Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Inspection report

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Ratings

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

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

Doncaster and Bassetlaw Teaching NHS Foundation Trust provides acute services for 420,000 across South Yorkshire, North Nottinghamshire, and the surrounding areas. The trust employs over 6000 staff.

The trust has over 8000 members and was one of the first ten trusts to achieve foundation status, which was awarded in 2004. The trust received teaching status in 2017 and trains approximately 25% of medical students and 30% of all other healthcare professional students in the trust's catchment area. The trust has four locations where services are provided:

- Bassetlaw District General Hospital
- Doncaster Royal Infirmary
- Montagu Hospital, Mexborough
- Retford Hospital

We carried out this unannounced inspection of 4 acute core services across 3 locations provided by this trust on 22-24 August 2023 and diagnostic imaging across 4 locations on 26-28 September 2023. We undertook this inspection because we had concerns about the quality of services. We also inspected the well-led key question for the trust overall on 2-4 October 2023.

We inspected urgent and emergency care services, medical wards, surgical wards, diagnostic imaging and maternity services at Bassetlaw District General Hospital and Doncaster Royal Infirmary. We inspected urgent and emergency care services, medical wards and diagnostic imaging at Montagu Hospital, Mexborough. We also inspected diagnostic imaging at Retford Hospital.

Our rating of services went down. We rated them as requires improvement because:

We rated safe, effective, responsive, and well led as requires improvement. We rated caring as good.

Our findings

In rating the trust, we considered the current ratings of the services we did not inspect this time.

The trust leadership team showed adequate experience and knowledge to lead the trust. The leadership team was newly formed with some recent key appointments. There was further work needed to ensure the Board was cohesive and unitary. They understood the priorities and issues the trust faced however there were several recent changes to organisational structures which would take time to embed.

The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Some enabling strategies were under review and newly developed.

Not all staff felt leaders were visible. Staff in areas where there were greater pressures, due to challenges recruiting staff, financial restraints, and patient demand, felt less supported by the senior leadership. There was further work to do to ensure all staff felt safe to speak up and to ensure the Board was effectively sighted on concerns raised by staff.

There were areas identified for improvement in governance frameworks and controls. There were areas of risk where assurance processes were not effective, and work was continuing to develop these. During our inspection we escalated several concerns regarding equipment, cleanliness, and management of medicines which the trust responded to and acted.

The trust collected data and analysed it however systems and processes were newly implemented and required further work to ensure the Board was fully sighted on key risks presented in the data.

Leaders and staff engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They worked with partner organisations to help improve services for patients.

The trust understood quality improvement methods and the skills to use them however some quality improvement priorities had not been achieved and were yet to be fully embedded.

How we carried out the inspection

The inspections of the trust's core services were led by a CQC operations manager and supported by eight CQC inspectors, one CQC regulatory officer, a CQC inspection planner and eight specialist professional advisors.

The inspection of the well-led key question (the trust's senior leadership and governance) was led by a CQC Deputy Director of Operations and supported by an operations manager, one CQC inspector, one CQC regulatory officer and an inspection planner. The team also received support from four specialist professional advisors and executive reviewers with a background and experience in NHS senior management.

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

Outstanding practice

We found the following outstanding practice:

Trust wide

Our findings

- The trust had been recognised nationally with its introduction of Magseed and Magtrace to help improve the accuracy and timeliness of breast tumour surgery. Clinicians were able to use a magnetic probe to guide them to the exact location of the tumour, allowing its extraction. This resulted in minimal removal of breast tissue.
- Over the course of 2023 the trust commissioned the dementia bus to come to all hospital sites to provide experiential learning to staff on living with dementia. Over 200 colleagues undertook the experience, 72 colleagues attended a similar experience in the learning disability bus.
- The trust had a nurse colposcopist who offered a staff smear service, with appointments available on site for colleagues to access.
- In partnership with South Yorkshire Police and Crime Commissioner (Doncaster) the trust had funded 2 domestic abuse liaison officers, they have worked collaboratively across the trust improving outcomes and sharing learning. They have supported the creation of a network of domestic abuse champions.

UEC Doncaster

- The service was a project lead for health inequalities at the trust. As such they had a public health consultant for health inequalities based onsite undertaking work around training and awareness for staff. For example, one training provider had supported quality improvement work with a focus on health inequalities to better address these across all their patient groups. At the time of our inspection leads were discussing how to link this internal work with their system partners.

Areas for improvement

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

Action the trust MUST take to improve:

We told the trust that it must take action to bring the following services into line with legal requirements.

Trust wide

- The trust must ensure staff feel supported to speak up by seeking and acting on feedback from relevant persons or other persons on the service provided in the carrying on of the regulated activity, for the purpose of continually evaluating and improving such services. The Trust Board must have effective oversight of all Freedom to Speak Up actions. **Regulation 17(2)(e)**
- The trust must ensure there are effective systems and processes to identify where quality and safety are being compromised and to respond appropriately and without delay. It must ensure it improves its clinical audit processes and systems. It must continue to improve governance processes in particular the senior oversight of risk, quality of data and the management of risk. **Regulation 17(1)(2)(a)**

Doncaster Royal Infirmary

Urgent and Emergency Care

Our findings

- The trust must ensure staff receive appropriate support, training, and appraisal as is necessary to enable them to carry out the role they are employed to perform. **Regulation 18(2)(a)**
- The trust must ensure staff follow infection control principles such as hand hygiene and bare below the elbows. **Regulation 12(2)(h)**
- The trust must ensure clinical areas are kept clean, cleaning records are up-to-date and staff clean equipment after patient contact, and label equipment to show when it was last cleaned. **Regulation 15 (1)(a)(e)**
- The trust must ensure it meets the requirements of relevant legislation and trust policy so that equipment is properly, used, maintained, and stored. **Regulation 15(1) (d)(e)**
- The trust must ensure the service's medical and nursing staff match the planned numbers. They must also ensure the service has enough medical staff with appropriate skill mix on each shift. **Regulation 18 (1)(2)(a)**
- The trust must ensure staff follow the proper and safe management of medicines, and the service uses systems and processes to prescribe and administer medicines safely. **Regulation 12 (2)(g)**
- The trust must ensure it maintains 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. This should include allergy status and the issuing of a warning wrist band when allergies have been disclosed, and complete recording of patient fluid and nutrition charts. **Regulation 17(2)(c)**
- The trust must ensure the service has effective systems and processes to assess, monitor and improve the quality and safety of the services provided in carrying on of the regulated activity. Where risks are identified the trust must have measures to reduce and remove the risks within a timescale that reflects the level of risk and the impact on people using the service. **Regulation 17(1)(2)(a)(b)**

Medicine

- The trust must implement effective systems and processes to ensure all nursing and medical staff are compliant with mandatory training, including but not limited to, safeguarding vulnerable adults and children, to a level appropriate for their role. **Regulation 18(2)(a)**
- The trust must ensure it has enough nursing, medical and support staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. **Regulation 18(1)**
- The trust must ensure the proper and safe management of medicines. **Regulation 12 (2)(g)**
- The trust must ensure substances hazardous to health are always stored securely, in accordance with Control of Substances Hazardous to Health Regulations 2002 and trust policy. **Regulation 15(1)(a)**
- The trust must ensure there is an effective process in place for ensuring equipment is in date and safety checked. **Regulation 15(1)(e)**
- The trust must ensure it improves appraisal rates in line with trust targets. **Regulation 18(2)(a)**
- The trust must ensure there are effective systems and processes to identify where quality and safety are being compromised and to respond appropriately and without delay. **Regulation 17(1)(2)(a)**

Surgery

- The trust must ensure that all staff particularly medical staff complete mandatory training in line with trust policy. **Regulation 18 (2)(a)**

Our findings

- The trust must ensure that all staff particularly medical staff complete safeguarding training relevant to their role. **Regulation 18 (2)(a)**
- The trust must ensure that staff adhere to uniform and Infection, Prevention, and Control policies in relation to bare below the elbows. **Regulation 12 (2)(h)**
- The trust must ensure it meets the requirements of relevant legislation and trust policy so that equipment is properly, used, maintained, and stored. **Regulation 15(1) (d)(e)**
- The service must ensure premises and environment are safe and secure. This includes but is not limited to ensuring storeroom doors are not left open or unlocked and COSHH cleaning chemicals and oxygen cylinders are safely stored. **Regulation 12 (1)(2)(d).**
- The service must ensure that appropriate malnutrition universal screening tool (MUST) risk assessments are completed and recorded for patients who required support. **Regulation 12 (1) (2) (a) (b)**
- The trust must ensure that all staff understand the trusts incident reporting system and that incidents are reported consistently and appropriately. **Regulation 12 (2)(b)**
- The trust must ensure risks in services are appropriately recorded, assessed, and regularly reviewed. **Regulation 17 (1) (2) (a)**
- The service must implement an effective system to monitor and improve compliance with medical appraisals and revalidation**. Regulation 17 (1) (2) (a)**
- The service must implement an effective process to manage, monitor and record the ambient temperature of rooms which store fluids and medication. **Regulation 17 (1) (2) (a)**

Maternity

- The trust must ensure that persons providing care or treatment to service users have the qualifications, competence, skills, and experience to do so safely. **Regulation 12 (1)(2) (c)**
- The trust must ensure that community staff are suitably trained for home birth emergencies. **Regulation 12 (1)(2)(c)**
- The trust must ensure that staff receive practical training sessions in the use of hoists and written guidance on hoist use in clinical areas. **Regulation 12 (1)(2)(b)**
- The trust must ensure that the storage of control of substances hazardous to health (COSSH) products is secure. **Regulation 15(1)(a)**
- The trust must ensure the proper and safe management of medicines. **Regulation 12 (1)(2)(g)**
- The trust must ensure ambient room temperatures are monitored and recorded in all room's medicines are stored. **Regulation 12 (1)(2)(g)**
- The trust must ensure that daily checks of emergency boxes for hypoglycaemia, cord prolapse, sepsis and pre-eclampsia take place as policy. **Regulation 12 (1)(2)(g)**
- The trust must ensure that the missing emergency medicine from each box is replaced. **Regulation 12 (1)(2)(g)**
- The trust must ensure that sharps bins are dated and signed on opening. **Regulation 12 (1)(2)(g)**
- The trust must ensure that oxygen is prescribed by a specialist practitioner after a clinical review and documented on the prescription chart. **Regulation 12 (1)(2)(g)**
- The trust must ensure that oxygen and Entonox cylinders are stored securely. **Regulation 12 (1)(2)(g)**

Our findings

- The trust must ensure that tamper proof seals and medicines lists are present in all the separate boxes used for specific conditions. **Regulation 12 (1)(2)(g)**
- The trust must ensure that medicines are stored in secure environments and that all entry/exit and cupboard doors are locked. **Regulation 12 (1)(2)(g)**
- The trust must assess, monitor, and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. **Regulation 17 (1)(2)(b)**
- The trust must ensure they have enough staff with the right qualifications, skills, training, and experience to keep women safe from avoidable harm and to provide the right care and treatment. **Regulation 18 (12)(a)**

Bassetlaw District General Hospital

Urgent and Emergency Care

- The trust must ensure staff receive appropriate support, training, and appraisal as is necessary to enable them to carry out the role they are employed to perform. **Regulation 18(2)(a)**
- The trust must ensure it meets the requirements of relevant legislation and trust policy so that equipment is properly used, maintained, and stored. **Regulation 15(1) (d)(e)**
- The trust must ensure clinical areas are kept clean, cleaning records are up-to-date and staff clean equipment after patient contact, and label equipment to show when it was last cleaned. **Regulation 15 (1)(a)(e)**
- The trust must ensure staff follow the proper and safe management of medicines, and the service uses systems and processes to prescribe and administer medicines safely. **Regulation 12 (2)(g)**
- The trust must ensure the service has enough medical staff, and always has a good skill mix of medical staff on each shift. **Regulation 18 (1)(2)(a)**
- The trust must ensure staff follow infection control principles such as hand hygiene and bare below the elbows. **Regulation 12(2)(h)**
- The trust must ensure staff complete, record, and monitor daily checklists for all adult and child emergency resuscitation trolley equipment across the department so it is safe to use. **Regulation 12(2)(e)**
- The trust must ensure the mental health assessment room has environmental risk assessments completed and signs informing patients and the public closed-circuit television (CCTV) is in use. **Regulation 15(1)(b)**
- The trust must ensure the service has effective systems and processes to assess, monitor and improve the quality and safety of the services provided in carrying on of the regulated activity. Where risks are identified the trust must have measures to reduce and remove the risks within a timescale that reflects the level of risk and the impact on people using the service. **Regulation 17(1)(2)(a)(b)**

Medicine

- The trust must implement effective systems and processes to ensure all nursing and medical staff are compliant with mandatory training. **Regulation 18(2)(a)**
- The trust must ensure it has enough nursing, medical and support staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. (Regulation 18(1))
- The trust must ensure the proper and safe management of medicines. **Regulation 12 (2)(g)**

Our findings

- The service must implement an effective process to manage, monitor and record the ambient temperature of rooms which store medication. **Regulation 17 (1) (2) (a)**
- The trust must ensure substances hazardous to health are always stored securely, in accordance with Control of Substances Hazardous to Health Regulations 2002 and trust policy. **Regulation 15(1)(a)**
- The trust must ensure there is an effective process in place for ensuring equipment is in date and safety checked. **Regulation 15(1)(e)**
- The trust must ensure it improves appraisal rates in line with trust targets. **Regulation 18(2)(a)**

Surgery

- The trust must ensure that all staff particularly medical staff complete mandatory training in line with trust policy. **Regulation 18 (2)(a)**
- The trust must ensure that all staff particularly medical staff complete safeguarding training relevant to their role. **Regulation 18 (2)(a)**
- The trust must ensure that staff adhere to uniform and Infection, Prevention, and Control policies in relation to bare below the elbows. **Regulation 12 (2)(h)**
- The trust must ensure it meets the requirements of relevant legislation and trust policy so that equipment is properly, used, maintained, and stored. **Regulation 15(1) (d)(e)**
- The service must ensure premises and environment are safe and secure. This includes but is not limited to ensuring storeroom doors are not left open or unlocked and COSHH cleaning chemicals are safely stored. **Regulation 12 (1)(2)(d).**
- The trust must ensure that all staff understand the trusts incident reporting system and that incidents are reported consistently and appropriately. **Regulation 12 (2)(b)**
- The trust must ensure risks in services are appropriately recorded, assessed, and regularly reviewed. **Regulation 17 (1) (2) (a)**
- The service must implement an effective system to monitor and improve compliance with medical appraisals and revalidation**. Regulation 17 (1) (2) (a)**
- The service must implement an effective process to manage, monitor and record the ambient temperature of rooms which store fluids and medication. **Regulation 17 (1) (2) (a)**

Maternity

- The trust must ensure that persons providing care or treatment to service users have the qualifications, competence, skills, and experience to do so safely. **Regulation 12 (1)(2)(c)**
- The trust must ensure that patients are prioritised based on risk or condition when being seen in the maternity day assessment unit so that patients who present with the highest risks are seen first. **Regulation 12(1) (2) (a)(b)**
- The trust must ensure they have enough staff with the right qualifications, skills, training, and experience to keep women safe from avoidable harm and to provide the right care and treatment. **Regulation 18 (12)(a)**
- The trust must ensure that staff receive practical training sessions in the use of hoists and written guidance on hoist use in clinical areas. **Regulation 12 (1)(2)(b)**

Our findings

- The trust must ensure that there is out of hours senior support in place for community midwives and community staff are suitably trained for home birth emergencies. **Regulation 12 (1)(2)(b)**
- The trust must assess, monitor, and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. **Regulation 17 (1)(2)(b)**

