to treat children in an emergency care setting.
- The service must ensure medicines are managed safely in its urgent and emergency care service at Scarborough Hospital.
- The service must ensure that computer screens showing patient identifiable information, are not left unlocked when not in use, in its urgent and emergency care service at Scarborough Hospital.
- The service must ensure it takes action to improve its performance in the RCEM standards in its urgent and emergency care service at Scarborough Hospital.
- The service must ensure all nursing staff have an up to date appraisal each year in its urgent and emergency care service at Scarborough Hospital.
- The service must ensure they continue to work to improve the following performance standards for its 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.
- The service must ensure the processes for the management of risks, issues and performance, and the governance and oversight of these processes are fully embedded within its urgent and emergency care service at Scarborough Hospital.

And for Medical care:

- The service must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced medical staff are deployed overnight for medicine wards on the Scarborough Hospital site to promote safe care and treatment of patients.
- The service must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced registered nursing staff are deployed across the medicine wards on the Scarborough Hospital site to promote safe care and treatment of patients.
- The service must ensure that all staff on medicine wards at the Scarborough Hospital site are maintaining securely and 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.
- 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.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	N/A	N/A	Inadequate	Inadequate	Inadequate
Medical care (including older people's care)	Inadequate	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Inadequate

Urgent and emergency services

Safe	Inadequate
Responsive	Inadequate
Well-led	Inadequate

Information about the service

The emergency department (ED) at Scarborough General Hospital provides services 24-hours per day, seven days per week. It is a trauma unit and treats level three patients (major and trauma patients). There are approximately 33,000 attendances each year. Of those attendances approximately 3500 were children under the age of 16.

Patients are streamed as they come into the ED by another provider who is not part of this inspection. All patients are initially booked onto the ED system. If they are transferred to the other provider, then their details are also transferred electronically. Patients who come in by ambulance are booked in and then triaged.

The ED consists of a first assessment area with five cubicles, a resuscitation unit with three cubicles including a designated paediatric cubicle. The main ED (majors) has 13 cubicles and two side rooms. There is no designated paediatric cubicle in this area.

There was a Homefirst (frailty unit) which had been open for a week at the time of the inspection and a same day emergency care unit (SDEC). The department did not have a paediatric area or a mental health area.

During the inspection, we visited the emergency department only. We spoke with 18 members of staff including registered nurses, health care assistants, reception staff, medical staff, and senior managers. We spoke with 11 patients and one relative. During our inspection, we reviewed 29 sets of patient records. These included records of mental health patients and children and young people who had attended the department as well as medical and nursing records.

Summary of findings

We carried out an unannounced inspection of the emergency department at Scarborough Hospital on the 13 and 14 January 2020 due to concerns of crowding and patient care.

During this inspection we used our focussed inspection methodology. We did not cover all key lines of enquiry, we looked at the safe domain and aspects of both the responsive and well led domains.

We rated the three domains as inadequate. We found that:

- There were not enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care. The department did not comply with a number of standards from the document 'Facing the Future: Standards for Children in Emergency Care Settings. June 2018 including - every emergency department treating children must be staffed with two registered children's nurses on every shift. They did not mitigate the risk by having enough appropriately trained staff with paediatric specific training on each shift.
- There were not enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care. There was not a consultant present in the department for 16 hours a day, seven days a week but there was a registrar (ST4) available 24 hours a day. Therefore, the department did not comply with the following standard from the document 'Facing the Future: Standards for Children in Emergency Care

Inadequate

Urgent and emergency services

Settings. June 2018' - every emergency department treating children must be staffed with a paediatric emergency medicine (PEM) consultant with dedicated session time allocated to paediatrics.

- The design, maintenance and use of facilities, premises and equipment did not always keep people safe. The department did not comply with the standard from the document 'Facing the Future: Standards for Children in Emergency Care Settings. June 2018' - emergency care settings are designed and provided to accommodate the needs of children and their parents/carers. There was no designated waiting area for children in the department and no specific cubicles for children in the majors area.
- The department did not have an appropriate room for mental health assessments that met the Royal College of Emergency Medicine (RCEM) guidance and Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services. There were no risk assessments carried out to mitigate this issue.
- Patients could not always access the service when they needed to. The department was not meeting the target for the national emergency care standard 4 hour and in November 2019 their performance was 40 to 44%. (The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department). Bed occupancy was very high and admission rates were high with just over 50% of ED patients admitted to hospital (England average 28%). Patients had to wait on corridors for cubicles in the department and during the inspection we saw that patients were in the department for just under 24 hours.
- Systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected were not always effective. The risk register for the service did not always reflect the current risks of the department.

However,

- The service had suitable equipment which was easy to access and ready for use. Cubicles in majors had central monitoring. The department was clean and tidy despite being extremely busy during the inspection period.
- Deteriorating patients were identified quickly and treatments were started in a timely manner. Triage staff were senior staff members, both nursing and medical and they worked well together. We saw that early warning scores were monitored and acted upon according to the trust policy on deteriorating adult patients. There were effective board rounds that were attended by a range of staff working across the ED and included senior decision makers. Patients who were kept on the corridor until a cubicle could be found were monitored by an experienced senior nurse and any deterioration in their condition was escalated appropriately.
- Staff and managers across the service promoted a culture that supported and valued one another.

Following the inspection given the concerns identified a Section 31 notice of decision and 29A warning notice of the Health and Social Care Act 2008 was issued to the trust requiring them to make significant improvements in the quality of healthcare provided.

Inadequate

Urgent and emergency services

Are urgent and emergency services safe?

Inadequate

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

There was enough equipment such as pulse oximeters, blood pressure machines and thermometers. All the bays in the first assessment unit had oxygen and suction. One of the bays had telemetry for cardiac patients.

We saw during the inspection that patients were cared for in the corridor. As the corridor was not wide enough for privacy screens there were privacy and dignity issues for patients who were being nursed in the corridor. The corridor was quite cold during the inspection though we saw that patients were offered extra blankets.

All the cubicles in majors had oxygen and suction and all had monitors that were monitored centrally. This enabled multiple members of the clinical team to observe the monitoring data and clinical condition for all the patients being cared for at that time. There were patient call bells in each cubicle.

Approximately fifteen of the patients in the department at the time of the inspection had flu symptoms or were suspected flu cases. There were not enough side rooms to isolate these patients and they were issued with disposable masks. There was no point of care testing for flu; this is when the testing is done in the department. Swabs had to be sent to the pathology laboratory and so patients had to wait up to two hours for flu swab results and longer at night. This led to delays in deciding treatment options for patients and attributed to the poor flow of patients through department.

There were resuscitation trolleys around the department which were sealed with a tamper evident tag. Trolleys were checked every day, and this was documented.

The resus area was well equipped and suitably staffed. Staff had immediate access to trust and national care pathways, such as for stroke and during the inspection we saw that the specialist nurse for stroke was supporting staff in resus. There were x-ray facilities adjacent to the ED for prompt diagnostic testing.

An agency member of staff told us that as part of their induction they were made aware of the location of the emergency equipment.

Despite the pressures on the department it remained clean and tidy during the inspection. There was a housekeeper for the department. We observed that cubicles were cleaned when a patient was transferred from the cubicle which usually took between five and ten minutes. If a patient had flu or diarrhoea and vomiting, then the cubicle needed to be deep cleaned before another patient could use it. This could take 20 to 25 minutes as curtains needed to be changed and the deep cleaning commenced. As there was only one housekeeper this could cause significant delays in ensuring the cubicle was available for another patient to use.

The department did not comply with the following standard from the document 'Facing the Future: Standards for Children in Emergency Care Settings. June 2018' - emergency care settings are designed and provided to accommodate the needs of children and their parents/carers. There was no designated waiting area for children in the department and no specific cubicles for children in the majors area.

Guidance from the Royal College of Emergency Medicine and the Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Servicesstates that an assessment room for patients with a mental health problem "must be safe for both the patient and staff. Therefore, there should be no ligature points, and nothing that can be used as a weapon. The room should have an alarm system and two doors (that open both ways)". There was no designated assessment room in the department. Staff told us that they sometimes used the relative's room. This was out of sight of the department staff and was unsuitable as it had ligature points, furniture that wasn't fastened to the floor, one door and had a mirror on the wall. Following assessment, patients had to wait in cubicles in majors or sat on chairs in the department in line of sight of the staff. As the department became busy this was distressing for patients.

Inadequate

Urgent and emergency services

Assessing and responding to patient risk

Risks to patients were not always assessed and their safety monitored and managed do they were supported to stay safe.

The median time from arrival to initial assessment was worse than the overall England median over the 12-month period from November 2018 to October 2019. The trust ranged from 18 to 22 minutes compared to the England average of 7 to 8 minutes in the recent six months of national data.

The department operated a 'streaming' system and patients were sent to the ED or to the GP led service which was not part of the inspection. Steaming was done by a senior nurse from the GP led service. The streaming nurse was provided from ED 8am to 8pm seven days a week and the post was back filled. The GP provider covered the period 8pm to 8am. Category one patients were sent to ED and category three patients were streamed to the GP led service. This meant there was a higher percentage of the overall patients who attended the department who were very poorly because the less ill patients were seen by the GP led service.

Following streaming in ED, walk-in patients went to the first assessment unit for triage and then first assessment. Patients who arrived by ambulance came through the specific ambulance entrance and to the first assessment unit for triage and first assessment. There were five bays in the first assessment unit.

If there was a queue for first assessment the risk to patients was mitigated by the ambulance assessment nurse who would prioritise patients going into first assessment and escalate deteriorating patients as necessary. In first assessment a history was taken from the patient and blood tests, electrocardiograms and radiological tests could be arranged, and a management plan was developed. If patients were unwell, they were sent to the resuscitation area. If they were not designated as clinically requiring resus, patients would either wait in the first assessment area until a cubicle in majors became available they would wait in the corridor in a queue for a cubicle.

The nurse staffing for the first assessment was a qualified nurse and two health care assistants. There was an advanced care practitioner and a middle grade doctor who also worked in that area.

The advanced care practitioner/ doctor working in the first assessment unit allowed for timely detection of the deteriorating patient and staff were able to quickly detect when a patient needed further monitoring. We observed staff in the first assessment unit liaising with the nurse in charge to get a monitored cubicle in majors.

The department did not have a specific assessment protocol as each patient was seen in first assessment and the plan of care was delivered from there so that patients were seen in time order if they could wait or immediately if they couldn't wait.

Routine monitoring of patients included respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, early warning scores, pain assessments and blood glucose levels. We saw that information was available to staff about pathways and protocols and that staff used it.

There was a patient assurance document (PAD) which was a checklist for patient comfort and safety. There were sections for each hour that the patient was in the department. We reviewed three of these forms for the patients who had been in the department for the longest. The longest wait was a patient who had been in department for 23 hours and six minutes at the time of our review. For this patient the document- had been completed every hour and there was clear documentation regarding pain, diet and fluids. We saw the patient had their catheter emptied and they had regularly received refreshments. We also saw that staff regularly apologised to the patient for their wait.

The second patient we reviewed had been in the department for 18 hours and 21 minutes at the time of our review. Documentation had been completed every hour and pain control was good. An incident form had been completed as the patient had missed their own medicines as they were in hospital. The patient was complimentary about their care and the consultant post take ward round was completed during their stay in the department and documented.

The third patient had been in the department for 18 hours and 39 minutes. Documentation was completed hourly and diet and fluids were given.

We saw that treatment for sepsis was commenced quickly, this was because the patients were seen by a doctor straight away and all fluids and intravenous

antibiotics prescribed as appropriate. We observed that patients were prioritised quickly and that they were moved to appropriate areas of the department. There were a number of patients with possible sepsis who came into the department during the inspection. We observed that they were identified quickly, and treatments were initiated within an hour of identification of sepsis. This was in line with the NICE guideline (NG51) Sepsis: recognition, diagnosis and early management.

Following assessment, patients were moved from first assessment and they went to a majors cubicle or onto the corridor if they were well enough. The corridor patients were looked after by a designated corridor nurse who was experienced. They were visually monitored, and repeat observations were recorded. The nurse worked from noon to 8pm but we saw that the department had begun to staff the period after 8pm due to the number of patients on the corridor.

There were 13 cubicles in majors with two side rooms. The cubicles were visible to the staff in the unit.

The service used the National early warning score version two (NEWS2) to identify deteriorating patients in accordance with National Institute of Health and Care Excellence (NICE) Clinical Guidance (CG) 50: 'acutely ill adults in hospital: recognising and responding to deterioration' (2007. There was an escalation policy for deteriorating patients which stated the threshold when patients needed to have their observations recorded. For example, all patients with a NEWS2 of five or higher should have had their observations repeated every hour. This information was captured on the patient tracker board at the nurses station. All the patients had their NEWS2 recorded and the time that it was last recorded. We looked at all patients on the board who had a NEWS score of five and above and saw that in all cases their observations had been recorded within the hour.

We saw that a patient was admitted to the department with a NEWS score of ten. This was clearly documented by the nursing staff and escalated to a doctor. Following a review by the doctor, flu swabs and blood gases were taken, and treatment was started immediately. This happened in the first assessment unit and the patient was moved to majors to await the results of flu swabs.

We saw that another patient had a NEWS score of two on admission and when this was re-checked it was raised to six. Escalation to the doctor took place and appropriate measures and treatments were put in place.

There were two hourly board rounds in the ED. These were attended by a range of staff from across the ED and were well managed. All patients were discussed, and treatment plans were updated, and diagnostic tests were followed up.

When children came into the department, they were streamed into the GP led service if appropriate. If the paediatric early warning score was greater than 10, they went to the paediatric resus bay. Other children went to the first assessment unit and from here some went to the children's assessment unit on the children's ward. On the inspection we saw that a very young child was assessed and sent to the ward within 90 minutes but other records we saw showed that children could have long waits, especially to be seen by the doctor, in the department. This was not on the department risk register.