Montagu Hospital, Mexborough

Urgent and Emergency Care

- The trust must ensure all nursing staff complete mandatory and safeguarding training modules relevant to their role as per trust policy to meet target. This must include training in the Mental Capacity Act or Deprivation of Liberty Safeguards. **Regulation 18 (1)(2)(a)**
- The trust must ensure staff keep all daily cleaning records and (fire and defibrillator) safety checks up to date. **Regulation 12 (2)(b)**

Medicine

- The trust must implement effective systems and processes to ensure all nursing and medical staff are compliant with mandatory training, including but not limited to, safeguarding vulnerable adults and children, to a level appropriate for their role. **Regulation 18(2)(a)**
- The trust must ensure it has enough nursing, medical and support staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. **Regulation 18(1)**
- The trust must ensure the proper and safe management of medicines. **Regulation 12 (2)(g)**
- The trust must ensure substances hazardous to health are always stored securely, in accordance with Control of Substances Hazardous to Health Regulations 2002 and trust policy. **Regulation 15(1)(a)**
- The trust must ensure there is an effective process in place for ensuring equipment is in date and safety checked. **Regulation 15(1)(e)**
- The trust must ensure it improves appraisal rates in line with trust targets. **Regulation 18(2)(a)**

Surgery

- The trust must ensure that staff adhere to Infection, Prevention, and Control policies in relation to cleanliness. **Regulation 12 (2)(h)**
- The trust must ensure it meets the requirements of relevant legislation and trust policy so that equipment is properly, used, maintained, and stored. **Regulation 15(1) (d)(e)**
- The service must ensure premises and environment are safe and secure. This includes COSHH cleaning chemicals being safely stored. **Regulation 12 (1)(2)(d).**
- The trust must ensure risks in services are appropriately recorded, assessed, and regularly reviewed. **Regulation 17 (1) (2) (a)**
- The service must implement an effective process to manage, monitor and record the ambient temperature of rooms which store fluids and medication. **Regulation 17 (1) (2) (a)**

Retford Hospital

Our findings

Diagnostic Imaging

- The trust must ensure that all staff know the emergency procedures that are in place for patients who may deteriorate. **Regulation 12(1)(2)(b)**
- The trust must ensure that there is a resuscitation trolley available to staff in case of emergency. **Regulation 15 (1) (f)**

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure it continues to operate effective systems to respond to complaints and take appropriate action without delay to any failures identified by a complaint or the investigation of a complaint.
- The trust should ensure it continues to roll out the Oliver McGowan statutory learning disability and autism training or equivalent.
- The trust should ensure it continues to improve diversity and equality at Board level.
- The trust should ensure it continues to complete the work needed to meet the requirements for the Accessible Information Standards.
- The trust should consider a review of the timescales for Disclosure and Barring (DBS) re-checks for executive and non-executive directors to be undertaken sooner than every 10 years.

Doncaster Royal Infirmary

Urgent and Emergency Care

- The trust should ensure staff always maintain patient's privacy, dignity, and confidentiality particularly in public areas.
- The trust should ensure it has effective processes to engage with staff particularly medical staff actively and openly.
- The trust should consider a standard operating procedure (SOP) for patients on the ambulatory pathway with clear guidance to follow.

Medicine

- The trust should ensure staff fully and accurately complete patients' fluid balance charts.
- The trust should ensure it always keep records secure.
- The trust should consider ways to improve the provision of ward meetings to share learning from incidents.
- The trust should have an effective process to review performance and manage risks at each hospital site.
- The trust should have an effective process to review performance and manage risks at each hospital site.

Surgery

- The trust should ensure that medicine audits are completed within timescales in line with trust policy.
- The trust should ensure that capacity assessments and best interest decisions are followed and recorded in line with legislation.

Our findings

- The trust should continue to ensure that complaints are responded to in line with timescales set out in the trust policy.
- The trust should ensure that refrigerator checks are consistently undertaken in line with trust policy.

Maternity

- The trust should ensure that legionella action plans for the antenatal clinic are in place and updated so any actions identified are responded to quickly.
- The trust should ensure that legionella testing records confirm actions taken should legionella be present.
- The trust should ensure that all equipment is serviced within its next service date.
- The trust should ensure that all resuscitation checklists include the name of the location and type of equipment named.
- The trust should ensure senior midwives and managers are visible on the clinical areas.
- The trust should ensure that all staff groups are aware of the freedom to speak up guardians and who they are across the trust sites.
- The trust should ensure a standard operating procedure is available for staff to refer to when fentanyl is drawn up by staff.

Diagnostic Imaging

- The trust should continue to ensure all staff complete mandatory training in line with trust policy.
- The trust should continue to ensure that all staff complete safeguarding training relevant to their role.
- The trust should ensure that all policies are reviewed within the review period set out in the policy.

Bassetlaw District General Hospital

Urgent and Emergency Care

- The trust should ensure it has effective processes to engage with staff particularly medical staff actively and openly.
- The trust should ensure staff always maintain patient's privacy, dignity, and confidentiality particularly in public areas.

Medicine

- The trust should ensure staff fully and accurately complete patients' fluid balance charts.
- The trust should ensure it always keep records secure.
- The trust should consider ways to improve the provision of ward meetings to share learning from incidents.
- The trust should have an effective process to review performance and manage risks at each hospital site.
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Surgery

- The trust should ensure that medicine audits are completed within timescales in line with trust policy.

Our findings

- The trust should ensure that capacity assessments and best interest decisions are followed and recorded in line with legislation.
- The trust should continue to ensure that complaints are responded to in line with timescales set out in the trust policy.
- The trust should ensure that refrigerator checks are consistently undertaken in line with trust policy.

Maternity

- The trust should ensure that legionella testing records confirm what actions were taken when legionella was present.
- The trust should consider storing the resuscitaire which is currently stored in the bereavement room in another cupboard outside of this room.
- The trust should ensure the birthing pools evacuation nets are serviced in line with manufacturer's instructions.
- The trust should ensure that all equipment is serviced within its next service date.
- The trust should ensure that clear guidance is in place to ensure pigeons do not enter birthing rooms.
- The trust should ensure that I am clean stickers are dated.
- The trust must ensure that all clinical guidance is current.
- The trust should ensure written revalidation guidance is in place for staff to follow.
- The trust should ensure a standard operating procedure is developed for the management of Fentanyl use as bolus doses.
- The trust should ensure staff report incidents following their occurrence.
- The trust should ensure that confidentiality is maintained when conversing with women and their families.
- The trust should ensure that senior midwives and managers are visible on the clinical areas.
- The trust should ensure that K2 technology is updated with national updates as soon as they are released.

Diagnostic Imaging

- The trust should continue to ensure that all staff complete safeguarding training relevant to their role.
- The trust should ensure that all policies are reviewed within the review period set out in the policy.
- The trust should ensure that all policies are reviewed within the review period set out in the policy.

Montagu Hospital, Mexborough

Urgent and Emergency Care

- The trust should ensure the MIU ambulance/resuscitation room is protected from flood risk and does not prevent patients who need emergency care from accessing treatment onsite.
- The trust should ensure the rear door magnetic locks are installed promptly to ensure safety of people who use the service and staff.
- The trust should ensure UTC signage inside and outside the building is correct and up to date.

Our findings

Medicine

- The trust should ensure staff fully and accurately complete patients' fluid balance charts.
- The trust should ensure it always keep records secure.
- The trust should consider ways to improve the provision of ward meetings to share learning from incidents.
- The trust should have an effective process to review performance and manage risks at each hospital site.
- The trust should have an effective process to review performance and manage risks at each hospital site.

Surgery

- The trust should ensure that refrigerator checks are consistently undertaken in line with trust policy.

Diagnostic Imaging

- The trust should continue to ensure that all staff complete safeguarding training relevant to their role.
- The trust should ensure that all policies are reviewed within the review period set out in the policy.
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Retford Hospital

Diagnostic Imaging

- The trust should continue to ensure all staff complete mandatory training in line with trust policy.
- The trust should continue to ensure that all staff complete safeguarding training relevant to their role.
- The trust should ensure that all policies are reviewed within the review period set out in the policy.
- The trust should ensure all equipment is safety tested in line with guidance.
- The trust should ensure there is water available to patients in the waiting areas.
- The trust should ensure there is hand gel available prior to entering the department at Retford Hospital.
- The trust should ensure that chaperone trained staff are available for patients who require a chaperone.
- The trust should ensure there are clear and available cleaning records in place.

Is this organisation well-led?

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

Leadership

The trust leadership team showed adequate experience, knowledge, skills, and abilities to lead the trust. They were aware that the leadership team was newly formed and there was further work needed to build a cohesive and unitary board. They understood the priorities and issues the trust faced however there were recent changes to organisational structures which would take time to embed.

Our findings

The board were visible and approachable in the trust for patients but not always for staff. They supported staff to develop their skills and take on more senior roles.

Since 2021 there had been a high turnover of executive directors due to promotions and personal reasons, the trust had recruitment gaps for the chief nurse, chief operating officer and chief people officer. This had a significant impact on the stability of the board where existing executive directors were holding large and varied portfolios and were unable to effectively function at pace.

From mid-2022 and January 2023 the trust had fully recruited to these positions, and it was felt the depth of experience was beginning to bring stability and balance to the board.

The chief executive officer (CEO) had been in post since 2017. The CEO was experienced with a background in senior executive nursing and management roles.

Executive directors had varied portfolios. The chief nurse had been in post since January 2023 and had made changes to the nursing structure strengthening leadership support by appointing a deputy chief nurse and 2 associate chief nurses for patient safety and quality and safe staffing.

There was currently an acting executive medical director. They were supported by 2 associate medical directors for clinical safety and professional standards. There were also medical directors for workforce and operational stability and optimisation.

The trust's chief finance officer had been in post since 2016. Due to the vacancy gaps at executive level, there had been interim management arrangements. The chief finance officer had again taken on this responsibility from early 2023 alongside responsibilities for recovery, innovation, and transformation.

To ensure additional board capacity a new deputy chief executive officer started in October 2023 with a focus on governance and strategic partnerships.

The trust leadership team had knowledge of current priorities and challenges across the trust and were implementing plans to address them. Work was continuing to streamline portfolios to ensure effective joint working. Non-executive and executive directors were clear about their areas of responsibility. However, directors acknowledged there was further work to do to build and embed a cohesive team and unitary board.

The board was not representative of colleagues from an ethnic or disability background. Board members acknowledged that the board lacked diversity in these areas. The trust had implemented a Board Development Delegate Programme (currently advertising for cohort 2) and second cohort of the reciprocal mentoring programme to address increased diversity in senior leadership. Further work was required to ensure the Board was representative of the population it served.

The trust chair had been in post since 2017 and was in the final term of office. Relationships between the chair and CEO were described as strong based on trust and challenge. The chair met with executives and staff often and directly.

There were 7 non-executive directors (NEDs), 4 of which had been recruited in the last 15 months. The NEDs had a range of leadership experience in the sectors of health, finance, and business. The NEDs chaired several trust committees, which reported to the trust board.

Our findings

The recruitment and induction of NEDs was positive. There was a considered approach to the skill set requirements when new NEDs were recruited.

Non-executive directors reported that relationships with the executives were supportive and there was sufficient challenge and influence to drive improvements. They were clear about their roles and responsibilities.

There was a programme of board visits to services. Directors spoke positively about their walkarounds which resulted in feedback from patients and staff to the board.

There was time set aside for board development which included sessions on the trust's future ambitions and key objectives. Governors and NEDs held joint development sessions which covered a range of training.

There was a clinical directors development program which focused on technical and leadership skills.

The trust operated through divisional teams. From April 2023 the divisions increased from four to five, creating an Urgent and Emergency Care (UEC) division, with cancer services being managed centrally. The trust had recruited a GP to the UEC divisional leadership team and a new divisional director for surgery.

We spoke with the divisional leads who had awareness of the challenges, including, workforce, performance, and finance. The leads acknowledged periods of uncertainty due to the gaps in the executive leadership but felt things were improving and becoming more streamlined with the new appointments.

Relationships between the governors and the Board were described as good. The governors were satisfied with their induction, training and information received from the trust. They felt they were included in decisions and attended Board meetings where they provided feedback.

As part of our well led inspection, we observed the public board meeting on 26 September 2023. The chair allowed members to engage and apply scrutiny to agenda items. Those attending were able to seek assurance and there was sufficient challenge on the key areas of risk. The trust had acknowledged the high-level feedback given by the CQC following the recent site inspection visits and informed the Board that action was being taken about the concerns we had raised.

Fit and Proper Persons Regulation (Directors)

The trust was compliant with the requirements of the Fit and Proper Persons Regulation. The trust had a standard operating procedure to support compliance with this regulation. The standard operating procedure established the checks required for all directors at the point of recruitment and the ongoing checks which were to be carried out to ensure directors continued to be fit and proper for their roles.

The standard operating procedure included a requirement for all directors to undertake a check with the disclosure and barring service at the point of recruitment and to have a recheck every ten years. Directors' files showed that the recruitment process for directors were in line with guidance.

All directors had received an appraisal within the last year, had undertaken an annual declaration of interests and had an up-to-date check with the disclosure and barring service in line with the trust's standard operating procedure. Directors received 360 feedback at least every couple of years and had monthly one to one meetings with the CEO.

Our findings

Vision and Strategy

The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Some enabling strategies were under review and newly developed. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had a vision and set of values with quality and sustainability as the top priorities. The vision was to be the 'Safest Trust in England, outstanding in all that we do'. The trust's values had not changed since the previous inspection and were designed to form the acronym 'We Care'.

The trust embedded its vision, values and strategy in corporate information received by staff.

The trust had recently updated and launched its Nursing, Midwifery and Allied Health Professional Quality Strategy 2023-2027 which identified new trust priorities and areas for improvement to ensure the trust delivered good quality sustainable care.

The new strategy had six key priorities for improvement for 2023/23 and adopted the same definitions of quality as the National Quality Board namely safe, effective, positive experience, well led, sustainably sourced and equitable.

The strategy had been produced with stakeholders across and external to the trust including patients. It was aligned with the trust vision and complimented the intentions of the Integrated Care System. There were several operational delivery plans to deliver the strategy.

The trust did not have a separate mental health or learning disability strategy. These were contained in the Nursing, Midwifery and Allied Health Professional Quality Strategy as part of the trust' commitment to caring for vulnerable patients. The trust did not have a clinical strategy but were part The South Yorkshire and Bassetlaw (SYB) Acute Federation which was made up of five acute NHS Trusts. The clinical strategy had been developed with clinicians and operational managers across the region. It set out the five-year clinical services framework for the SYB Acute Federation to support acute service development and delivery. It aligned with the wider work of the Integrated Care Board 5-year Joint Forward Plan and the South Yorkshire Integrated Care Partnership Strategy.

The impact of the trust not being included in the new hospital build programme was clear, particularly regarding the trust's approach to long term strategy and planning. There was work needed to develop and articulate the trust's future strategy and this would support the trust's identification and management of strategic risks.

The leadership team monitored and reviewed progress on delivering the strategy and local plans.

Culture

Not all staff felt respected, supported, and valued. The trust was committed to ensuring patients, their families and staff could raise concerns without fear. However, there was further work to do to ensure all staff felt safe to speak up and to ensure the Board was effectively sighted on concerns raised by staff.

Staff were focused on the needs of patients receiving care. The trust promoted equality and diversity in daily work and provided opportunities for career development.

Our findings

At a local level most, staff were positive about their departments and local leadership teams; they were able to speak to local leaders about difficult issues when things went wrong.

Colleagues respected one another to achieve the desired outcomes for patients, relatives, and carers. All staff were committed to improving the quality of care and patient experience.

However, during our discussions with staff groups not everyone felt respected supported and valued. We had received several whistleblowing concerns where employees felt a lack of respect, listening and 'compassionate leadership' from the trust. Staff in areas where there were greater pressures, due to challenges recruiting staff, financial restraints, and patient demand, felt less supported and listened to by the senior leadership.

There was a Freedom to Speak Up (FTSU) policy. The FTSU guardian worked 20 hours per week and had recently committed to an additional 10 hours to support the roll out of the Speak Up Partners support and trust wide Just Culture work. The guardian worked to the National Guardians Office job description and was up to date with training and development.

The FTSU guardian reported to the executive lead for FTSU (Chief People Officer) with support from the CEO and non-executive director for FTSU. Bi-monthly reports were presented to the People Committee and the Board by the FTSU guardian. These reports followed the national board reporting template provided in the NHSE and NGO guidance on reporting to boards. An annual report was presented at the Board.

Formal meetings were held monthly, the guardian had open access to the CEO and executive lead for speaking up to discuss any concerns that required escalation, executive input, or support. The FTSU guardian linked in with regional and national networks to share good practice and learning.

The trust had a FTSU Governance Group known as the Speak Up Forum. This met bi-monthly to consider national and local strategic context in relation to FTSU.

The trust also had FTSU partners who were staff working in departments and areas including HR, estates, quality improvement, staff side, and patient safety. The trust's process encouraged staff to raise concerns directly with partners, so they had a choice in who to talk to, as well as the FTSU guardian. The intention of this was to ensure staff received a quicker resolution to their concerns. The guardian and partners met every other month to discuss the themes and trends from concerns raised by staff.

The July 2023, FTSU bi-annual report to the Board showed 45 cases were raised with the guardian during April 2022 - March 2023 compared to 79 cases in 2021/2022. The most frequently stated reasons for contacting FTSU were concerns about patient safety, worker safety and wellbeing, inappropriate behaviour and systems and processes.

However, as the trust's process encouraged staff to approach the FTSU partners rather than the guardian in the first instance, the report did not include the details of concerns raised directly to the partners. The trust did not have a process to capture these concerns centrally. This meant the Board were not fully sighted on the numbers of concerns raised by staff through the trust's FTSU process. Following the inspection, the trust informed us they were undertaking further work to triangulate themes from concerns raised through different routes.

During the inspection most staff said they were aware of how to contact FTSU. However, we received several enquiries from staff who shared their negative opinion of speaking up, as such there was further work needed to ensure all staff felt safe to speak up.

Our findings

The trust 2022 staff survey results showed the response rate was 65.2% which was 21% higher than similar organisations. The trust scored significantly higher than the sector average in 5 out of 7 NHS People Promise questions.

In comparison with results in 2021, the trust was significantly better on two themes: 'We are always learning' and 'We are a team' with no significant difference for the remaining seven themes. There were no themes where the trust had scored significantly worse than the sector or significantly worse compared to last year's results.

The trust recognised there were still areas for improvement and further development. The results had been shared with divisional teams. The People Committee had oversight of improvement plans at a divisional level.

The trust completed the annual data reporting for the Workforce Race Equality Standards (WRES) and the Workforce Disability Equality Standards (WDES) for 2023/23. A summary of headlines, improvements and areas for continued development was reported to the Board in July 2023. The trust's EDI action plan had been refreshed to align with the six actions to address discrimination introduced nationally by NHS England.

The WRES data showed minimal or no change in the number of employees who were not from a clinical background declaring an ethnicity across the different bands of workforce. Similarly, WDES data showed minimal or no change in the number of employees declaring a disability across the workforce.

The staff survey 2022 showed the trust scored 5.8% against the sector score of 9.6% for the question. In the last 12 months, I have personally experienced discrimination at work from a manager / team leader or other colleagues. For the question I think that my organisation respects individual differences (e.g., cultures, working styles, backgrounds, ideas, etc) the trust scored 72% against the sector score of 67%.

The trust had an equality, diversity, and inclusion (EDI) network with a range of representation. There were also a number of staff networks which had a programme of bi-monthly meetings. The EDI lead was developing a stakeholder network forum where people with protected characteristics could meet with the executive team and raise questions and concerns. EDI walkabouts took place to enable people to have discussions and feel inclusive. Diversity and inclusion were reported at the People Committee.

Non-Executive Directors were positive about the culture of the organisation. They had a good working relationship with the CEO and other executive directors.

The trust had completed staff engagement sessions on developing a new Leadership Behaviours Framework. This was aligned with the trust's 'True North' strategic objectives and values.

There was a workstream led by the people, organisational development, and patient safety teams on Just Culture. There were 6 workstreams, including patient safety, employee relations, training and development and engagement and feedback. There were several planned actions, which were being monitored through the Just Culture Steering Group.

Staff in frontline services knew about the Duty of Candour and how to apply it in practice. As part of our inspection, we reviewed 6 serious incident investigations completed by the trust. The trust applied the Duty of Candour correctly in each of the records.

There were opportunities for career development and progression. The trust scored 63% compared to the sector score of 54% for the question My organisation acts fairly about career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability, or age.

Our findings

We met with the guardian of safer working. This role was introduced nationally to protect patients and doctors by making sure doctors were not working unsafe hours. The guardian was allocated 2 PAs a week in their job plan for the role.

The guardian's clinical role had moved outside of the trust which made it difficult to engage with the trainees and have a presence on the wards. The trust was in the process of splitting the role with a new deputy who would be physically present in the trust. The post was out to advert at the time of our inspection.

There was a junior doctors' forum with good attendance from all specialities. The guardian reported good relations with the medical director and chief people officer.

Overall, there was a low number of exception reports however the guardian reported trainees felt they could report concerns. The main themes were about gaps in medical rotas, but this had improved since the percentage of unfilled posts had reduced.

A quarterly report showing themes and trends was presented to the Board and to the Local Negotiating Committee.

Governance

Governance processes were not robust and did not always give board assurance. However, leaders were improving governance processes, throughout the trust and with partner organisations. There were areas identified for improvement in governance frameworks and controls. Most staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The trust had structures, systems, and processes to support the delivery of its strategy including board committees, divisional committees, and team meetings. There was an established set of board committees and arrangements for reporting to the Board.

Papers for board meetings and other committees were of a reasonable standard and contained appropriate information. Work was continuing to improve the quality of data to the Board.

The company secretary had been in post since 2020. They had good oversight of the board assurance framework (BAF) and were responsible for organising the board papers and committees.

However, an external audit report for 2022/2023 gave moderate assurance with areas for improvement in the framework of governance, risk management and control and that some inconsistent application of controls put the achievements of the organisation's objectives at risk. The trust was taking action to address these areas.

The BAF was being reviewed following the report by internal auditors to provide greater focus on strategic risks. It identified risks to the implementation of the trust's strategy and was linked to relevant corporate risks. The framework was supplemented by a corporate risk register which captured significant risks and reported to the Board. Relevant sections of the BAF were allocated to each of the board committees for review with a focus on gaps and remedial action.

The trust's Risk Appetite Statement for 2022/23 outlined the level of risk the trust was willing to take to achieve its objectives. There was 1 low risk, 4 high and 1 significant risk. With the revised BAF a Board workshop had been scheduled to review and assess the trust's current risk appetite and this would be completed annually.

Our findings

There were arrangements for financial governance and controls. Assurance systems were reviewed by internal and external auditors. The financial plans were overseen by the Finance and Performance Committee and through the Board in workshops and formal Board meetings.

The Audit and Risk Committee was chaired by a non-executive director. This committee was responsible for providing assurance to the Board on the trust's system of internal control through independent review of corporate governance and risk management arrangements. The Audit Committee reviewed its effectiveness with input from the trust's internal and external auditors.

The chief finance officer was, Interim Director of Recovery, Innovation and Transformation. The trust had established a Transformation and Recovery Board to strengthen the oversight of delivery of the transformation programmes. There was engagement with the integrated care system to identify transformation and development opportunities which enhanced the services for Doncaster and Bassetlaw communities and staff. Transformation programmes included the Bassetlaw Emergency Village and the Montagu Elective Orthopaedic Centre.

Performance against the corporate objectives 2023/24 was reviewed every 3 months by the Board. The objectives were aligned to the trust's strategic aims. The July 2023 report showed quarter 1 objectives were all in progress.

Partnerships were beginning to be embedded and strengthened with the ICS and other national work programmes. Executive and non-executive directors were engaged in wider system developments. Leaders understood the benefits of system wide working to improve patient care for people across the Doncaster and Bassetlaw area.

There were changes in governance structures to streamline workforce planning. A new Workforce Education and Training Committee chaired by the People Officer met in June 2023 to oversee workforce planning and development. This committee was developed to streamline and amalgamate the previous Training and Education Committee and Workforce Planning Committee.

The trust had a quality learning disability steering group which met quarterly. The group reviewed complaints, incidents, learning disability mortality reviews. This information was used to improve services for people living with a learning disability and autistic people.

During the core service inspection staff said they understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team.

Management of risk, issues, and performance

Leaders and teams did not always use systems to manage performance effectively. There were areas of risk where assurance processes were not effective, and work was continuing to develop these. Clinical audit processes were inconsistent in their implementation and impact. The trust had plans to cope with unexpected events.

During the inspection we identified several areas of risk where there was work in progress or a need for further development. An example was the trust's training compliance for child safeguarding which had consistently sat at less than 60% and where there did not appear to be a sense of urgency. Similarly, adherence to the Mental Capacity Act had only recently become a priority for the trust.

The trust had introduced a system to monitor action plans across the trust.

Our findings

The trust systems for clinical audit assurance were not effective. Directors acknowledged there was a need for improvements to the trust's approach in this area. This was supported by an external governance clinical audit review in June 2023 which reported limited assurance. During the inspection we found there were some areas of care which were not currently audited effectively including safeguarding practice and sepsis care.

The trust was carrying out a deep dive in response to clinical audit delivery with key performance metrics, including reliability and validity of audit results and any risks associated with the current non-compliance.

The trust did not investigate serious incidents within the timeline required by the current national guidance of sixty days. This risked further incidents due to the length of time taken to complete investigations and identify lessons learnt from incidents.

We reviewed six serious incident reports including one incident which was classified as a never event. None of the incident investigations had been completed within the sixty-day timescale with the time taken to complete investigations ranging from the shortest at 99 days to the longest at 543 days.

Due to capacity issues in the investigation team, the trust had implemented a 'stop the clock' on some historic incidents there were no incidents of this nature at the time of inspection.

The trust's investigation reports were written in plain English with medical terminology explained throughout. There was evidence of patient and family involvement in investigations, including additional questions from patients and families which had been answered in investigation reports.

All reports identified where action had been taken immediately to reduce the risk of recurrence, and all included an action plan for further improvements. However, during our inspection, we found some areas for example in urgent and emergency care and maternity where staff were not able to articulate an understanding of lessons learnt from incidents.

In maternity, we reviewed a recent incident meeting the criteria for a Healthcare Investigation Safety Branch (HSIB) referral. The review of this incident had not been completed to identify initial learning and staff could not evidence changes in practice because of the incident, including potential improvements to risk management processes.

Prior to our inspection, the trust had recognised there was a significant number of serious incident action plans which had not been fully closed, either because the actions had not been implemented, could not be evidenced, or had been superseded by actions from more recent incidents. The trust had implemented a stocktake of serious incident action plans and were addressing these issues.

The trust had a Performance Assurance Framework which was updated in August 2023. The framework set out the lines of accountability and escalation processes. This was to enable the Board to understand, monitor and assess quality and performance and act when performance against targets deteriorated.

Divisions were held to account through performance overview and support meetings which were chaired by the Chief Finance Officer. The frequency of the meetings was dependent upon the relative performance of the division.

The Risk Management Policy had been refreshed to reflect current working arrangements and feedback from internal audit. The Risk Management Board was newly established and met monthly. This was an operational group reporting to the Trust Executive Group. It was made up of the divisional directors and other appropriate members of the trust.

Our findings

Each division and department were responsible for maintaining its own risk register, which was a standing agenda item on the divisional governance team meeting. Any risks identified as 'extreme' were escalated through the Risk Management Board to the Trust Executive Group for action.

In interviews with executives and senior leaders, they reported on the trust's top risks. These included the estate, finance, long waiting lists; workforce shortages This reflected the risks identified in the BAF.

The trust was aware of the financial challenges it had as well as those of the wider system. There were plans in place to monitor and manage these financial challenges; this included developing Quality Impact Assessments to ensure patients and the local community received equitable services.

The trust's reported deficit for month 5 (August 2023) was £3.4m, which was in line with plan. Year to Date (YTD) the trust's reported deficit at month 5 was £19.8m, which was in line with plan.

The year-to-date cost improvement programme (CIP) was £6.4m of savings against the plan submitted to NHS England of £4.9m. Further work was being undertaken to identify the full year target of £22.1m. In 2022/2023 the trust delivered £19.4m of CIP savings against a planned £19.3m in-year. Currently the trust was forecasting to deliver plan at a £26.8m deficit, this was not without significant risk with a potential position of a £38.9m deficit.

The key financial risks were staffing costs, length of patient stay, theatre inefficiencies and the backlog in estate maintenance.

Overall, the trust had arrangements to enable it to plan and manage its resources with opinions from the external auditors for March 2023 reflecting this position.

The trust monitored performance by way of dashboards and key metrics. The quality dashboard was being improved to pull together data sources for quality metrics. The chief nurse was driving the use of data to provide a stronger level of assurance for patient safety.

The trust continued to experience the impact of the COVID-19 pandemic and recent industrial action regarding performance and outcomes for patients.

There were continuous challenges with bed occupancy levels which impacted on access and flow throughout the hospitals. For the period September to November 2023 the % bed occupancy including escalation beds for the trust was 98.4% which was higher than the national average of 92.8%.

In terms of elective recovery in October 2023, the 18-week consultant led referral to treatment times was 61.5% against a goal of 92%. This had deteriorated over the last few months. Also, in October 2023 there were 1420 patients who had waited more than 52 weeks. These numbers had increased compared to September 2023 where there was 1335 patients waiting over 52 weeks.

Trauma and Orthopaedics and Ear Nose and Throat had the highest number of waits. Alternate patient pathways had been explored including virtual wards and clinics and the operation of a same day emergency care provision (SDEC).

Our findings

Cancer waiting metrics, as of September 2023 included the following. The proportion of patients seen by a specialist within two weeks of GP referral were 83.6% against a target of 93%. The 62-day wait for patients referred with suspected cancer was 73.6% against a standard of 85% and 31-day treatment performance for patients was 93.6% against as standard of 96%.

Work was ongoing to strengthen clinical validation and prioritisation of patients waiting for a clinical review. There was a review of the trust policy for Clinical Harm and Standard Operating Procedures were being developed. This was being risk assessed and escalated to the Risk Management Board for monitoring.

Progress had been made with Patient Safety Incident Response Framework (PSIRF) implementation and the trust was in line with the national implementation plan for transition to the PSIRF model. Progress was monitored monthly by the PSIRF implementation group.

There were processes for mortality reviews. There were 12 medical examiners. We reviewed five examples of structured judgement mortality reviews (SJR) completed in 2022/23. The purpose of the SJR is to provide information from which local teams or the organisation can learn. This approach requires reviewers to make safety and quality judgements over phases of care.

The SJRs used the recognised headings as set out in Royal College of Physicians (2016) Using the Structured Judgement review method. The systems and processes were in line with national guidance and from the sample reviewed the processes were being followed.

However, the completion rate was described as poor. The trust was addressing this by improving clinical engagement in the SJR process and protecting time for clinicians to complete the reviews. Meeting minutes showed divisions attended the monthly mortality review group to share learning through the divisional governance processes.

A new accreditation framework had been drafted and shared widely for comments. The accreditation process linked to a quality and audit app and the planned quality dashboard, to enable triangulation of data. The draft accreditation documents were being trialled in 4 clinical areas. Peer assessment questions were being developed to ensure consistency of the peer assessment process and the full launch was planned for September 2023 when the first peer visits would take place.