Mental health patients were seen by the psychiatric liaison team Monday to Friday 9am to 5pm, this team was from the local mental health trust. Staff told us that they were responsive to calls and would often come down to the department during the day to actively look for patients. Out of hours and at weekends the service relied on a crisis team from the local mental health trust. We were told there were delays in staff responding to calls and they would often only communicate with staff by phone and not see patients face to face. This meant that a patient who came in at 5pm may have to wait till the psychiatric liaison team came in at 9am the following day and at weekend they could wait from Friday evening till Monday morning. The department did not audit the waiting times for the crisis team. If the service needed a social worker to support mental health patients this could involve longer delays.

There was no appropriate waiting area for mental health patients in the department. RCEM guidance and Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services state that the assessment room must be safe for both the patient and staff. Therefore, there should be no ligature points, and nothing that can be used as a weapon. The room should have an alarm system and two doors (that open both ways). Patients with mental health conditions were asked

to wait in the relatives' room which had a number of ligature points, furniture that was not fastened to the floor and there was a mirror which could be used to harm themselves or others. The relatives' room was not in the line of sight of any staff. Otherwise patients could wait in a cubicle in majors or in a seating area in majors. Staff told us that this was unsuitable as when the department was very busy patients could become quite agitated.

Although there were no suitable areas in the department for patients with mental health issues to be assessed or to wait, environmental risk assessments to help keep patients safe were not undertaken by staff. This put staff and patients at risk. Staff told us that they were really concerned about this. This was an issue at the last inspection and was not on the department risk register.

In addition, risk assessments were not carried out for individual patients with mental health issues who were waiting in the department. Following assessment by a doctor, patients would wait for assessment from mental health services. No risk assessments had been carried out in eight of the patient records that we looked at for patients with mental health problems. In one of these records a patient had come to further harm in the hospital department. Following this there was no incident recorded and no safeguarding referral had been made.

All staff we spoke with knew how to raise the alarm and seek urgent help in an emergency situation. There was a responsive security service on site, and we saw in the ED that there was a link to the police station.

There was a dedicated safeguarding nurse in the ED to support staff.

Nursing staffing

There were not enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care.

The service had used the Baseline Emergency Staffing Tool (BEST) to determine the staffing for the department. We were told that this exercise was about to be repeated. There were 58 nurses in the ED, which was a mixture of qualified and unqualified staff. There were seven band 7's, twelve band 6's, fourteen band 5's,13 band 3's, and 10 band 2's.

The vacancy rate was 0.38 band 7's, 0.75 band 6's, 2.33 band 5's and 5.8 band 4's. These band 4's were currently in training and were due to start in the department when they had completed their training. The matron told us they that had identified areas in the department where they could place the new staff.

On the early shift there were seven qualified staff and six health care assistants, on the late shift there were nine qualified staff and six health care assistants and on the night shift there were six qualified staff and five health care assistants.

Each shift had a band seven or band six nurse in charge, they were always a substantive member of staff. The service had a clinical educator post that was not included in the staffing numbers who oversaw the mandatory training and the ED specific training. There were six advanced care practitioners, five were qualified and one was still doing their training. Three had recently left the service. The service was looking to cover six shifts a week in minors to make up for the vacancies.

The service had recently opened the Homefirst unit (Frailty unit) which was permanently staffed, and they were recruiting additional staff at the time of the inspection.

There was always one nurse who was assigned to resus and we were told that another nurse would be moved into that area if necessary. If patients were ventilated an anaesthetist and an operating department practitioner stayed with the patient.

Staff from the department and agency staff would pick up additional shifts to support the service but there was a reliance on bank and agency staff to cover gaps in staffing. We were concerned that of the six qualified staff covering the night shift during the inspection four were bank/agency staff. However, these were their own bank staff and agency staff who had previously worked in the department.

Senior nursing and medical staff told us they felt there were not always enough nursing staff for the department. Nursing vacancies were on the risk register and had been so since February 2019. The senior manager for the department had oversight of the risk. The risk was scored as harm - moderate harm (three) and likelihood- very likely (five) giving an overall score of 15.

The department had both bank staff and agency staff who were used regularly. All the ones we spoke with had completed an induction and were familiar with the department. These staff were able to cover at short notice for sickness and increased demand. Some staff had been with the department a long time but preferred to work as agency staff. The department was having some success with persuading them to take permanent contracts.

During the inspection we saw that senior staff requested additional staffing to support the department. The matron told us that they never refused requests for additional staffing and that shifts were usually filled.

The department did not comply with the following standards from the document 'Facing the Future: Standards for Children in Emergency Care Settings. June 2018':

- every emergency department treating children must be staffed with two registered children's nurses.
- each emergency department treating children must have a member of staff with APLS (or equivalent) training at all times.
- every emergency department treating children must have their qualified staff trained in infant and child basic life support (BLS).
- every emergency department treating children must enable their staff to attend annual learning events that are specific to paediatric emergency medicine.
- Mitigating actions for non-adherence to the standards could have included at least one registered children's nurse, or an adult nurse who has undergone appropriate training on each shift and a workforce plan to address these issues. These actions were not in place.

The clinical educator had put in place some training around paediatric competencies working with the Yorkshire and Humber critical care network and 36% of staff had accessed this training. Only 15% of staff had completed the advanced paediatric life support training (APLS) and 35% had paediatric immediate life support training.

There was a range of other paediatric training available for staff in the department including cross speciality multi-disciplinary paediatric emergency training (CRUMPET) and EMBRACE training for the transfer of critically ill children. Numbers accessing these courses were low. We were told that it was a struggle to get paediatric training for staff and that courses were often run at York Hospital which was a considerable distance away.

There was no training for staff in mental health conditions and the use of risk assessments to keep people with mental health conditions safe while they were in the department.

Medical staffing

There were not enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care.

At our inspection in 2017 and 2019, the trust was not meeting the RCEM standard of consultant cover for 16 hours each day. We told the trust it must continue to recruit staff and ensure there were sufficient suitably qualified, competent and experienced staff on duty to meet the needs of patients. At this inspection, there was not a consultant present in the department for 16 hours a day, seven days a week but there was a registrar (ST4) available 24 hours a day (as per Royal College of Emergency Medicine Workforce Recommendations).

The department did not comply with the following standards from the document 'Facing the Future: Standards for Children in Emergency Care Settings. June 2018'. every emergency department treating children must be staffed with a paediatric emergency medicine (PEM) consultant with dedicated session time allocated to paediatrics. There was no workforce plan in place to mitigate this risk

The care group lead, who was also the lead for medicine, described the consultant staffing in the emergency department "as good as it has ever been". There were three consultants, two locum consultants and two associate specialists who acted up on the consultant rota. This allowed a 1:6 rota. The service had recently recruited a consultant from York Hospital who was the clinical director for the service. Six out of eight of the middle grade staffing was filled and all ten of the junior doctor posts were filled. There were two registrars who worked overnight with two junior doctors.

Inadequate

Urgent and emergency services

The locum doctors who worked in the department were very experienced and had worked within the department for a long time. They chose to be locum doctors but were very valued members of the team.

On the same day emergency care unit (SDEC) there was a medical consultant from the acute medical unit, in the Homefirst unit there was an experienced GP/locum consultant. The care group lead said that the teaching of junior doctors was not as good as they would have liked but that they were working to improve this. They said they had trouble recruiting staff and that overseas doctors who came to the department soon left to go to a bigger hospital.