The trust used the Safer Nursing Care Tool (SNCT) to inform its nursing establishments. A refresh of data was due in November 2023. The Safe Staffing Policy was also being redrafted to reflect the changes since the appointment of an Associate Chief Nurse for staffing. This would address out of date safe staffing policies, embedding of the safe staffing 'red flags' and improvements in rostering.

During 2022/2023 the trust had recruited 82 internationally educated adult nurses and 5 children's nurses. In September 2022, 65 newly qualified nurses were recruited and 80 were due to start in the trust during September and October 2023.

The chief nurse was the executive director for safeguarding adults and children. There was a safeguarding structure, but changes were being made to strengthen safeguarding resources. A new safeguarding lead had been appointed in April 2023 and 2 domestic abuse liaison officers.

Annual safeguarding reports were presented at the Board. There was external overview and collaborative working with system partners such as the police, other safeguarding teams in the 2 local authority multi agency services. Divisional leads attended the strategic safeguarding committee, and shared learning with divisions.

Our findings

There was a named lead for mental health, autism, and dementia. Acute liaison nurses for learning disabilities worked at both Doncaster and Bassetlaw. There was a system to identify when a patient with learning disabilities attended the emergency department. The trust had 100 suitably trained learning disability ambassadors from clinical and non-clinical roles. We were informed the trust did not have specific training for learning disabilities but were in the process of rolling out the Oliver McGowan statutory learning disability and autism training.

The trust was aware of the gaps and risks in safeguarding processes including uptake of training and had a workplan to address these. Work was continuing to improve audit of safeguarding practice which was identified as a key priority. Work was progressing on sexual safety.

The director of infection prevention and control (DIPC) was a microbiologist and reported to the chief nurse. The DIPC was supported by a team of senior nurses and doctors. There was representation of IPC across various governance and risk committees. The IPC Committee reported to the Patient Safety Review Group, which then reported to the Clinical Governance Committee.

The prevention of clostridium difficile infection was identified as a challenge against the nationally set thresholds for the year. The trust remained just within normal variation. At the time of inspection, the number of cases for the financial year was 25 against a reduced trajectory of 42.

All cases were reviewed by the infection prevention control team. Each division had a specific action plan and reported to the IPC Committee who had oversight. During our inspection we did observe lapses in staff complying with infection prevention and control measures. Also, some areas across the hospitals were not clean.

The IPC team reported effective partnership working across the integrated care system and with acute and community services. The team had been involved in projects to improve catheter infection and hydration to reduce the risk of Acute Kidney Injury with good outcomes.

The trust was not included in the New Hospital Programme. Resource constraints were evident in the condition of the estate and frustrations were expressed at the lack of capital for renewal of key infrastructure. There were continued challenges around the maintenance of an aging estate and compliance with the latest statutory guidance.

The Estates Director reported £74m had been invested to keep up with the backlog in maintenance. Work to develop appropriate plans and cases for funding continued and a business case was being prepared for additional capital to support the reduction of back log maintenance.

The trust was working with system partners to identify a deliverable programme of work which reduced the risk associated to the infrastructure, and provide modern, fit for purpose facilities for patients and the work force.

There were processes to monitor estate compliance. There was a structure for fire safety reporting through various committees to the Board. There was a series of ongoing planned maintenance including first alarm testing and fire compartmentation. The trust had a fire improvement plan notice and an action plan to address the requirements.

Areas of risk were included in the corporate risk register and reviewed by the Board. The Board had received an assurance report on the recent national concerns relating to reinforced autoclaved aerated concrete and were one of the first trust's to successfully remove this.

Information Management

Our findings

The trust collected data and analysed it however systems and processes were newly implemented and required further work to ensure the Board was fully sighted on key risks presented in the data. Data or notifications were submitted to external organisations. The information systems were secure.

The trust was in the process of developing an improved data driven organisation. During interviews we had feedback relating to the confidence of the Board in the data used to monitor performance, quality, and risk.

There was further work to do to make data useful, meaningful and ensure that the Board was effectively sighted on key risks presented in the data. Some of the data systems and dashboards we saw were newly implemented and required further work to fully populate and embed.

The trust had a digital strategy which had been signed off by the Board. The trust worked closely with the South Yorkshire and Bassetlaw Integrated Care System (ICS) on digital priorities, this included procurement of an integrated electronic patient record system.

The Caldicott Guardian worked with the senior information risk owner (SIRO) and processes were in place to ensure data was protected.

The trust completed the annual self-assessment tool to measure their performance against the National Data Guardian's 10 data security standards. The Data Security and Protection Toolkit Assurance report June 2023 showed there was significant risk assurance in all 10 areas.

The trust had monitoring systems to detect cyber events. There had been no downtime because of any cyber-attacks. The trust completed simulations for cyber-attacks and had done some examples of spoof spyware.

General Data Protection Regulation arrangements were embedded. Information governance systems were in place including confidentiality of patient records.

Feedback surveys were sent to people accessing the services of the trust; this captured information relating to the local population, including protected characteristics, enabling the trust to make improvements.

Data or notifications were submitted to external organisations however we had to request data several times to inform the inspection.

Engagement

Leaders and staff engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The Patient Experience Strategy was in the new Quality Strategy. This contained keyobjectives to improve patient experience alongside delivery plans and success measures.

The trust's ability to actively engage with people had been impacted by not having a patient engagement lead for a period of time. This post had now been recruited to and relationships were rebuilding with stakeholders. The lead had established links with Healthwatch and approached various community groups including the Doncaster Deaf Trust to gain feedback in trust improvement programmes.

Our findings

There were examples of service user involvement. Patient groups had been invited to walk around Bassetlaw hospital to feedback on the challenges of finding their way around the site. Also following engagement with patients on the frailty unit at Doncaster pictorial food menus had improved.

Patients and carers had opportunities to give feedback on the service they received. The CQC Adult Inpatient Survey 2022 showed the trust scored about the same as most other trusts for all 49 questions. The overall experience score was 8.1 which was about the same as other similar trusts. An action plan had been developed to address the areas of improvement.

The trust was trying to improve the response rate to the Family and Friends test. The Patient Experience Annual Report April 2022 – March 2023 showed the overall response rate was below 10%. This was significantly below the average response rate of other trusts. The trust had implemented the use of QR codes to obtain feedback from people and improve response rates.

There was further work needed for the trust to become compliant with the Accessible Information Standard (AIS). The trust had a working group to ensure implementation, the group included representation from the partially sighted society.

Some changes were completed, such as communication needs were recorded in the nursing assessment, reception area in the ophthalmology clinic was yellow with black writing for the visually impaired and IT systems included alerts for patients with communication needs. The Patient Experience and Involvement Committee were monitoring progress.

The trust had 157 volunteers. There was a recruitment and induction process for volunteers.

The patient experience team were working to maximise the contributions made by volunteers and

were actively recruiting more voluntary staff at the trust.

There were plans for winter. The trust participated in operational and surge planning across the integrated care network to develop escalation frameworks across the system.

Working in partnership with two additional trusts, the trust was leading the programme to implement a new, dedicated orthopaedic hub in South Yorkshire. In the first year of operation the centre planned to undertake approximately 2,200 orthopaedic procedures on behalf of the partner trusts, equating to about 40% of the current orthopaedic waiting list.

Staff Engagement

The trust's People Strategy 2023-2027 was aligned to the four pillars of the NHS People Plan. The strategy had been developed with staff engagement and feedback from national staff surveys. Progress against the strategy was monitored by the People Committee.

The trust's engagement score was 6.7 which was in line with other sectors. Staff satisfaction regarding motivation and involvement were similar to 2021 scores. The questions that scored in the bottom range were concerned with flexible working, discrimination on the grounds of age, discussions about team effectiveness, and changes made because of reported errors and near misses.

Our findings

The trust had developed a behaviours framework the 'DBTH Way' which was approved by the Board in May 2023. A plan was being developed to introduce and embed 'The DBTH Way' into working life at the trust, for example in recruitment, appraisals, learning and development, and induction. It was recognised that it would take some time for this to be achieved across the trust. Progress was being monitored by the People Committee.

Staff were involved in decision making about changes to trust services, for example in developing trust wide strategies and transformation plans. However, in the 2022 staff survey there was a slight decline for the questions about being able to make suggestions to make improvements and make decisions on changes that affected work/team/department compared to the sector average.

There were various engagement channels and activities. Staff had opportunities to meet with the executive team and to hear about the latest developments and ask questions. The CEO and leadership team visited areas in the trust. There were star awards recognising teams and showcasing learning.

Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up-to-date information about the work of the trust and the services they used.

Learning, continuous improvement and innovation

Although staff were committed to continually learning and improving services the trust did not achieve all its quality improvement priorities. The trust recognised that this area needed further improvement. They had an adequate understanding of quality improvement methods and were promoting the skills and developing the capacity to use them. Leaders encouraged innovation and participation in research.

The trust was participating in national improvement and innovation projects. The commitment and investment in quality improvement was clear and leaders spoke positively about the impact of this on patient outcomes.

Staff had training in improvement methodologies and used standard tools and methods. Since April 2023 the Quality Improvement (QI) team have engaged in quality improvement conversations with 902 people (including training) and across 21 new teams / projects. To date, 44 people had been trained to QI level 1 and 7 had been trained to level 2. There were currently 67 active QI projects registered on the trust database.

The previous QI strategy was due to be refreshed after 2022. A draft strategy had been aligned to incorporate the newly published NHS Impact (Improving Patient Care Together). The QI strategy was being presented to the Trust Executive Group in November 2023.

However, the trust did not achieve all its QI priorities for 2022/2023. For example, there was a QI initiative for falls prevention. Although several areas of improvement had been introduced there were still nearly 50 falls with severe and moderate harm. The trust recognised that QI methodologies needed further embedding following the relaunch of the strategy.

The trust was actively participating in research. There was a Research and Innovation Strategy 2023-2028. This set out the key priority areas including tackling poor health and wellbeing in communities, improving maternal and child health, better patient outcomes and using digital transformation to address unmet health needs.

Our findings

The trust confirmed their delivery on the Clinical Research Network (CRN) contract reflecting the breadth and depth of research studies currently offered. The Born and Bred in Doncaster was shared as an example research study that supported the new R&I strategy in establishing a secure data environment, collaborating with health and care partner organisations across Doncaster Place and developing future academic partnerships around maternal and child health.

The trust also showcased their development plans and delivery to date around their structured support to grow clinical academics and skills in research across the whole of their workforce, aligned to patient need and clinical expertise.

The trust had introduced an inspection app used to assess and improve quality across clinical areas. It provided live, automated reporting to show what areas were doing well and where they needed to improve. Some outpatient departments were now on the system and maternity and paediatrics had just commenced. There was further work to improve action plan monitoring and analysis.

We saw examples in Urgent and Emergency Care where staff used falls kits for patients at high risk of falls which contained yellow socks and a blanket. We saw staff administering these and they worked well as a visual prompt. Signs asked staff to see yellow and think falls risk. Staff also had access to a falls holistic care team and a therapy assistant practitioner.

The trust had launched eObservations supported by a service called NerveCentre. This allowed patient observations to be recorded digitally using a hand-held device and avoided completing paper-based forms. The system calculated whether results fell within the 'normal' range for the patient and would alert a senior nurse or doctor if urgent attention was needed.

External organisations had recognised the trust's improvement work. Individual staff and teams received awards for improvements made and shared learning. Examples included the introduction of Magseed and Magtrace to help improve the accuracy and timeliness of breast tumour surgery. Clinicians were able to use a magnetic probe to guide them to the exact location of the tumour, allowing for its extraction. This resulted in minimal removal of breast tissue.

Over the course of 2023 the trust commissioned the dementia bus to come to all hospital sites to provide experiential learning to staff on living with dementia. Over 200 colleagues undertook the experience, 72 colleagues attended a similar experience in the learning disability bus.

The trust had a nurse colposcopist who offered a staff smear service, with appointments available on site for colleagues to access.

The trust Sharing How We Care newsletter was used across the trust to share learning from patient safety events. A focus on sepsis was included in the January 2023 newsletter.

The trust had a full network of professional nurse and midwifery advocates who worked across the trust providing clinical supervision and support, they offered this service to registered nurses and midwives and more widely.

There was a network of over 100 learning disability ambassadors who supported and advocated for people with a learning disability. The ambassadors provided learning and expertise to colleagues,

In partnership with South Yorkshire Police and Crime Commissioner (Doncaster) the trust has funded 2 domestic abuse liaison officers, they have worked collaboratively across the trust improving outcomes and sharing learning. They have supported the creation of a network of domestic abuse champions.

Our findings

The trust had been named Employer of the Year at the Doncaster Business awards 2023. This was in relation to improved NHS staff survey results, implementation of the RACE Equality Code Quality Mark and action plan on equality diversity and inclusion. This also included the trust's focus on rewards, recognition and health and wellbeing.

Ward 17 had received NHS Gold award winning project for get up, get dressed, get moving. This resulted in 90% of patients getting out of bed, physiotherapy referrals from the ward had reduced by 66% and occupational therapy referrals by 72%.

The trust had received a pastoral care quality award for international nurses and midwives. This showed commitment to supporting internationally educated nurses and midwives at each stage of their recruitment.

Complaints

Between April 2022 and March 2023 739 complaints were reported to the trust. This was a 12.5% increase compared to 2021/2022. The main themes from complaints were communication, cancelled appointments, delays in tests, missed diagnosis and patient care.

There had been a backlog of overdue complaints. The trust plan was to have no complaints over 6 months by the end of June 2023 which was achieved and none over 3 months by the end of August. At the time of inspection there were 3 remaining complaints to achieve the target.

We reviewed the records of six complaints made by patients between 2022 and 2023. The trust had investigated and responded to four of the six complaints within the timescale required by the trust's complaints policy. Two complaints were responded to outside of the required timescale although the trust had acknowledged the lateness within the response for one of these complaints.

Most complaint responses fully addressed the points raised by the complainant and offered an apology where there was an identified lapse in the way care had been provided.

There was a move towards managing complaints through verbal outcomes which had been identified from patient feedback to ensure complaints were resolved quickly. The trust was trying to introduce more face-to-face early resolution meetings however some clinical areas were reluctant to move to this way of working.