We observed consultants and other doctors working in the department. They led the treatment of the sickest patients and supported the more junior staff. There was strong teamwork between the nurses and the doctors in the department and one of the consultants said that it was noticeable when all members of the team were from the staffing establishment that the department ran well. The medical consultant from the SDEC and the GP from the Homefirst unit worked together with the consultants from ED to move appropriate patients into their areas to support the ED consultants. All staff were present at the two hourly board meeting when all patients were discussed, and appropriate patients were moved into other areas. We saw that this happened with patients who were on the corridor. Medical staff from SDEC and Homefirst would actively seek out appropriate patients for their areas.

We spoke with three doctors who were training in the department or had recently trained in the department. Feedback was positive, and they said that their induction had been good and that everyone was supportive. One of them was a specialist doctor who told us that the consultants would not let them do nights until they were happy with their competencies.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Inadequate

Access and flow

Patients could not always access the service when they needed to.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard over the 12-month period from November 2018 to October 2019.

From January to October 2019 performance against this standard showed steadily increasing median times to treatment. Recent performance has generally been approximately 30 minutes longer than the England average and the standard.

The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From December 2018 to November 2019 the trust failed to meet the standard and performed much worse than the England average.

Over the 12 months from December 2018 to November 2019, 169 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours in a month were in spring and autumn 2019.

From November 2018 to October 2019 the monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was worse than the England average.

From November 2018 to October 2019 performance against this metric showed the percentage of patients that left the trust's urgent and emergency care services before being seen for treatment rose steadily from 3.0 to 6.0%, not following the national trend.

From December 2018 to November 2019 the trust's monthly median total time in A&E for all patients was higher than the England average.

From December 2018 to November 2019 performance against this metric showed the monthly total times got longer, not following the national performance.

According to the operations manager about 75% of patients admitted to the department breached the national emergency care standard (4 hour). We saw that delivery of the national emergency care standard (4 hour)

up to November 2019 was 40 to 44%. The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

Bed occupancy was at 97 to 98% (National Institute of Health and Care Excellence advises a bed occupancy rate of 85%) and admission rates were high with 51 to 53% of type one patients admitted to hospital, compare to the England average of 28%.

There were systems in place to monitor and manage the flow of patients through the ED to either discharge or admittance to the hospital. The clinical team could see on the IT system the length of time patients had been in the ED, who had been referred and required admission. The system allowed them to have an overview of bed availability and the flow of patients coming into the ED. This was discussed at regular bed meetings throughout the day and plans made. We saw evidence of this during our inspection. However, this system was not effective; poor access and flow of patients through the hospital was creating significant delays in admitting patients from ED onto wards to enable them to receive timely and appropriate care and treatment.

There were periods of overcrowding when ambulance crews could not offload patients at the hospital. This meant that patients were cared for in corridors either by ambulance staff or ED staff. As part of the mitigation there was an experienced 'corridor nurse' from noon till 8pm to look after the patients on the corridor. We saw that the service provided additional corridor cover after 8pm during the inspection as there were a number of patients on the corridor at 8pm when the nurse went off shift. While patients were on the corridor we saw they were monitored and cared for and that any deteriorating patients were treated in a timely manner.

There were daily bed meetings and we attended the 3.00pm and 4.30pm meeting on the 13 January and the 9.00am meeting on the 14 January. There was a managed bed status with predictions of non-elective demand based on previous data. The meeting started with ED - Operational Pressures Escalation Level (OPEL) status, numbers in attendance, how many breaches, how many in the department and how many waiting for admission. There were operational managers and managers there from most departments and they discussed who had been / could be discharged that day and what options there were for discharges requiring community packages of care. They reviewed planned admissions for the next day and did cancel one non-urgent patient who was due to come in on the 14 January 2020. Capacity was reviewed in SDEC and the Homefirst unit, patients discharged to these units were taken off the timing clock for the ED performance standard.

We attended an internal review of the OPEL four status that the hospital had been in over the previous weekend. This was with the departmental chief operating officers from York and Scarborough with the first on call over the weekend and the bed manager. There was learning that came out of this and they told us they had a learning log on the intranet so other staff would see the learning.

On the Tuesday of the inspection at 8.26am all the cubicles were full in the department and two patients had been bedded down in the SDEC overnight. There were 11 patients who were in breach of the four-hour national emergency care standard and the longest time that a patient had been in the department was 16 hours and 42 minutes. All patients had been assessed and treated appropriately by the ED staff and were waiting for a bed in the hospital. Patients were kept on trolleys overnight and not transferred to beds, yet we saw that there were beds in the hospital. This meant patients comfort and care needs were not always met. The matron said that they would try to accommodate patients in beds in the future.

When the hospital had been at OPEL three on the previous day, there had been 107 patients in the main department. Thirty-eight patients were admitted and there were over 50 breaches, 77 patients were discharged or went to SDEC or the Homefirst unit.

At the weekend when the department had been at OPEL four, there had been three waves of ambulances from 5pm onwards. There were 16 patients waiting for beds, five were in SDEC and three were in resus which had led to a lack of senior decision makers in the main ED which made the situation in the ED worse. The hospital had opened every escalation bed that it had including the surgical assessment unit. There were 124 attendances but there had been a backlog of patients from Saturday. Most of the patients in the department were frail or elderly.

Urgent and emergency services

There was little flow out of the department for a number of reasons. Many of the medical consultants were locums and were risk averse, this meant that they were more likely to admit patients to the hospital. Staff told us that patients were discharged from the hospital late in the day and so these beds were unavailable for patients. Patients often waited a long time for a speciality review and so patients were kept in the ED even though the consultants in the department could not do any more for them.

Scarborough had lost a number of services with patients now having to travel to York and other centres for treatment. This was for specialities such as ear nose and throat, urology, neurology, ophthalmology and maxillofacial. Patients who were admitted through the ED for these services, then had to wait for a bed at Scarborough and then a bed at York for treatment leading to delays in their treatment. On the inspection we saw that a patient needed an urgent vascular intervention at another hospital and there was a delay in their ambulance transfer.

There was a post take ward round on the morning of the inspection with a number of speciality consultants visiting the department, we saw consultants from orthopaedics and cardiology in the department. They identified appropriate patients who could be moved to their wards without the patient going to the acute medical unit. Staff told us that it could be difficult to get surgeons to come down to the department to see patients. One of the three medical consultants on the acute medical unit worked in the ED to support the medical patients.

All GP referrals for every speciality were sent to the ED and not to assessment units. This meant that these patients had to go through the ED process to get a speciality referral. Speciality doctors preferred that patient risk was focused in the ED and not on their wards, but patients had a long wait to see their appropriate doctor.

The same day emergency care (SDEC) unit functioned 24 hours a day. This was a joint venture between the ED and the acute physicians and used ambulatory pathways. This had started in August 2019 with support from the Emergency Care Intensive Support Team (ECIST). Patients were not part of the four-hour standard for emergency department admissions and were treated as an in-patient admission. We saw that the doctors in SDEC worked with the doctors in ED to identify appropriate patients. These included patients with conditions such as pulmonary embolism and deep venous thrombosis or who needed intravenous antibiotics. The trust was looking at a business case to permanently fund the nurse staffing in the SDEC.