There are some areas where there was further work needed to change the culture. The trust was addressing this with complaints training. An external company was providing staff with new training on writing complaint responses and mediation skills. The training was being completed by the patient advice and liaison team and appropriate members of staff responsible for complaints. The intention was to train 4 trainers.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Mar 2024	Requires Improvement ↓ Mar 2024	Good ➔➔ Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024

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

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall trust	Requires Improvement → ← Mar 2024	Requires Improvement ↓ Mar 2024	Good → ← Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024

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

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Bassetlaw District General Hospital	Requires Improvement → ← Mar 2024	Requires Improvement ↓ Mar 2024	Good → ← Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024
Doncaster Royal Infirmary	Requires Improvement → ← Mar 2024	Requires Improvement ↓ Mar 2024	Good → ← Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024
Montagu Hospital, Mexborough	Requires Improvement ↓ Mar 2024	Good → ← Mar 2024	Good → ← Mar 2024	Good → ← Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024
Retford Hospital	Requires Improvement ↓ Mar 2024	Not rated	Good → ← Mar 2024	Good → ← Mar 2024	Good → ← Mar 2024	Good → ← Mar 2024
Overall trust	Requires Improvement → ← Mar 2024	Requires Improvement ↓ Mar 2024	Good → ← Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024

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

Rating for Bassetlaw District General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↓ Mar 2024	Good →← Mar 2024	Good →← Mar 2024	Good →← Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024
Services for children & young people	Good Jul 2018	Good Jul 2018	Good Oct 2015	Good Jul 2018	Good Jul 2018	Good Jul 2018
Critical care	Requires improvement Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015
End of life care	Good Oct 2015	Requires improvement Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015
Surgery	Requires Improvement ↓ Mar 2024	Good →← Mar 2024	Good →← Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024
Urgent and emergency services	Requires Improvement →← Mar 2024	Requires Improvement ↓ Mar 2024	Good →← Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024
Maternity	Requires Improvement →← Mar 2024	Good →← Mar 2024	Good →← Mar 2024	Good →← Mar 2024	Requires Improvement →← Mar 2024	Requires Improvement →← Mar 2024
Diagnostic imaging	Good ↑ Mar 2024	Not rated	Good →← Mar 2024	Good →← Mar 2024	Good ↑ Mar 2024	Good ↑ Mar 2024
Outpatients	Good Feb 2020	Not rated	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020
Overall	Requires Improvement →← Mar 2024	Requires Improvement ↓ Mar 2024	Good →← Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024

Rating for Doncaster Royal Infirmary

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↓ Mar 2024	Good →← Mar 2024	Good →← Mar 2024	Good →← Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024
Services for children & young people	Requires improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Critical care	Requires improvement Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015
End of life care	Good Oct 2015	Requires improvement Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015
Surgery	Requires Improvement ↓ Mar 2024	Good →← Mar 2024	Good →← Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024
Urgent and emergency services	Requires Improvement →← Mar 2024	Requires Improvement ↓ Mar 2024	Good →← Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024
Maternity	Requires Improvement →← Mar 2024	Good →← Mar 2024	Good →← Mar 2024	Good →← Mar 2024	Requires Improvement →← Mar 2024	Requires Improvement →← Mar 2024
Diagnostic imaging	Good ↑ Mar 2024	Not rated	Good →← Mar 2024	Good →← Mar 2024	Good ↑ Mar 2024	Good ↑ Mar 2024
Outpatients	Good Feb 2020	Not rated	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020
Overall	Requires Improvement →← Mar 2024	Requires Improvement ↓ Mar 2024	Good →← Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024

Rating for Montagu Hospital, Mexborough

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↓ Mar 2024	Good → ← Mar 2024	Good → ← Mar 2024	Good → ← Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024
Surgery	Requires Improvement ↓ Mar 2024	Good → ← Mar 2024	Not rated	Good → ← Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024
Urgent and emergency services	Requires Improvement → ← Mar 2024	Good → ← Mar 2024	Good → ← Mar 2024	Good → ← Mar 2024	Good ↑ Mar 2024	Good ↑ Mar 2024
Diagnostic imaging	Good ↑ Mar 2024	Not rated	Good → ← Mar 2024	Good → ← Mar 2024	Good ↑ Mar 2024	Good ↑ Mar 2024
Outpatients	Good Feb 2020	Not rated	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020
Overall	Requires Improvement ↓ Mar 2024	Good → ← Mar 2024	Good → ← Mar 2024	Good → ← Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024

Rating for Retford Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Requires Improvement → ← Mar 2024	Not rated	Good → ← Mar 2024	Good → ← Mar 2024	Good ↑ Mar 2024	Good ↑ Mar 2024
Outpatients	Good Feb 2020	Not rated	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020
Overall	Requires Improvement ↓ Mar 2024	Not rated	Good → ← Mar 2024	Good → ← Mar 2024	Good → ← Mar 2024	Good → ← Mar 2024

Bassetlaw District General Hospital

Blyth Road
Worksop
S81 0BD
Tel: 01909500990
www.dbh.nhs.uk

Description of this hospital

Doncaster and Bassetlaw Teaching NHS Foundation Trust provides acute services for 420,000 across South Yorkshire, North Nottinghamshire, and the surrounding areas. The trust employs over 6000 staff.

Bassetlaw Hospital is an acute hospital with over 170 beds, a 24-hour ED and a full range acute clinical services to the local population including:

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Maternity and gynaecology
- Outpatients and diagnostic imaging
- Critical care
- End of life care
- Children and young people's services
- Breast care unit

Maternity

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

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

Mandatory training

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

The 2019 inspection identified that the service provided mandatory training in key skills to all staff; however, not all staff had completed it, and safeguarding training shortfalls were observed as completion rates were below trust target of 90%. At this inspection, the 2022/23 mandatory training logs provided by the trust for midwifery and medical staff identified continued shortfalls in mandatory training compliance. The trust target of 90% for completion of mandatory training was not achieved by some staff groups.

Trust information provided following the inspection confirmed the following overall levels of compliance: Midwifery and Nursing Staff – Compliance of above 95% was observed for the maternity pastoral team. Compliance ratings were identified amber and red where compliance fell between 66.67% to 84.85%. Community midwives' compliance at Bassetlaw District General Hospital was 80.52%.

Medical staff compliance was 67.11% (Obstetrics and Gynaecology) which meant 51 of 76 medical staff had completed their mandatory training.

Training dates were released to all managers to allow for allocation within the roster. Staff who required a yearly update received three email reminders and if the training was not completed, following the third reminder, their names were shared with the clinical director.

Mandatory training compliance and attendance was monitored by the practice educator and updates shared with managers. Staff training records stored on their electronic staff record also identified training expiry dates. Non-compliance was escalated to line managers and additional management support ensured all staff were released to attend training. Some staff we spoke with said staff were allocated mandatory training time which had been removed if there were midwifery staffing shortfalls. Medical staff said their training time was protected which ensured completion of allocated training subjects and said they were encouraged by senior staff to attend the mandatory training sessions.

Mandatory training was completed face to face and as electronic learning. Staff were alerted when they needed to update their training and each staff member had 7.5 hours of protected time to complete and /or attend training sessions. Some staff had tried to book places on mandatory training courses in September 2023, however, there was no availability until November 2023.

Maternity

Whilst on site we reviewed some consultants, doctors, and midwives training records in key areas such as practical obstetric multi-professional training (PROMPT) training, cardiotocography (CTG) and level 2 resuscitation training and noted that all training sessions for these staff groups fell below the trust target of 90%. Training compliance for consultant staff and midwives ranged from 73% (consultants CTG and foetal monitoring) to 84.2% (midwives resuscitation level 2 adult and neonates).

Following the inspection, we received some staff training compliance records. The consultant and midwife's compliance levels confirmed ongoing non-compliance for PROMPT, fetal monitoring and cardiotocography training sessions. Training compliance was below the 90% trust target for both staff groups and ranged from 76.92% to 84.62% compliance across these training sessions for both staff groups. The master compliance spreadsheet confirmed additional training sessions were booked for some non-compliant staff. Later, additional training information statistics now confirmed 100% of consultants had completed cardiotocography training sessions.

New doctors who had started in post three-weeks previously compliance ranged from 37.84% attendance at the foetal monitoring day to PROMPT at 59.4%. Staff said the maternity service had planned to ensure that all doctors had completed their training by December 2023.

The trust said that sepsis recognition and the national early warning score (NEWS) were covered within any course which had a deterioration element such as the PROMPT training package but not currently as stand-alone training.

National Health Service Professionals and agency staff were supported by the trust to complete PROMPT and fetal monitoring training sessions.

The report for neonatal life support (NLS) training for midwives dated July 2023 identified the status and overview, including risks for NLS training. The risks were red, amber, and green rated; the milestone deadline, compliance level and expected dates of completion were identified.

Neonatal life support training compliance at the end of July 2023 confirmed 198 of all midwives out of 227; 87.2% of midwives had completed this training against a training target of 90%. Separate training figures confirmed 100% (28) of bank and agency staff and 85.4% (170) of midwives had completed this training. Systems were in place to capture future midwives training which was due and for those 29 non-compliant midwives of which 24 had NLS dates booked.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, although, training records were not available to confirm staff safeguarding training compliance levels.

Nursing, medical and midwifery staff received training specific for their role on how to recognise and report abuse. The trust safeguarding training target was 90%. The trust confirmed Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) training was part of the adults safeguarding level 2 e-learning module which was no longer sufficient to meet the recommendations within the intercollegiate document. The relaunch of the mental health training included a more detailed package. As MCA/DoLs training was combined with level 2 adult safeguarding training the trust was unable to report on this separately.

Maternity

Adults and children's safeguarding training statistics at levels 1-3 were submitted by the Trust. At Bassetlaw District Hospital we observed compliance for both safeguarding trainings generally fell below the Trusts training target of 90% for both medical and midwifery staff groups. Compliance ranged from 53.33% to 75% for midwives. Medical staff compliance was identified as 66.67%.

The safeguarding lead midwife told us they delivered a mandatory study day every four to six weeks for staff and recent topics included substance misuse, bereavement, safeguarding, screening, and diabetes.

Staff confirmed that mental health drop-in sessions were provided for staff; another mental health update was planned for September 2023.

The safeguarding and vulnerabilities midwives had planned an infant crying awareness week to raise awareness about shaking injuries to babies. They had secured funding for cakes and stalls and had developed easy read booklets to share across the team. We were told that discussions around ICON (I – Infant crying is normal: C – Comforting methods can help; O – It's OK to walk away; N – Never, ever shake a baby) took place at discharge for all patients.

Overall accountability for safeguarding lay with the Chief Executive Officer at the trust.

The Chief Nurse was the strategic and professional lead for safeguarding adults' practice.

The trust strategic safeguarding people board was chaired by the deputy chief nurse and was attended by safeguarding professionals from both clinical commissioning groups.

The trusts safeguarding team worked across all hospital sites and networked with other local authorities and hospitals.

The 2022/23 trust safeguarding report confirmed 100% attendance and report writing to child protection case conferences. These conferences ensured a plan was in place to keep children safe and eliminate the risk of harm.

Maternity service safeguarding leads worked across both sites. Staff we spoke with across the service expressed an excellent working relationship with the specialist midwives.

Staff were able to identify adults and children at risk of, or suffering, significant harm; knew how to make a safeguarding referral and who to inform if they had concerns. Safeguarding changes and updates were cascaded to staff through operations meetings.

The safeguarding team joined the daily staffing huddle to share information.

Policies and guidance which related to safeguarding, baby abduction and associated issues was in place. Safeguarding team information was displayed in areas we visited.

The trusts electronic system had flags on patient records that indicated domestic abuse, social services involvement, and other areas of concern. We were shown multiple records where the flags were in place. Women's records showed safeguarding assessments and background checks were completed. We reviewed six women's records all of which confirmed the safeguarding safety log was completed to record child protection information sharing checks and SystmOne checks with primary care records.

Maternity

A baby abduction drill had taken place across both maternity units three-months ago. The outcome was to improve security measures. Staff said a security system timeline had been developed to assist with the improvement of security measures. We did not see a copy of this security guideline and were not informed of the progress made to-date against the timeline.

Safeguarding supervision sessions were introduced in the last four months. Safeguarding lead midwives had implemented virtual safeguarding supervisions and staff were given protected time to attend them. Community midwives said they were allocated safeguarding supervision sessions which they completed when able.

The safeguarding supervision training report confirmed compliance between 16.6% (Labour ward and maternity day assessment unit) to 25% (A2) attendance by staff.

There was a shortfall in supervision compliance in the other maternity areas across maternity services so overall compliance was 25.5% for the entire maternity service. Further dates were to be offered from October 2023 and additional funding was secured for a further four supervisors so that a cascade model of supervision could be implemented.

The safeguarding and vulnerabilities midwives worked closely with external stakeholders and spoke of a new initiative which was a multi-agency meeting between the local authority, police, health visitors, drug, and alcohol service to ensure support was provided to women that needed it.

The safeguarding team gave examples of how they liaised and managed to reach out to hard-to-reach communities in their area. The service was currently working with an external organisation to support black ethnicity and asylum seekers as this population group had increased in numbers. A female genital mutilation service was in place as guidance for staff for women who had female genital mutilation performed.

If a woman was assessed as risk of suicide or self-harm the mental health crisis team was contacted. The service had policies, risk assessments and record notifications which were utilised when women showed signs or had a history of previous mental health concerns. This meant that all staff were kept informed of the woman's mental health status which was recorded electronically.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect women, themselves, and others from infection. They kept equipment and the premises visibly clean.

Infection prevention control (IPC) link midwife roles were present within the service. Clinical areas infection prevention control link midwives accessed additional training.

Ward areas were visibly clean however, we observed the tops of the monitors in the triage area / maternity antenatal assessment unit were dusty and informed staff of this. Staff immediately cleaned both monitors.

Ward areas had suitable furnishings which were clean and well-maintained. Staff cleaned equipment after patient contact and labelled equipment to show it was cleaned. The current pool cleaning guidance reflected current practice.

Daily water flushing was in place for the pool room. Flushing of taps helped control legionella in hot and cold-water systems. Trust records confirmed legionella testing dates throughout 2022 and 2023 for the maternity service. When there was a presence of legionella on testing the service did not confirm what actions were taken in response to the legionella finding.

Staff followed infection control principles including the use of personal protective equipment (PPE). Hand rub was located throughout the unit. National Patient Safety Agency five moments to hand hygiene and hand cleaning techniques were displayed throughout the maternity unit, except in labour ward.

The trust target for hand hygiene compliance was over 95%. Staff completed yearly hand hygiene competency assessments. Monthly hand hygiene audits from February until August 2023 across the service compliance ranged from 80% to 100%. On two occasions compliance was recorded as 80% and 95% as one staff member was seen to be not bare below the elbow.

The trust confirmed five cases of puerperal sepsis and other puerperal infections within 42 days of delivery and readmission rates for infections in mothers and babies in 2022/23. Postnatal readmissions were reviewed within 72 hours via the twice-weekly multidisciplinary incident review meeting. The only thematic trend identified from these reviews was that of raised body mass index over 35 and post-delivery wound infections and sepsis. The PICO dressing was utilised and there were no trends or themes with clinicians. PICO is a wound care system, which provides suction known as negative pressure wound therapy. This draws out excess fluid from a wound and provides a compressive force.

The trust confirmed these reviews identified good practice of treatment within the golden hour once sepsis was suspected, multidisciplinary involvement of interventional radiology and the skin integrity team. These incidents had not met the criteria for moderate harm investigation or serious incident investigation. One action was to disseminate information and education to staff was monitored in governance meetings by the governance team and closed within date.

The service performed well for cleanliness. Weekly and monthly ward accreditation audits identified some shortfalls for each clinical area. At Bassetlaw District General Hospital, five monthly audits were reviewed where compliance ranged from 87.5% on one occasion to 100%. Where compliance was identified as 87.5% the non-compliant areas were noted at the start of the assurance report, however, it was not clear whether these areas were actioned on labour ward.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The 2019 maternity inspection identified the following breaches of regulation:

At the 2019 inspection we found that staff did not have local guidance for staff to follow when monitoring and responding to changes in temperature outside of accepted limits for the freezer and fridges used to store medicines and milk. At the August 2023 inspection this requirement was achieved. We checked the baby milk fridge, medicines fridges and a medicines freezer in maternity and found no gaps in the recording of daily temperatures.

At the 2019 inspection we found that Entonox gases were not removed from birthing rooms and no atmospheric checks were in place to monitor levels of Entonox gases. At the August 2023 inspection labour ward rooms had scavenging systems in place to remove Entonox (nitrous oxide) gases. The 2023 service report identified no concerns.

Maternity

At the 2019 inspection not all staff had received training in the use of hoists and written guidance was not available for staff on use of the hoist. The service had YouTube type guidance for the evacuation of women from a birthing pool in an emergency. This guidance was practical in its nature and demonstrated how the midwifery team would move a woman from the birthing pool in an emergency.

At inspection staff did not confirm they had received training in the use of hoists, and there was no written guidance on hoist use seen in clinical areas. Following the inspection, the Trust confirmed that hoists were not used in clinical areas.

There were no specific pool room evacuation guidelines, the trust provided photo guidance to support staff training. The service said initial training was undertaken by all coordinators and core labour ward staff. The birthing pool at the Bassetlaw District General Hospital (BDGH) site was out of commission for several months but was now operational. The service planned to roll out training following the relaunch of midwife led pathways for all staff on labour ward.

Pool service records were not seen. The pool evacuation net had a service requirement of 6-monthly services stitched into the equipment; however, the net had never been serviced. Staff from both hospital sites were unaware of the evacuation nets service requirement.

Sticker confirmation of in date portable appliance testing was displayed on equipment. We checked baby and adult resuscitation trollies and defibrillators on all the wards we visited. Daily checks and items on them were all up to date and accurate. Emergency boxes for hypoglycaemia, cord prolapse, sepsis and pre-eclampsia were stocked appropriately with daily checks evident.

Following the inspection, the trust submitted equipment maintenance calendar logs for February 2023 which confirmed equipment service completion dates for maternity services at BDGH. Service spreadsheets confirmed servicing of equipment across the service had taken place. Equipment electrical safety tests, service and recalibration dates were identified. The spreadsheet confirmed five pieces of equipment electrical safety tests were due from December 2021 to November 2022. Two thermometers were due recalibration, one in October 2022, the other was stated as recalibration required.

The clinical environment comprised of ward A2 a 17-bed antenatal and postnatal ward; labour ward which comprised of three delivery rooms, one pool delivery room and the bereavement suite. Staff said they were trying to secure additional funding to upgrade the bereavement suite.

The maternity day assessment unit (MADU) was located between the labour ward and ward A2; should bad news be communicated a room in ward A2 was used.

The design of the environment had suitable facilities which included drinks stations used by women and their families. Local clinical environments were well maintained, soft furnishings wipeable, and corridors uncluttered.

Entry to the units was via a bell operated entry system and close circuit television was in place. Baby's wore ankle bracelets to confirm their identities.

Staff told us there had been a problem with pigeons nesting outside of the window of the pool birthing room; windows were kept closed so pigeons did not enter the rooms. Staff said they were unaware of what actions if any were being taken in response to this issue.

All equipment was tagged with recent 'I am clean' stickers, however, no date was recorded on the stickers.

Women could reach call bells and staff responded quickly when called.

The entrance to the antenatal and postnatal ward displayed a personal welcome board which included a display names and weights of babies that had been born that month. In addition, information was displayed to support fathers. It also advertised an app which was an essential guide to support them through ICON, to reduce baby shaking incidents.

The trust theatre ventilation systems verification report for the BDGH, confirmed the last annual review as the 12 July 2023; one concern related to room pressures not conforming and some additional recommendations made. The certificate of calibration issued on the 24 July 2023 confirmed an overall pass was awarded. The trust did not send supporting documentation to confirm that the additional recommendations were acted upon.

Faulty or broken community midwifery equipment was sent to the community midwifery manager who arranged repair or replacement.

The service confirmed community midwives carried a delivery pack plus bag and mask.

Placement of home birth equipment in the woman's home took place in advance of the home birth. Home birth drugs were supplied in a locked container for storage in the patient's fridge from 37 weeks' gestation. The home birth drugs, and home birth equipment were checked and signed for on a weekly basis to ensure they are complete and in date.

The trust loan worker policy provided clear guidance to ensure the safety of midwifery staff in the community.

Staff disposed of clinical waste safely and clinical and domestic waste containers were clearly labelled.

Arrangements for the control of substances hazardous to health (COSSH) were in place and substances were stored securely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration.

The 2023 'Yorkshire and the Humber in-Utero Transfer Guideline (v5)' was produced in consultation with a transport service, local NHS Hospitals Trust, the operational neonatal network, and regional maternity colleagues. The document covered all aspects and escalation pathways associated with transfer to another provider. This document / agreement was next due for review in April 2024.

Women who attended for appointments were seen in the maternity day assessment unit (MADU), in order of attendance, rather than on risk classification. Staff confirmed all high-risk women were referred to Doncaster Royal Infirmary.

The obstetric triage pathway identified that all women booked for maternity care at Doncaster or Bassetlaw were provided with a triage telephone number to ring if they had pregnancy or postnatal related concerns or when they go into labour. All calls were centralised to a dedicated single point of access telephone triage service at the Doncaster site. The midwife who took the call decided the priority for admission or if it was appropriate to refer the woman to an alternative service. If a woman was invited in for assessment, reception should be notified, and the maternity notes requested for the patient to collect on their way to triage.

The critical care team are available 24/7, whilst the critical care outreach team was available in daytime hours. Maternal critical care leads liaised and planned with the obstetric unit for expected cases.

Community midwives completed practical obstetric multi-professional training (PROMPT) training for general emergencies. They had not received specific emergency training for home births and told us they would ring 999 in an emergency in line with trust guidance and then proceed to the requisite emergency guidance dependent on the clinical scenario.

Staff completed sepsis training which was part of the PROMPT training package. Please see the sepsis training compliance levels within the mandatory training key line of enquiry.

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

For obstetric emergencies we saw the use of scribe sheets. No proformas were displayed in birthing rooms as they were accessed through the electronic K2 system. Discussions with staff confirmed they did not all follow the same process when actions and intervention times were recorded. Some staff recorded the actions and interventions, whilst other staff recorded them directly on to the K2 electronic system.

Postnatal women who experienced a post-partum haemorrhage were cared for in the intensive care unit or on the labour ward dependent on acuity and dependency.

Staff handovers:

Staff shared key information to keep women safe when handing over their care to others. Operations calls across the service and hospital sites took place at 8:30am, 1pm and 4.30pm. Shift changes and handovers included all necessary key information to keep women and babies safe. Safety huddles took place as part of the handover, with medics and sometimes an anaesthetist present.

Risk assessments:

Staff completed risk assessments and psychosocial assessments for each woman on admission and on arrival, using a recognised tool. This was reviewed regularly, including after any incident. The psychological assessments were carried out on those women thought to be at risk of self-harm or suicide. The service monitored the antenatal risk assessments such as 'When mental health issues have been identified, has a plan been made, and potential problems in Postnatal period been acknowledged.' Compliance in 2022 was 73.33% (Quarter 1) to 100% (Quarter 2).

The booking appointment was the first in a series of risk assessments undertaken at every antenatal appointment, to ensure the appropriate health professional provided the care. Risk assessments included social and medical assessment of the woman's mental health. Ongoing reviews of women's risk status took place at each appointment. Concerns resulted in consultant obstetrician referrals. We reviewed 16 women's electronic records all confirmed risk assessments were completed.

During the first booking appointment the community midwife discussed and offered a range of screening tests, including blood tests and ultrasound scans designed to check the mother's health and baby's health and wellbeing.

Maternity

Risk assessment of venous thromboembolism (VTE) and bleeding risk took place on admission to the service. We reviewed 16 women's records and 16 VTE assessments were documented. We were told that the night midwives reviewed VTE assessments and escalated to senior staff if needed. The service audited women's antenatal VTE assessments; 100% compliance in completion of assessments was identified in quarters one to three in 2022.

Women's records and audit data showed carbon monoxide monitoring for all women were completed at booking. A pilot audit of carbon monoxide monitoring took place in October 2023; the maternity service audit confirmed 38% of 150 women, 12% of which were smokers had carbon monoxide levels monitored of these 5.8% (1) were referred.

Deterioration tools in use:

Deteriorating patient guidance, tools and specific condition guidance was in place and generally within review dates.

Electronic tools identified women at risk of deterioration. This tool identified an electronic maternity early obstetric warning score (MEOWS). MEOWS is a system designed to allow early recognition of physical deterioration. At the 2019 inspection monitoring of women's maternity early obstetric warning scores were in place however, we were unable to ascertain whether scores were being escalated appropriately and whether patient outcomes had improved through this monitoring process. At this inspection we were told that escalation would take place to the obstetric senior house officer or paediatrician. The five women's records we reviewed confirmed MEOWS was scored and escalated when required.

The working copy of the documentation audit (v1) for 2022 confirmed scoring against individual criteria over four quarters in the areas of antenatal care, intrapartum, continuous electronic fetal monitoring, and post-natal care. The two postnatal MEOWS audit annual scores were 98% and 100%.

Staff said they would escalate concerns and request an urgent review by the medical team if a woman's or babies condition deteriorated. This referral included the use of the situation, background, assessment, and recommendation (SBAR) communication tool.

Safety Audits:

The trust confirmed the service had developed the 'Maternity Local Safety Standard for Invasive Procedures (LocSSIP) Outside of Obstetric Operating Theatres' guidance.

Use of surgical safety checklists for all cases in the maternity theatres took place. We were unable to observe the use of surgical safety checklist checks for caesarean sections as no women had these procedures during the inspection. Surgical safety checklists audits from week commencing the 20 March 2023 to 21 August 2023 confirmed 100% compliance for sign in, time out and sign out checks. Surgical safety checklists audit outcomes from 1 September 2022 to 1 September 2023 confirmed 100% compliance for pre-anaesthetic time out and pre-incision STOP whilst, all personnel participate in sign out in full was score 66.7% for main theatres.

Three women's records confirmed swab counts took place post vaginal birth, caesarean section, and suturing.

On labour ward fresh eyes audits were completed hourly with the band 7 coordinator as a buddy.

In addition, the K2 monitoring system was in the labour ward office and the door was locked to ensure confidentiality. However, the door would be left open when temperatures were high due to a lack of ventilation.

We were also told that staff could not see the CTG monitoring platform which was based in a locked clinical room.

Monthly fresh eyes monitoring of intrapartum foetal monitoring reduced poor outcomes for babies. Cardiotocography (CTG) readings were interpreted through monthly fresh eyes audits. Fresh eyes audits were undertaken across the maternity service. The April and July 2023 fresh eyes audits reported on the findings across both maternity services. The April and July 2023 monthly fresh eyes audits reviewed 35 (April 2023 audit); 41 and 42 sets of notes (July 2023 audit). The audit data for both mostly showed an improving picture of fresh eyes reviews within 15 minutes. The April 2023 audit scores ranged from 73% (March 2023) to 74.9%. July 2023 audit scores ranged from 78.6% (May 2023) to 77.8% (July 2023).

There was some fluctuation in compliance against the number of fresh eyes reviews completed after 15 minutes and for those fresh eyes review not completed. Themes included failure to undertake fresh eyes reviews in the second stage of labour. Reminders were given that fresh eyes reviews of the CTG be performed during the latent stage of labour, during induction and during the second stage of labour. Both audits identified action plans with timescales of August and up to September 2023.

Midwifery staffing

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

The 2019 maternity inspection identified staffing shortfalls; this remained an area of concern at this inspection.

Hospital Midwives

The maternity service had an agreed funded establishment for midwives and support staff to provide minimum staffing levels to ensure safe delivery of care to the women and babies.

Daily, the supernumerary band 7 manager of the day monitored staffing levels across the service sites using the birth rate plus app, redeploying staff where necessary. Maternity escalation plans advised staff on managing situations where staffing fell below an acceptable minimum, or the workload exceeded safe working.

At night there was an on-call system in place. Senior midwives in the service including the Director of Midwifery provide this on call cover from home and attend the sites when required based on the escalation policies in place.

No consultant midwives worked within the service.

A pay incentive was introduced to encourage midwives to work additional bank shifts to cover the shortfalls in midwives. Recently, this rate was reviewed so that the full rate was now being paid to cover those shifts such as bank holiday, night and weekend shifts which were difficult to fill. The community midwifery team also retained the full pay incentive rate as they remained short staffed.

The maternity service created several senior midwifery posts which provided additional support to the service. Some of these posts included a maternal medicine post, , vulnerabilities midwife, audit guideline midwife, project lead for Ockenden and the equity and equality lead midwife.

Staff said no written revalidation checks guidance was in place and over the last year two midwives had not revalidated when they were due to. Following the inspection, the Trust said department managers had received monthly updates of those midwives who's registrations were due to expire or had expired via an electronically generated report.

Staffing Levels and Acuity

Birthrate Plus was the recommended decision support tool for assessing and determining midwifery staffing levels and was used in conjunction with professional judgement to calculate the workforce required to deliver safe maternity services. A full assessment using the tool was undertaken on the case mix from September to December 2021. The trust received the final assessment report in August 2022. The report was presented at the Trusts Board of Directors meeting on the 28 March 2023. The recommendation was the Board approve the recommendation to seek a regional approach in relation to the required numbers of registered midwives over and above the existing establishment.

The 'Agency and Incentives in Maternity Paper – March 2023 confirmed the current funded position was 189.45 whole time equivalent (WTE) staff of which 169.04 wte were contracted; 154.18 wte midwives were at work and 14.86 wte midwives were on maternity leave which left a deficit of 35.27wte midwives. Staff confirmed maternity leave absence would improve throughout 2023 if midwives returned to work their usual hours.

The recent birthrate plus 2022 reassessment of staffing data showed an uplift in midwifery staffing funded positions at 218.04 wte, which left a deficit of 63.86 midwives. Staff sickness was not included and was approximately 8%.

The service was significantly challenged with the current vacancy and maternity leave position and by providing maternity services on two sites. The service placed all vacant shifts out for NHSP cover and achieved between 40-75% cover. The amount of agency midwives had decreased since summer 2022, and shift fill from NHSP was variable.

We asked qualified staff whether staffing levels were safe and were told they were at band 7 level. Labour ward and the central delivery suite had supernumerary band 7 senior midwives on day and night shifts. At Bassetlaw District General Hospital (BDGH) if the band 7 midwife was not supernumerary on the shift an incident form was completed and red flag raised.

Daily staffing levels discussions took place; this included the Monday staffing huddle for the week ahead and Fridays prior to the weekend. Staffing gaps were filled by permanent staff and bank staff; agency staff were employed if shifts were not filled by the first two staffing options. The ward manager adjusted staffing levels daily according to the needs of women.

Escalation and unit closure decisions were made by following the South Yorkshire Local Maternity Network Service escalation process. The service was also supported following redeployment of healthcare support workers and operating department practitioners from the acute service.

Separate staffing establishments existed for both maternity units.

Staff said a total of six midwives worked across A2, the maternity day assessment unit (MADU) and labour ward. The MADU operated from 08:30 – 20:30 and was staffed by two part-time midwives. Ward A2 staff confirmed staffing levels comprised of two registered midwives at band 6 and/or band 5 and a band 2 maternity support worker. An additional midwife was employed on late shifts on Tuesdays and Thursdays as this was when caesarean sections took place. Staff said there had been frequent changes in ward managers at Bassetlaw District General Hospital (BDGH).

Labour ward rotas showed most shifts were covered by two to three registered midwives; the third midwife was the band 7 coordinator who was supernumerary. Maternity support workers worked alongside registered midwives on labour ward and ward A2.

On the 23 September 2023, the labour ward coordinator was supported by three band 5 midwives. The band 6 midwife who had not previously worked in the maternity day assessment unit (MADU) was redeployed to work there.

Shortfalls in registered midwives were confirmed when we reviewed staffing rotas for labour ward and ward A2 for December 2022, May, and August 2023.

We looked for band 7 and band 6 midwife cover availability on days and nights. The December 2022 rota was a joint rota with ward A2. The rota confirmed that labour ward had band 7 midwives cover 24/7; with a minimum of two band six midwives supported by band 5 midwives and maternity support workers.

May and August 2023 staffing rotas confirmed band 6 and band 7 midwife cover 24/7, however, staff told us that some August shifts were covered by permanent band 6 and band 7 staff due to gaps in the rota. On ward A2, bank and agency use totalled 49 shifts in August 2023.

Staff said bank shifts were connected to the NHS Professionals hospital bank service who filled outstanding bank shifts.

Staff shared a future staffing rota dated 2 October to the 29 October 2023 which was partially approved for both hospital maternity sites. Labour ward had 88 midwife shifts uncovered. Staff said the October rotas were delayed due to the review of band 6 review cover for each area to ensure equality of skill mix in each area.