There was a HomeFirst (frailty unit) that functioned Monday to Friday 9am to 8pm. This had been open a week at the time of our inspection. We were told that this would function till 10pm, seven days a week when the model became more embedded and additional staff were recruited. The medical cover was from a GP who had worked in the ED department for many years. There was a band seven nurse and they were in the process of recruiting a band six. There was also support from the physiotherapy/ occupational therapy service. The doctor and the senior nurse actively pulled appropriate patients into the service, for example, we observed that medical staff were selecting patients from the ambulance queue before they had their first assessment.

Staff were trying to link more closely to community services and said they would benefit from having a social worker embedded into the team to support discharge. There was currently some pharmacy support for ED but Homefirst said that they thought a pharmacist embedded in their service would be beneficial to support medicines management.

During the inspection the Homefirst unit had taken 15 patients from ED, of these one was admitted to a medical bed, 12 were discharged on the same day and two remained overnight. The patients were bedded down overnight in the SDEC which was open 24 hours a day. However, this environment was not appropriate for overnight stays; during the night there was activity on the unit and patients were left on trolleys.

The service was looking at nurse led discharge from the Homefirst unit to speed up the discharge process. Patients could be discharged to local hospitals such as Bridlington and Malton to the care of the elderly wards and for rehabilitation.

Are urgent and emergency services well-led?

Inadequate

Urgent and emergency services

Inadequate

Leadership

Leaders at all levels did not fully understand the challenges to quality and sustainability, especially with regard to children and patients with mental health conditions; they had not identified actions needed to address them. Local leaders were visible and approachable. However, their ability to effectively manage the department was limited by staff shortages and poor access and flow of patients through the hospital.

At trust level the newly formed leadership team were committed and working hard to improve patient safety and care within the department. However, they had not been in position long enough to have had an impact and were not properly sighted upon key risks within the department such as the risk to children by failing to implement The Royal College of Paediatric and Child Health Emergency Care Standards.

Leaders had not effectively acted upon breaches to regulation which CQC had identified in its October 2019 report.

Leaders at all levels were aware of challenges the department faced regarding access and flow, but strategic change to address this was slow. There appeared to have been a previous disconnect between the local leadership and that of the trust in terms of prioritising actions to keep patients safe, especially in relation to paediatric care and mental health provision, as well as improving access and flow throughout this hospital and to other trust services.

The emergency department was part of a care group with the medicine services at the hospital. The care group lead used to be the medical director for the ED. The current clinical lead for the ED was new in post and had come from York Hospital.

At a daily operational level, the local leadership was trying to deal with and mitigate service pressures. There were two hourly board rounds led by a consultant and these meetings were well organised with a strict agenda and tasks allocated appropriately. The corridor nurse was an experienced nurse (Band seven) who worked well to support safe patient care on the hospital corridor.

The local leadership and management of the Same Day Emergency Care unit (SDEC) and the Homefirst unit was working well. There was support from the acute medical consultants in the SDEC who worked with consultant colleagues in the ED to identify appropriate patients who met the criteria for the SDEC.

The HomeFirst Unit was led by a GP and an experienced nurse. The unit had recently opened; from observation we could see that they worked closely together providing leadership for all staff who worked on the unit.

There was visible nursing leadership in the ED. The senior nurse in charge was visible to all staff.

The band seven nurses in the department were responsible for their own team of band sixes and band fives, they were responsible for their skills and competencies.

Vision and strategy for this service.

Plans for the future vision were in development with involvement from staff, patients, and key groups representing the local community. However, there was a lack of effective interim plans in place to manage current risks and priorities.

There was a vision for the service and a bid had been submitted for a new build of the department. However, from Board papers we reviewed and from speaking with staff there were concerns that this would take too long, and the process needed to be accelerated to meet the needs of staff and patients to deliver quality care. A strategic outline business case was in development which was the first part of a national three-stage approval process. The business case, if successful was not due to be implemented until 2024.

In addition, a review was ongoing for the Humber Coast and Vale integrated care system (ICS) that was looking at service configuration for this geographical area. It had not yet been translated into a robust and realistic strategy with well-defined objectives that were achievable and relevant.

In the meantime, there was a lack of effective interim plans in place to manage current risks such as poor access and flow, and not meeting national guidance for patients with mental health conditions or paediatric care.

There were escalation plans to manage surges in patient numbers on a daily basis that were used during the inspection and we viewed minutes of meetings where escalation plans had been implemented. We saw that senior staff reviewed episodes of overcrowding, breaches and the department being at OPEL level four. Learning from this meeting was put onto the hospital intranet.

Governance, risk management and quality measurement

Systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected were not always effective.

Not all risks identified as breaches to regulations in the CQC inspection report from October 2019 had not been effectively acted upon or mitigated.

There had been no risk assessment or gap analysis of the service against national guidance for key patient groups such as paediatrics or those with mental health needs; this guidance included Royal College of Emergency Medicine (RCEM) guidance, Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services and the Facing the future: standards for children in emergency settings.

The consultants told us that the relationship with the streaming part of the service was not as good as they had hoped and that there were no joint meetings between them. They had hoped for a more collaborative relationship and that the service could be even better with a more collaborative approach and more shared staff.

Most departmental staff we spoke with were aware of the risks in the department, but these were not always reflected on the risk register. This included the lack of suitable accommodation for patients with mental health problems and for children and young people in the department. We reviewed the risk registers sent to us by the trust and found they were not robust; with limited assurance of both effective mitigation and dates when actual actions were reviewed.

We saw that there were senior managers in the department during the inspection. They were aware of the situation in the department regarding poor access and flow of patients which created significant delays in admitting patients onto wards; some patients were not receiving appropriate care in a timely way, exposing them to the risk of harm. There was limited evidence of any strategic impact, with the exception of the implementation of the SDEC and Homefirst units within the department itself.

We were told there was a bi-weekly governance meeting for the care group which reviewed the governance of the department and reviewed incidents including any serious incidents. Learning from this was disseminated across the care group. These were not being used effectively as risks were not being appropriately addressed, mitigated and managed.

We saw during the inspection that not all incidents were reported by staff. This failure to report incidents prevented senior staff being able to investigate any incidents and to share learning around the department to prevent them happening again and meant escalation of risk and appropriate and timely mitigation of actions did not take place effectively.

Culture within the service

Staff and managers across the service promoted a culture that supported and valued one and other. However, there was not a positive safety culture for escalating concerns and ensuring actions were taken.

Staff worked well together as a team and worked collectively to respond to every day pressures and demands but did not ensure risks were addressed, mitigated and escalated. Not all incidents were reported.

Senior managers and nursing staff including the matron were visible in the department. The senior manager for the department said that they came into the department every morning on their way to their office to see the situation in the department.

Consultants told us that although the agency staff were good, team working was most effective when the shifts comprised the permanent staff.

Inadequate

Urgent and emergency services

Staff we spoke with said they worked really hard and enjoyed working in the department.

There had been a recent focus on training and development with the appointment of the practice educator role, staff thought this was positive.