Midwife recruitment

Recruitment of band five midwives from within the local maternity services regional network had taken place. This recruitment originally stood at 52 whole time equivalent (wte) midwives, however, some of these midwives had chosen to work in other hospitals so now the maternity service's expectation was that 35 wte midwives would start at the trust in October or November 2023. Following the inspection, the Trust confirmed that it had been anticipated that all 52 wte would not join the Trust. It had been approved at the start of this process that job offers could be made above the planned establishment due to this; this also included the recruitment of experienced midwives.

Staff said there had been some international recruitment.

Midwife to birth ratio

To provide a safe maternity service, the Royal College of Midwives (RCM) says there should be an average midwife to birth ratio of one midwife for every 28 births. The maternity service had not met their target of 95% for women receiving one to one care in labour at the 2019 inspection when the ratio was 1:32. At this inspection midwife to birth ratio compliance at Bassetlaw District General Hospital was 99.20% for July 2023. We asked why 100% compliance was not achieved and were shown some red flag data which identified there had been a delay in a time critical activity. The red flag identified a delay between admission for induction and induction proceeding. Data which did not include Birthrate Plus data confirmed BDGH had achieved 100% compliance for the midwife to birth ratio since April 2023. Current data did not include the Birthrate Plus data due to the manufacturer updating this system, so this data was not available.

Community Midwives

Maternity

Maternity Community Caseload 2022/23

The maternity service paused the continuity of carer workforce model since July 2021. The Birthrate Plus Assessment report presented to the Trust Board of Directors on the 28 March 2023 said when continuity was recommenced a reassessment using the continuity of carer workforce model toolkit would take place. This was because this model of providing care had a different workforce requirement that was likely to increase. Currently, community staff told us that they employed hybrid working where staff worked two months on the maternity wards and one month in community.

The 2019 maternity inspection identified current community midwifery caseloads did not reflect the current ratio of 98 cases per wte. midwife. (National Institute for Health and Care Excellence guidance) The caseload information for midwives who worked 37.5 hours weekly ranged from 66 to 166 women per caseload. At this inspection, staff confirmed caseloads for community midwives varied and one midwife had 106 patients on their portfolio. The additional workloads were due to vacancies within the service.

Community caseload information provided by the service confirmed community midwives' caseloads ranged from 21 (south team) to 118 (north team). However, not all community midwives worked full-time, and we observed some part-time midwives with higher caseloads, for example a midwife employed at 0.60wte in the east team had 79 women on their caseload as of the 7 August 2023. Overall, it appeared that all but three midwives' community caseloads were within the NICE guidance for community midwifery caseloads of 98 cases per wte midwife in the north, south, east, and central community teams. Caseloads for the three midwives which fell outside of this ranged from 99 to 118 cases per wte midwife.

The community midwives told us that they were well supported by the specialist lead midwives when this was needed. Staff described close working relationships with the community midwives.

Community midwives had an on-call escalation between 5pm and 10pm where they could be called in to support staff on the maternity wards. They gave examples of staff being called in to work outside of these hours and they would be expected to do their normal hours the following day. Staff said they were on call for home births and had no day of rest factored in following a birth even if late at night. Following the inspection, the Trust said that should a midwife be required to work beyond 10pm they would have an 11-hour break minimum before returning to work the next day and that there was no expectation that the midwife worked the next day.

Women's and Children's Division Statistics:

Nursing and midwifery absence rates from 2022 to 2023 were 7.12% which equated to 807 absence occurrences.

Nursing and midwifery labour turnover rates from 2022 to 2023 were 51 staff which equated to 39.92 full time equivalent leavers. There were 54 starters which equated to 46.27 full time equivalent starters.

Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

The service had gaps in medical staffing rotas, which were covered by locum staff. Medical staff had the right qualifications, skills, training, and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

Maternity

Staff confirmed that separate staffing establishments existed for both maternity units.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

We requested evidence to confirm the actual and planned numbers of consultant staff and other medical staff who worked within the maternity service and this information was not provided which meant we were unable to report on whether the medical staffing levels followed the relevant Royal College guidance.

All consultants and their teams saw women on the antenatal and postnatal wards every morning. During these ward rounds those women suitable for discharge and / or transfer were discharged or transferred.

In addition, women whose care was midwife led or they had an uncomplicated vaginal delivery and intrapartum and postnatal period were reviewed if requested.

Medical staff confirmed consultants were approachable and were well supported by them. Staff at various levels confirmed the workloads were quite heavy due to there being one registrar and senior house officer working overnight; however, said this was usually manageable.

Cross-site rotas confirmed senior paediatrician cover 24/7 to support the maternity service.

Second opinions by other consultants could be accessed easily to aid clinical decision making.

Medical staff were allocated to a 1:8 rota and said all rota slots were complete. Staff described medical rotas as manageable with on-call arrangements identified. Staff spoke of the internal use of locum medical staff when required.

A consultant was in the hospital from 8.30 to 5pm. The service always had a consultant on call during evenings and weekends. We reviewed the April, May, June, and July 2023 consultants' rotas at Bassetlaw District General Hospital which identified when locum doctor cover was required. The rotas confirmed between six to 16 shifts each month were required to be filled. Most unfilled shifts related to weekday working. The service said all labour ward and central delivery suite shifts were prioritised which meant they were all covered with no gaps in the rotas. Where deficits existed, locum shifts were advertised and when unable to cover the on calls rotas were prioritised. Consultants were on call during evenings and weekends.

During out of hours times consultant staff if at home would need to be within 30 minutes access to the hospital. There was no written trigger list for consultant attendance at the hospital.

Designated anaesthetic cover was in place for labour ward until 5pm, after this an on-call resident anaesthetist took over. They had a theatre recovery team available out of hours if needed.

Staff raised concerns at the 2019 inspection that GP trainees cross covered neonates and maternity overnight as both were seen to be high risk specialities.

Consultants worked across both hospital sites.

Managers made sure locums had a full induction to the service before they started work.

Women's and Children's Division Statistics:

Medical and dental absence rates from 2022 to 2023 were 2.12% which equated to 96 absence occurrences.

Medical and dental turnover rates from 2022 to 2023 were 16 which equated to 16 full time equivalent leavers. There were 24 starters which equated to 23.58 full time equivalent starters.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Women's notes were comprehensive, and all staff could access them easily.

When women transferred to a new team, there were no delays in staff accessing their records.

We reviewed 16 women's records; risk assessments were completed, consent detailed where needed and identification whether the women was on a high or low risk pathway. Discharge planning was evident in 10 women's records.

Staff used an electronic system to record patient care and treatment. Paper notes were minimal. Paper records were safely stored in locked metal cabinets in the areas we visited.

Expectant mothers held their own paper copy of the growth chart records and were able to view their maternity records online using a unique log-in onto the electronic records system.

Women's notes were comprehensive, and all staff could access them easily.

We looked at 16 records on the electronic system (K2) and found they were correctly completed. All entries were automatically dated and signed. Admission risk assessment including assessment of venous thromboembolism risk, foetal movements were checked on each antenatal visit, carbon monoxide levels were monitored, urine test recorded each visit, routine enquiry about domestic abuse was recorded.

Mental health team referrals for mothers were through the electronic K2 system to the mental health nurse and midwife.

Midwife led referrals took place, for example, for babies with a tongue tie condition would be referred to the infant feeding team who in turn would refer the baby onto an NHS Trust to treat this condition.

When the mother and baby were discharged home their details were added to the ward discharge book. Daily checks of discharges ensured discharge information was shared with the mothers GP, community midwife and health visitors. In addition, should the mother come from out of area their midwife was contacted.

Each baby's red book was completed and given to the mother. The babies blood screening results were entered into the red book and electronically on the K2 system. Staff said the screening midwives checked that relevant blood screening had taken place prior to the baby's discharge home.

When advanced care planning was required, the bereavement midwives supported the mother and family.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Maternity

Staff followed systems and processes when safely prescribing, administering, recording, and storing medicines. Staff stored and managed all medicines and prescribing documents safely.

Medicines were stored securely throughout the inpatient service and antenatal clinics. The antenatal unit had emergency medicines grab boxes which were signed and dated. The Anti-D fridge on the antenatal unit was checked daily, was locked and secure. Anti-D was only needed if a rhesus negative woman was pregnant with a rhesus positive baby.

Staff reviewed each woman's medicines regularly and provided advice to women and carers about their medicines. We reviewed 10 prescription charts and saw that staff had completed medicines records accurately and kept them up to date.

Staff followed national practice to check women had the correct medicines when they were admitted, or they moved between services. Staff reviewed women's medicines regularly and provided specific advice to women and carers about their medicines.

Daily checks of the medicine fridge and freezer were up to date.

Emergency boxes for hypoglycaemia, cord prolapse, sepsis and pre-eclampsia were stocked appropriately with daily checks evident. The emergency drugs pack on ward A2 were sealed and identified the expiry date of the pack.

Controlled drugs were stored in designated cabinets. We undertook random stock checks on three items and noted they matched the number of stocks detailed in the controlled drug book. Monthly checks of controlled drugs had taken place and were recorded in the controlled drug book. We observed that Oromorph (known as morphine sulphate) a strong pain killer medicine had not been dated when opened. The shelf life of morphine sulphate oral solution is reduced to 90 days once opened so it is important the date the medicine is opened is documented.

We observed the controlled drugs key was not separate to the other drug keys.

The early pregnancy assessment unit keys were stored in a key code safe. There was no stock check form or signing in / out forms for medicines and staff were unaware of any need for such forms. Staff said they ordered stock when it was low. There was a signing in out form for prescriptions and appropriate storage of prescription pad/ recording of script numbers.

Fentanyl solution infusion bags were being decanted by staff into syringes. This practice was escalated with the maternity team as this was not usual practice and staff were advised these syringes should have been destroyed. Staff said the pharmacy had advised them to draw the fentanyl up into 10ml syringes for epidural use from the intravenous fentanyl bags. We were told the reason for the bolus dose was because the anaesthetic team did not use patient-controlled analgesia pumps or intravenous infusion equipment and an investment would be required to purchase this equipment. Staff said they did not agree with this practice. A standard operating procedure (SoP) from pharmacy to support this procedure was not in place; staff said the SoP was being developed.

We were told the Trust had taken immediate action when this issue was raised. Following the inspection, the Trust said there was a SoP in place at the time of inspection, but on review of the SOP when the issue was identified, the trust reviewed practice and amended the SOP immediately. Following the inspection, the trust also informed CQC they had purchased new infusion pumps for this purpose.

Maternity

The service had systems to ensure staff knew about safety alerts and incidents, so women received their medicines safely.

Staff said pharmacists from the Doncaster Royal Infirmary supported the Bassetlaw District General Hospital (BDGH) site. Pharmacy support was on the BDGH site Monday to Friday.

The trust said medicines were audited yearly. Medicines management and controlled drugs audits had taken place on the 6 July 2023 (Controlled Drug audit) and 11 July 2023 (Medicines management audit) for labour ward and ward A2. Controlled drug compliance ranged from 71.4% on ward A2 to 91.7% 0n labour ward. Shortfalls were identified for both audits. Medicines management audits compliance was 93.8% for Labour ward and 100% on ward A2.

At the 2019 inspection the patient group direction (PGD) paperwork did not clarify which midwives had completed competencies in this area and who were currently approved to carry out this task. At this inspection we saw midwives training documentation which was signed and dated by them and their assessor to confirm they were competent to give PGDs. Patient Group Directions (PGDs) were in use within the maternity service and had been signed and dated by midwives. The overall responsibility for the organisation, monitoring, and reporting of the trusts safe and secure handling of medicines lay with the chief pharmacist. However, responsibility for compliance against policy requirements rested with the management team of the division.

All PGDs were reviewed by the PGD review group, which was a sub-group of the drugs and therapeutics committee, following approval of the drugs and therapeutics committee, its chair requested approval from the trust lead clinician for clinical governance.

Incidents

The service managed safety incidents well. Staff recognised and mostly reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service, however, staff were not always able to describe the learning following some serious incidents. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The trust acted with transparency when it came to incidents. They displayed serious incident investigations and learning on a governance board on ward A2 and listed the most recent themes for the previous month.

Managers investigated incidents thoroughly and women and their families were involved in these investigations. Managers debriefed and supported staff after any serious incident, however, staff were unable to describe any immediate learning following one serious incident they described. We discussed the incident review process associated with this incident and noted that all necessary actions were taken throughout this review. Staff said feedback was shared locally and at team meetings. However, some staff said they had not reported all incidents as they did not have time.

Daily reviews of all incidents highlighted which incidents met the 72-hour review criteria. The local maternity network service proforma was completed for case review and presented at the incident review meeting (IRM) on Mondays and Thursdays. If escalation was required, an email was sent to the trust patient safety incident investigation team to arrange a date for review and invite the consultant who had assisted with the IRM review. At this meeting, a decision was made as to whether the incident was moderate or serious incident status.

Staff said monitoring of incidents took place through weekly incident and notes audits.

Senior managers and executive team members had completed training in serious incidents; most had attended a five-day course.

Oversight of SIs was through the governance and risk midwife. The governance team had oversight of incidents, actions and end dates and contacted the relevant handler to see if they required support. The serious incident panel met weekly to discuss SIs. All SIs were flagged at the divisional governance meeting and when closed agreed through divisional governance meetings.

Staff reported serious incidents (SIs) in line with trust policy.

Trust wide evidence confirmed that nine serious incidents were identified within the children and families division for 2022/23 and 2023/24.

These incidents were closed in January 2023. Two incidents were referred to the Healthcare Safety Investigation Branch (HSIB). The outcome of the HSIB investigations identified that no root cause was identified, and the incidents were closed. Learning and recommendations were identified for each of the incidents, however, it was not evident of the progress made against each recommendation.

Six SIs were reported in 2023, two of which in June and August 2023 were identified as a HSIB investigation. The August 2023 incident identified that the HSIB investigation was declined, and a potential internal investigation would take place. The June 2023 HSIB referral investigation was identified as ongoing. We observed that both incidents had a duty of candour letter sent within 10-days of the initial discussion.

Escalation of incidents was discussed at the divisional governance board. Those incidents which required escalation were presented to the trust board and children's and families board for further discussion/review.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation when things went wrong. Staff we spoke with were aware of their responsibilities in relation to the duty of candour and incident reporting. Staff said incidents were reported through the incident reporting system, for example in the antenatal clinic the largest number of incidents related to antenatal screening.

Multi-agency involvement ensured women and their babies safeguarding needs/incidents were identified and these needs were met. Safeguarding concerns flagged up on the woman's electronic record to alert members of the multidisciplinary team.

Staff met to discuss the feedback and look at improvements to patient care; feedback was shared locally and at team meetings and incidents discussed at the clinical governance meetings.

The bereavement midwife documented the loss of a baby through the incident reporting system. The labour ward lead, governance lead and governance midwife completed the MBRRACE form which was shared at the trust peri-natal mortality meeting. Baby deaths were tracked through the weekly peri-natal mortality meetings between Doncaster and Bassetlaw hospitals.

Trust 'National Perinatal Mortality Review Tool (PMRT) audits dated 20 April 2023 and 10 May 2023 confirmed a total of three perinatal deaths at Bassetlaw District General Hospital. One perinatal death was reported to the Healthcare Safety Investigation Branch.

Maternity

Is the service effective?

Good

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.

Staff followed policies to plan and deliver high quality care according to evidence-based practice and national guidance. The service audit guidelines midwife worked with the multi-disciplinary team to ensure guidelines were kept up to date. Policies were standardised across the service.