Consultants and locums told us that they had a good relationship with the executive team and they understood the pressures on the department. They said the work done with Emergency Care Intensive Support Team (ECIST) had been very helpful. There were good working relationships with acute medical staff but this did not seem to be the case with other specialities.

Learning, continuous improvement and innovation

There were examples of staff improving services with the development of the SDEC and the HomeFirst services. Some learning from incidents occurred. However, not all incidents were reported.

Medical care (including older people's care)

Safe

Inadequate

Information about the service

At Scarborough Hospital medical care was provided across various wards including: an acute medical unit (AMU), and an ambulatory care unit, and covered different specialities, such as general medicine, stroke rehabilitation, cardiology, respiratory, endoscopy, and elderly care and old age.

We visited the AMU and the following wards: stroke rehabilitation, general medicine, coronary care unit (CCU), respiratory, and elderly care and old age.

We spoke with 28 staff (including medical and nursing staff), one patient, two carers, and reviewed five patient records.

We last inspected this service at this location in June 2019. Following that inspection, we rated the safe domain as 'inadequate'. Pending publication of that rating we sent the trust a letter of intent to take enforcement action, dated 25 June 2019, under section 31 of the Health and Social Care Act 2008. This focussed on staffing numbers on certain medicine wards and keeping of accurate patient records. The trust responded with a plan to address our concerns. We decided to monitor the situation by, amongst other actions, receiving weekly nurse staffing reports about the medicine wards we had identified.

By December 2019 these reports indicated that there was no significant improvement. They showed that the trust was unable to maintain the staffing numbers it had planned on the medicine wards we had identified.

On 20 December 2019 we sent the trust a request for information under section 64 of the Health and Social Care Act 2008. We did this to support us in deciding whether we needed to take any action to keep patients safe. On receipt of the trust's response we decided to conduct this unannounced focussed inspection.

Summary of findings

At Scarborough Hospital on 13 and 14 January 2020, we carried out a focussed unannounced inspection of medical care (including older people's care).

This inspection was conducted because, on the medicine wards, we had concerns about patient safety.

We inspected the safe domain with a focus on environment and equipment, assessing and responding to risk, staffing, patient records and incident reporting. We found that the rating for Safe remained as inadequate.

Our key findings were:

- Opportunities for staff to identify and quickly act upon patients at risk of deterioration were potentially missed or actions not always documented.
- The service did not have sufficient nursing staff with the right qualifications, skills, training and experience which meant there was a risk they could not keep patients safe from avoidable harm and to provide the right care and treatment.
- Systems for recording clinical information, risk assessments and care plans were not used in a consistent way to ensure safe care and treatment for patients. Whilst staff mostly completed electronic risk assessments on time, there was an absence of care plans. What was recorded was not always clear, up-to-date or detailed. Staff found the electronic patient record and paper records difficult to work with and staff knowledge about how to use the electronic records system was variable.
- Not all incidents were being reported and investigated to identify mitigating actions to prevent reoccurrence and reduce the risks to patients.
- The ward environment on one ward we visited did not support staff in keeping patients safe.

However,

Medical care (including older people's care)

- Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

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.

Further, on 21 January 2020, we sent the trust a warning notice under section 29A of the Health and Social Care Act 2008, stating that the quality of healthcare provided by the trust for the regulated activity of treatment of disease, disorder, or injury required significant improvement. We required significant improvements in record keeping and incident reporting by 18 February 2020 and staffing on the medical wards by 21 April 2020.

Are medical care (including older people's care) safe?

Inadequate

Environment and equipment

We found the ward environment on one ward we visited did not support staff in keeping patients safe.

At our last inspection we noted that ward environments were not always suitable, in terms of layout, to support staff in keeping patients safe.

On one ward we visited, which we had not focussed on at our last inspection, on speaking with staff, we learned that staff had to often deal with confused, wandering and sometimes aggressive patients. This led us to look in detail at the access and entrance to the ward, and what the trust had put in place to support staff in keeping patients safe.

We noted that the ward opened out to an adjacent stairwell which posed a risk to patients with dementia or confusion who were not aware of their surroundings and/or were determined to leave the ward. In terms of the doors to the ward we noted there was a confusion handle fitted high up on the door. This was a handle that one had to turn up rather than down to release the door catch. However, staff explained that their patient cohort were often able to operate the confusion handle and open the doors.

Staff had tried to mitigate the risks by moving such patients to the middle of the ward but when staffing numbers were stretched this did not always work.

Also, on the ward there was a circle in the ceiling giving access to a dome that was opaque and formed part of the roof structure. We saw that paint was visibly peeling from this aspect of the ceiling and it appeared there were signs of water damage. This was un-sightly and it also posed a health and safety risk to staff and patients as it was an environmental hazard.

Staff explained that they had requested that the doors to this ward, given the patient cohort and the challenges with staffing, be changed to magnet locks with swipe access. Also, they had asked for the ceiling to be dealt with. However, we were told that feedback had been given; although the trust was aware of the issues, there was

nothing that could be done. This was because of a combination of financial constraints and not having space to decant the ward to so that works could be done on the ceiling.

Assessing and responding to patient risk

We found examples where opportunities for staff to identify and quickly act upon patients at risk of deterioration were potentially missed or actions not documented.

The trust used a nationally recognised electronic tool called National early warning scores version two (NEWS2) to record clinical observations which supported staff in identifying a deteriorating patient.

We found one record where the NEWS2 score, generated by a patient's observations, did not appear to have been utilised effectively to both identify a deteriorating patient and then trigger appropriate escalation. When we discussed this with staff we were told there was a standard operating procedure (SOP) in place, but it had not been used by staff for this patient. If it had been used the patient would probably have received treatment sooner.

On another record we found that a NEWS2 score had been recorded, not on the NEWS2 chart provided, but on a multi-disciplinary record. This meant, because it was not recorded on the NEWS2 chart, an opportunity to escalate the risk to the patient may have been missed.

Another record showed that a NEWS2 score of six had been generated from observations but there were no entries in the records we saw about how this had been escalated.

Further, we found another record where a medical staff member had noted they had seen a patient but not made any entry in the records. Linked to this, across the records we looked at, we found examples where the level of detail recorded by medical staff was lacking. For example, a lack of noting of discussions about ceiling of care.

In other records we found that the time of initiation of a falls care plan was so vague that it was not possible to identify whether harm had occurred by delay in initiation of the care plan. On this same record we also found staff were using paper NEWS charts from 2014 which had no escalation prompts. This could lead to a different calculation of risk as NEWS had been replaced with a newer version, NEWS2.

Staff did report some positive changes. For example, a midday briefing with medical staff had been introduced on the Beech ward. This meant medical staff went through patients one by one to identify a patient for discharge or at risk. Staff reported that patients were seen in a timely way because medical staff had to be ready for the briefing.

We looked at trust generated reports about whether NEWS2 observations had been done on time. The trust set a target of 90%. As an example, for three medicine wards, in the period April 2018 to December 2018, all wards consistently scored over 90%. This did not correlate with what we found on inspection.

Nurse staffing

The service did not have sufficient nursing staff with the right qualifications, skills, training and experience which meant there was a risk they could not keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

At the inspection in September 2017, we said that the trust was breaching a regulation and must ensure that there were sufficient numbers of suitably qualified staff deployed to meet the needs of patients. We found that this breach again at the last inspection in June 2019.

The trust responded to our concerns about staffing by recruiting agency staff on a block booking basis and by other actions, such as recruitment of staff from abroad. However, we found from data the trust supplied that as the months progressed after our June 2019 inspection, that the ability of the trust to maintain the increased staffing numbers using agency staff was challenging and at times had declined.

For example, using the weekly registered nursing staffing reports the trust had sent us, we found, the percentage of shifts where registered nursing numbers were met, (shown in brackets below) were as follows: for the weeks commencing 7 to 28 October 2019, Beech ward (53%); Coronary Care Unit (CCU) (38%) and Ambulatory Medical Unit (AMU) (38%). For the weeks commencing 4 to 25 November 2019, Beech ward (35%); CCU (45%); AMU (28%). For the weeks commencing 2- 12 December 2019, Beech ward (57%); CCU (50%); AMU (45%).

Medical care (including older people's care)

Whilst the trust told us there were no patient safety concerns we found examples where there was potential harm to patients and staff, because of this challenged staffing picture. For example, we found a patient who required one to one care. However, owing to staffing pressures, the necessary additional staff member was not available for two out of three shifts that day. We did note that staff had tried to mitigate the risk to them and the patient as best they could with the staffing they had.

Staff we spoke with described the acuity tool used by senior staff to plan staffing numbers as being heavily weighted towards the acute aspects of patient care as opposed to the dependency aspects of a patient. Staff felt this downplayed the impact on them of having to care for patients who were confused, agitated or aggressive, or those requiring care for every aspect of their stay in the hospital. Staff described the impact of having staff taken away in these circumstances, to fill gaps in other wards, as being extremely challenging. Other staff told us they could have patients that were not deemed to require level two care, but the patient was still critically ill and had a high coma score, but it appeared this was not considered when deciding to move staff.

When this feedback was set against the context of what we found below under 'incidents', it suggested that the challenges of staffing numbers, and the impact it had on staff and on patients, was not being fully recognised by the trust or the wider system partners.

On all the wards we visited staff reported being short of planned staff on at least one shift on the day we inspected. This was either because the staff were being moved to fill a gap in staffing on another ward or because the request for agency/bank staff had not been fulfilled. This was confirmed on the staffing boards displayed and by the weekly monitoring reports we had received after the inspection.

We spoke with staff about the staffing levels. Most staff we spoke with described high use of agency staff by the trust as coming with its own challenges. For instance, staff said sometimes the agency staff were not competent to look after the patient cohort on that particular ward. For example, one staff member explained that agency staff they had worked with could not do observations or blood sugars. Other staff explained that some agency staff considered doing the medical round was all that was required of them or that agency staff could only do basic work. Even if agency staff were useful, staff explained that they were often moved around to help out on other wards, so the additional agency staff spend was not always helping on their ward. Some staff described how risk assessments were missed due to the impact of agency staff.

The picture staff we spoke with described, of staff being moved around, is also evidenced from the weekly staff monitoring reports the trust had sent to us since our last inspection. These showed staff regularly being moved to fill gaps in staffing on other wards. Whilst this may have been the trust moving staff to mitigate other risks it did not help staff felt it did not mitigate patient risk on their ward or help staff morale.

Staff repeated what we had been told at the 2019 inspection around being uncomfortable working on unfamiliar wards. We found different wards used different methods for documenting key patient information in records (see below); this made it even harder for staff who were unfamiliar with the ward to work safely on a different ward.

Overall staff we spoke with felt that, even with the additional agency staff, matters had not improved that much since the last inspection, either because agency staff needed support, or because shifts were not filled, or if they were, staff were moved to other wards.

We asked ward managers what type and frequency of ward meetings they had. Ward managers described recently starting team meetings again and then only once a month. Ward managers could not describe audits they were doing, apart from the records audit, and that was done by staff senior to them.

We were concerned that, because staff had been working with short staffing for a number of years, there was a risk that incidents may go un-reported. Staff we spoke with confirmed that challenged staffing numbers did impact on their ability to report incidents. However, no ward manager or senior staff member we spoke with had done anything recently with their staff to ensure these incidents were reported.

We were concerned about the suppressing effect short staffing numbers was having on staff behaviours, not just in terms of reporting incidents, but also in their ability to meet as a team, and their morale, and their ability to conduct audits to ensure that standards were maintained.

Medical care (including older people's care)

Records

While staff mostly completed electronic risk assessments on time, there was an absence of care plans. What was recorded was not always clear, up-to-date or detailed. Staff found the electronic patient record and paper records difficult to work with and staff knowledge about how to use the electronic records system was variable.

At the September 2017 inspection, we said the trust should consider raising awareness of the importance of accurately recording nutrition and hydration intake on food and fluid balance charts. At the June 2019 inspection, we said the trust should ensure staff completed records accurately and contemporaneously.

In response to our previous concerns about record keeping by staff, the trust indicated that it was going to work with its information technology team to improve the electronic patient record and also, pending any changes, pilot a paper-based record for staff to record important information. The trust was also going to start an audit of records. At this inspection we found that the pilot was still ongoing. According to the trust's improvement plan, the pilot was to be considered on November 2019 and next steps to be agreed.

We found that senior staff were conducting monthly records audits. The audit was in two parts. Part one looked at the standard of note keeping, such as, were entries signed, dated, and name printed. Part two looked at completion of risk assessments and care plans. The trust shared with us three months of past audits for the Beech ward and the CCU. These were two of the medicine wards we had concerns about at the June 2019 inspection and which we visited on this inspection. Broadly, what these audits showed was that staff were completing risk assessments on patients but, with minor exceptions, care plans were not present. The audit had a space to make manuscript notes on it about what actions the trust had taken. It was unclear what action the trust had taken about the care plans issue because there was nothing in the manuscript notes present on the audit.

The out turn of the trust's monthly audits noted above agreed with what we found on our review of five sets of patient records.

We found staff were completing the patient risk assessments on the electronic patient record system provided by the trust but there were, with minor exceptions in relation to falls, no care plans. This meant it was difficult and time consuming to track whether staff had carried out the actions generated by the risk assessment. For example, one record we looked at showed a nutrition assessment had been done which showed a care plan was required but it had not been done. On the same record a care plan was in place following a falls risk assessment. On another record we found delays in risk assessments being done, and delay in care plans being initiated.

One ward was using a paper record called a core care plan and intentional rounding document to record details of actions staff had taken to comply with the electronic risk assessments. However, there was no care plan. It meant it was very time consuming to track the position about care in relation to a patient. Discussions of ceiling of care were not always recorded.

On another record on a different ward we found it difficult to ascertain all doctor roles, grades, or names on all entries. We saw that the ceiling of care box had been ticked but could not find a record of the discussion with the patient or relatives in either the paper or electronic records. The fluid balance chart did not document totals for input and output.

A further record on a different ward showed job roles were not legible in all entries. The medical staff attending had not documented anything in the records. The ceiling of care was noted but with no record of the discussion with the patient or family. This ward used a paper record called six activities of living. Times of assessment were not seen for a wound care plan. The fluid balance chart did not document totals for input and output. This record was using out-dated NEWS charts with a 2014 version control.

On a different ward another record we looked at showed the legibility of the signature was poor and we were unable to consistently assess the grade of doctor. We found patient identifiers missing on some pages and missing times and dates for some entries. The fluid balance chart did not document totals for input and output.

Staff we spoke with told us that when staffing was under pressure one of the first things to not get fully completed were documentation and assessments.

Medical care (including older people's care)

Following the June 2019 inspection, the trust told us it was considering appointing a specific digital lead and in the meantime was reviewing how the current electronic systems supported safe patient record keeping.

On a general level we found the conjunction of the electronic patient record and the paper records was, of itself, a patient risk, which had not improved. Staff we spoke with described it as 'difficult'.

For example, if staff did a falls risk assessment, the electronic system would generate actions, and was meant to generate a care plan. But staff told us they were unable to print out a care plan.

Some staff knew how to interrogate the electronic patient record better than other staff.

Overall, we were left with a confusing picture about what staff could access or not access on the electronic patient record which was a risk. For example, some staff told us only medical staff could access the medicine part of the electronic patient record whereas other staff said they could do it.

We saw one staff member had to contact the trust's information technology team in order to extract information they needed to write a serious incident report. Staff explained that it was difficult to manage patient records with some electronic assessments being difficult to work with, such as bed rail assessments, and other ones not creating a care plan, which meant staff had to keep a paper record. Staff said there used to be a paper booklet at the end of the patient bed, (similar to the one the trust was piloting) but staff felt the trust needed to use one or the other and not both.

One ward we visited had created a good and poor example of record keeping showing new staff what standards of record keeping they expected.

Staff told us part of the reason given for poor record keeping by staff was because they did not know what was expected of them and because of a lack of time.

Incidents

We found several examples where staff had not reported incidents, whether actual or a near miss.

Given the challenging staff picture and the consequent pressures this placed on staff, we did not have confidence that staff were routinely reporting incidents.

Whilst senior staff felt staff were encouraged to report incidents, and some staff we spoke with confirmed this, senior staff had no trigger to alert them to do an investigation into whether staff were reporting incidents.

At the 2019 inspection we reported that the trust's own audit committee had stated there was limited assurance on incident reporting. Further to this, with challenged staffing for a number of years, senior staff had not done anything recently with staff to improve incident reporting.

By way of context, a data resource we share with the trust called 'Insight', showed that, in the period October 2018 to March 2019, the median time taken to report incidents at this trust was 76 days compared to 29 days for all other NHS trusts. However, the same data source showed this trust was performing the same as other trusts in terms of potential under reporting.

Where staffing numbers were challenged we were concerned that reporting of incidents could be adversely impacted so potentially contributing to a false picture of patient safety. What we found on speaking with staff and reviewing records were as follows:

On one record we found that a patient had potentially not received an indicated treatment or intervention on time. On speaking with staff, they reported that no incident report had been made. This represented a missed opportunity to learn because staff told us the apparent delay could easily have been avoided by contacting an outreach team.

Some staff we spoke with said they were encouraged to report incidents or knew how to report them. However, staff also described finding a patient who was meant to have one to one care (that was not possible owing to staff shortages) being found hanging out of their bed. This incident was not reported, and nor could we find any record of it in the patient's notes. Other staff told us about an agency staff member who had discharged a patient without the appropriate paperwork. This was not reported. Staff reported patients not getting turned or intentional checking of patients by staff, (called 'COMFE' rounds), not being done when staffing was short. This had not been incident reported. Some staff said they only reported

incidents where there had been patient harm, and not near misses. Other staff we spoke with described being in the process of reporting an incident, but owing to short staffing, having to attend to patient care, so after a long shift, they had not reported the incident. Other staff told us about agency staff, (who were entitled to two half-hourly breaks) who, over the weekend shifts, went on breaks without telling the nurse in charge. This left the nursing workforce short in charge of some very poorly patients. This was not reported as an incident.

Considering the trust's own audit committee reported limited assurance on incident reporting, and that staffing numbers had been challenged for some time, we sought assurance about what senior staff had done to address the incident reporting culture at the trust. For example, we asked senior staff about whether they had done any re-fresh with staff about incidents and incident reporting. We were told this had not been done recently. Further, we wanted to understand whether senior staff had any triggers to help them identify an under-reporting culture. So, we asked senior staff whether they had an estimate of how many incidents they would expect to routinely see; they told us they did not have one but did regularly receive incident reports. However, senior staff told us they did regularly review safe care, look at complaints, and datix reports, on a dashboard they received.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

In Urgent and Emergency services;

- The service must improve the flow of patients through the emergency department and the hospital so that patients are assessed, treated, admitted and discharged in a safe, timely manner. Regulation 12(2)(b)
- The service must ensure there are sufficient numbers of suitably qualified, skilled and experienced doctors and nurses to meet the needs of patients in the Emergency Department, especially in relation to paediatric care. Regulation 18(1)
- The service must ensure that care is provided in line with national standards and risks to patients and children attending the emergency department identified, mitigated and effectively managed. Regulation 12(2)(a)(b)
- The service must ensure that there is an effective system to identify, mitigate and manage risks to patients who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines. Regulation 17(2)(a)(b)

In Medical Care services;

- The must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced registered nursing staff are deployed. (Reg 18).
- 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. (Reg 17(c))
- The must ensure systems for recording clinical information, risk assessments and care plans are used in a consistent way across the medical wards. This should include ensuring staff are aware of how to effectively use systems to identify, assess and monitor patients at risk of deterioration. (Reg 12).
- The must ensure systems and processes for staff to report incidents are capable of giving senior staff objective assurance that reporting of incidents can be effectively monitored and audited so that actions can be taken if there is evidence that there may be under reporting of incidents. (Reg 17)

Action the provider SHOULD take to improve

In Urgent and Emergency services;

- The service should provide mental health training for staff who work in the department
- The service should ensure that patients waiting to be admitted have the appropriate care including access to a bed when they are in SDEC or the emergency department overnight.
- The service should consider reviewing and extending the Homefirst unit opening hours to seven days a week.

In Medical Care services;

- The should continue to improve its electronic patient record and the fit between the paper record and the electronic patient record.
- The service should review the environment to ensure that it is fit for its purpose and keeps people safe, especially people with confusion or dementia.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Safe care and treatment. Regulation 12.** The regulation was not being met because: • Access and flow of patients was creating significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment. Reg 12(2)(b) • Patients who presented with mental health needs were not being cared for safely in line with national guidance (RCEM guidance and Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services). Reg 12(2)(a)(b) • The department was not meeting the standards from The Royal College of Paediatric and Child Health Facing the future: standards for children in emergency settings. Reg 12(2)(a)(b) 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. Reg 12(2)(a)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The regulation was not being met because:

This section is primarily information for the provider

Enforcement actions

- There was not an effective system to identify, mitigate and manage risks to patients who presented to the emergency department with mental health needs. The system did not take account of the relevant national clinical guidelines. Reg 17(2)(b).
- Not all incidents were being reported and investigated to identify mitigating actions to prevent reoccurrence and reduce the risks to patients.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The regulation was not being met because: We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients. Reg 18(1)