The maternity clinical guidelines group met monthly and was chaired by the consultant lead for guidelines and the clinical governance midwife as deputy. The clinical governance administration and clinical governance lead consultant co-ordinated the review and posting of all operational policies and clinical/non-clinical guidelines. We reviewed five clinical guidelines and observed two were out of date and one was due a review shortly. This guidance included: prevention of early onset of group b streptococcus infection, (January 2022), neonatal hypoglycaemia (September 2023) and newborn infant physical examination (July 2023). The DBTH Short Risk Register also identified out of date maternity guidance and policies as an extreme risk.

Staff said guidance for women who wanted to receive care outside of current guidance was in place.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives, and carers.

An example of monitoring of women's care was confirmed after the review of women's notes which confirmed 'Fresh Eyes' of cardiotocography was performed for five women who required this process during their birthing session.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural, and other needs.

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. The Making Mealtimes Matter' initiative meant all non-essential ward activity stopped during the meal service and all activities shifted to support patients to eat.

Staff completed nutritional assessments on all women on their admission to the service. Women's records showed that initial advice on diet, folic acid was given when they booked into the service.

Specialist support from staff such as dietitians was available for women who needed it.

Women confirmed they were happy with the variety and choice of food on offer at the hospital.

Water jugs and disposable cups were available for women's use in clinics and by beds.

Facilities were available for breast and formula feeding mothers.

Infant feeding advice was available for parents which advised on breast feeding. Peer support groups provided additional support.

Pain relief

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

Staff were able to access guidance to assist them when caring for women in labour which included guidance on pain management, for example, Guidelines for the care of women in labour and guidelines for epidural analgesia in labour (v3).

Anaesthetists provided a 24-hour epidural service which staff confirmed provided quick responses to staff requests for pain relief for women.

Staff prescribed, administered, and recorded pain relief accurately.

Staff used the maternity early warning score (MEOWS) to assess women's pain and gave pain relief in line with individual needs and best practice. We saw MEOWS pain scores recorded in five women's records. The 2022 MOEWS audit confirmed 100% of women's pain was documented and escalated if required in labour.

Staff used pictorial communication tools for woman and families who had difficulty communicating.

Staff discussed all pain options and women received their preferred choice of pain relief.

Women said they had received their preferred method of pain relief quickly after requesting it and were aware of the types of pain relief available which included epidural, nitrous oxide (Entonox) and intramuscular pain relief. Women confirmed assessment and management of their pain and pain medicines received was well managed by staff.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women. The service had been accredited under relevant clinical accreditation schemes.

To improve patient outcomes the service had developed a better birth maternity improvement plan which identified core competencies midwifery and medical staff were expected to achieve over a three-year period; year one was 2023/24. Twelve competency modules were identified with the expected targets with monitoring systems and action plans to be identified. The competency modules included the saving babies lives care bundle, smoking in pregnancy, neonatal basic life support and fetal growth restriction. The document confirmed when learning took place this evidence could be added to the tracker. As this was a new initiative it was too early to confirm whether patient outcomes had improved.

Maternity

The service action tracker (July 2023) monitored progress against ten safety actions identified by the clinical negligence scheme for trusts (CNST) a maternity incentive scheme to support the delivery of safer maternity care. Each safety action had a designated operational lead, monthly compliance levels identified, actions required and supporting evidence. The tracker was red, amber, green rated. We observed progress made in some areas rated amber and green, however, safety action 8 which related to training plans, inhouse and one day multi-professional training was mostly rated red. This was because most areas were identified as non-compliant, and most training compliance levels fell below 90%.

The fetal monitoring midwife worked 15 hours weekly and was based on the Bassetlaw District General Hospital site. This role was implemented four years previously following the Ockendon review of maternity services. This midwife undertook fetal monitoring audits; monitored, and reviewed incidents and guidelines, and provided assurance reports to the CNST. Following audit reviews, the cases were shared with the obstetric team and one to one feedback provided if required. The midwife was also responsible for delivering staff fetal monitoring training and competency assessments.

The service had full accreditation for Baby Friendly Status awarded in July 2017 by the United Nations International Children's Emergency Fund (UNICEF). The UNICEF UK Baby Friendly Initiative supports breastfeeding and parent infant relationships by working with public services to improve standards of care. The trust was reassessed on the on 24-25 May 2023 and 27-28 June 2023 for UNICEF UK Baby friendly initiative accreditation. The outcome of this assessment identified that the service fell short of some standards for re-accreditation. The trust was informed that either a follow up assessment or further evidence was needed and that plans should be made for this to occur by March 2024.

Managers shared and made sure staff understood information from the audits and ensured that improvement was checked and monitored. One example was monthly ‘fresh eyes’ audits the outcomes have been reported in the assessing and responding to patient risk section of this report.

The service participated in relevant national clinical audits and a comprehensive programme of repeated audits to check improvement over time. We saw a copy of the ‘Obstetric & Maternity Audit Plan 2023/24’ which was split between: National, Ockenden, Saving Babies Lives, National Institute of Clinical Excellence (NICE) and Local.

The audit programme was also informed by the outcomes of the Healthcare Safety Investigation Branch report findings, outcome of labour audits and audits on the management of 3rd or 4th degree tears.

The outcome from the 3rd or 4th degree tear audit carried out from May to October 2022 said improvements were needed; there was inadequate documentation for the reason of delay of repair within one hour and limited documentation of type and duration of antibiotics and laxatives. Recommendations and an action plan resulted; a reaudit was planned for 1 December 2023.

The induction of labour (IOL) midwife undertook monthly audits of IOL outcomes which were shared with staff. We were told there was no obstetric oversight of this process. When necessary, staff contacted the consultant / on-call consultant for advice. Monthly audit results confirmed when IOL clinical guidelines were not followed reasons were captured and confirmation of consultant involvement identified.

At the 2019 CQC (Care Quality Commission) inspection staff said that staffing shortfalls meant midwives were not routinely performing new-born and infant physical examination (NIPE) checks. At this inspection staff said the NIPE checks were now completed by paediatricians who would refer the baby to the relevant specialist.

Maternity

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The 2019 inspection of the maternity service identified shortfalls in staff appraisal completion against the trust target of 90%. At this inspection staff appraisal completion statistics for all staff groups confirmed that the trust target was not achieved. The 2022/23 appraisal statistics for nursing and midwifery staff were 83.33% (12 staff appraisals were due; 60 were completed) whilst 44.44% of medical staff (five appraisals were due; four appraisals were completed.) We observed an improvement in midwifery appraisal completion rates from the previous inspection where appraisal completion was 41%, however, medical staffing appraisal completion rates had decreased since the last inspection.

Managers gave all new staff a full induction tailored to their role before they started work which was confirmed by the midwives we spoke with. Medical staff spoke of local inductions and a six-week shadowing time introduced the doctor to the service. One doctor said they had not had a separate trust induction.

Staff had an identified mentor and preceptor and were supernumerary for two to four weeks dependent on their personal needs and role. Newly qualified midwives followed a 12-to-18-month preceptorship programme. New doctors also completed an induction prior to working in the unit.

A core competency framework was agreed yearly with the local maternity and neonatal system which identified the module, target, training details and monitoring for a three-year period. The service provided a blank copy of this document, so we were unable to ascertain what progress was made against the core competencies identified for the maternity service.

Managers identified the training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff discussed their training needs with their line manager and were supported to develop their skills and knowledge.

Professional midwifery advocates supported midwives and could also provide supervision if requested by the midwife.

Midwives, nursing associates and medical staff completed revalidation processes to remain on their professional registers.

The service was supported by a band 7 education lead midwife and two part-time clinical band 6 (1.2 whole time equivalent) midwives. Two midwifery clinical educators covered both hospitals. The clinical educator reported monthly reports on medical staff / staff training compliance and circulated this information to key people throughout the service.

The education team's responsibilities included the midwifery preceptorship programme, organisation of multi-professional training and the updating of staff who worked within maternity. Training was based upon requirements from national guidance and because of incidents, complaints, and claims. Staff training was captured on a database that logged the individual's engagement and progress with professional development and skill maintenance.

The education priority was to deliver face to face training over the midwives first year. The clinical skills included, venepuncture, cannulation, intravenous additives, speculum use, epidural top-ups, catheterisation, and perineal repair competences.

The service supported students on placement and maintained close links with the universities.

Staff maintained their expertise pertinent to their role, for example, specialist midwives and community midwives worked within the acute service if there were staffing shortfalls or to maintain and develop their expertise further in specialist areas, for example, diabetes, bereavement.

Simulation training across the maternity service included shoulder dystocia leading to neonatal resuscitation, cord prolapse in theatre leading to preterm neonatal resuscitation, maternity pool evacuation and baby abduction scenarios. Training attendance records confirmed all simulation training exercises undertaken.

Junior medical staff gained skills through completion of rotational posts, accessed mandatory training/teaching sessions, such as K2 training and the practical obstetric multi-professional training (PROMPT) training package. Educational supervisors supported the doctors and some doctors said they had sufficient supervision and regular meetings with their supervisor. In addition, Friday afternoon teaching sessions and a half day per week for professional development was protected. However, other senior staff said they had no protected sessions for continuous professional development, although did have protected time to meet their educational supervisor.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team and held multidisciplinary meetings to benefit women and provide safe care. Involvement of the multidisciplinary team was documented within women's records we reviewed.

Multidisciplinary attendance at labour ward and unit meetings took place. The meeting handover format followed the situation, background, assessment, and recommendation format.

Staff worked across health care disciplines and with other agencies when required to care for women, for example, paediatricians and anaesthetists worked with the obstetricians and midwives.

The anaesthetic and obstetric teams worked closely with the intensive care consultant and critical care outreach charge nurse.

There was 24-hour availability of anaesthetists in the maternity unit, although, working relationships with the anaesthetists were described as poor. Staff said and we were not given reasons for why anaesthetists had not always attended in a timely manner for category two and three caesarean section handovers. Staff confirmed anaesthetic attendance had taken place for handovers for emergency caesarean sections / category one caesarean sections.

Midwifery staff worked closely with safeguarding, learning disabilities and mental health teams when supporting vulnerable women.

Joint working took place between the maternity, neonatal, safeguarding, and paediatric teams when young women under 16 years of age entered the service.

Domestic abuse discussions took place with the woman at their initial booking and second assessment. Confirmation of domestic abuse instigated a referral to the safeguarding team, women's GP's, and health visitors. Domestic abuse discussions took place and were documented in 10 of 16 woman's records reviewed.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Women were reviewed by consultants depending on the care pathway.

Consultants were present from 8.30am to 5pm and on call from 5pm to 08:30am. Consultant staff were often on-call from home.

Consultant presence on the maternity unit meant emergency/non-emergency admissions were seen within 14 hours of arrival in the hospital.

Consultant anaesthetist cover on labour ward was available from 8am to 1pm Monday to Friday. Resident anaesthetist or middle grade anaesthetist provided cover from 1pm to 8am Monday to Friday. Anaesthetists provided a 24-hour epidural service.

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

The early pregnancy assessment unit opened from 8am to 4.30pm Monday to Friday.

Maternity triage was provided by designated staff from ward A2 or the maternity day assessment unit when open.

Health Promotion

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

Three specialist midwife's primary purpose was to support and work with women to ensure they received the appropriate care and support, during and post pregnancy.

The maternal medicine specialist midwife primary purpose was to support the development and implementation of pathways and services for women requiring access to specialist care for significant pre-existing medical conditions during pregnancy.

The pelvic health midwife supported and reduced the number of women living with pelvic floor dysfunction in England postnatally and in later life.

The public health midwife role was to develop, implement and manage all elements of the public health agenda to improve women's wellbeing, promote healthy lifestyles and tackle inequalities.

To meet national priorities to improve health the service implemented a comprehensive local maternity network service equity and equality action plan schedule dated March 2023. The action plan identified key deliverables, success measures, trust lead and red, amber, blue, and green rating status. The areas currently rated red related to some data collection and parent information which was currently under review.

Clinical areas displayed information promoting healthy lifestyles, health promotion and support.

Free parent education programmes were available for women, partners, birth partners, family, and grandparents to attend across both hospital sites.

Carbon monoxide readings were offered to all women at booking. All women who smoked, or had high carbon monoxide readings, were offered referral to the smoking cessation service.

Staff completed medical, social, and psychological assessments on women to individualise support for each woman. Ongoing assessment reviews took place to monitor changes to health and social status and where necessary safeguards were identified.

Assessment of maternal mental health needs continued during, and post pregnancy and women were signposted to support, when necessary, for example, talking therapies, peer support.

Whooping cough and flu vaccinations could be accessed by pregnant women.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit women's liberty.

At the 2019 inspection we found that staff did not demonstrate a good understanding of mental capacity, best interest, and deprivation of liberty. Staff were unable to demonstrate they knew how to support women who lacked capacity to make their own decisions. At this inspection staff were able to demonstrate a good understanding of mental capacity, best interest, and deprivation of liberty.

The trust confirmed that Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) training was part of the adults safeguarding level 2 e-learning module. The trust has identified this was no longer sufficient content to meet the recommendations within the intercollegiate document. As part of the mental health training launch a new package was being adopted. As MCA/DoLs training was combined with L2 adult safeguarding training the trust was unable to report on this separately.

Adults safeguarding training statistics at levels 1-3 were submitted by the Trust. At Bassetlaw District Hospital we observed compliance generally fell below the Trusts training target of 90% for both medical and midwifery staff groups. Compliance ranged from 53.33% to 75% for midwives. Medical staff compliance was identified as 66.67%.

When patients could not give consent, staff made decisions in their best interest, considering women's wishes, culture, and traditions. Staff gained consent from women for their care and treatment in line with legislation and guidance and made sure women consented to treatment based on all the information available. Staff clearly recorded consent in the woman's records.

Staff told us they always asked for verbal consent before providing any care or treatment and documented this in the patients' records.

Staff said women's mental health was assessed on entry to the service and throughout their pregnancy. If any concerns about the women's mental health were raised, they referred the woman to the mental health service. Where women had pre-existing mental health needs ongoing liaison took place with mental health professionals.

Maternity

Is the service caring?

Good ➔➔

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

Compassionate care

Staff treated women with compassion and kindness and took account of their individual needs. Women's privacy and dignity was respected, although, there were occasions when confidentiality was not maintained.

Observations of staff interactions with women confirmed that staff were respectful and took time to interact with women. Staff were discreet and responsive with women and those close to them in a respectful and considerate way.

Staff understood and respected the personal, cultural, social, and religious needs of women and how they may relate to care needs. We spoke with three women and their partners. They all said that they had excellent care and spoke highly of the staff and how hard they worked. Women said, staff had kept them informed in all care and discharge decisions.

Women in the maternity day assessment unit described personal discussions being overheard by other women and families as discussions took place around the beds in the unit.

Women also described situations where they were distressed at the tone of a telephone conversation and the length of time the Doncaster triage team had taken to answer a call.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs. Staff knew how to access medical and psychological support for women with mental health needs.

Emotional support

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

Staff gave women and those close to them help, emotional support and advice when they needed it, and chaperones were available to women.

One woman told us that they had seen several midwives throughout their pregnancy and they had been frustrated by the length of their induction of labour wait.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Bereavement study day compliance for 2023 confirmed that 57.8% (111) midwives and 42.6% (32) maternity support workers had completed this training.

Bereavement services were available for all families experiencing loss. Families could make an entry into a special memories book in the hospital chapel if they wished. However, staff were sensitive to their needs and acknowledged that not all women would want a reminder of their loss.

Bereaved parents could access support through the bereavement midwife, the chaplaincy and counselling services. The trust bereavement lead midwife worked across site and was a great support to the wider team. The lead had secured funding to develop the new bereavement suite that was due to open on the ward. Access to this bereavement suite allowed parents to spend time with their baby. A cold cot was available in the room to place the baby in which allowed the woman / parents additional time spent with baby. Memory boxes and clothing for baby was also provided.

The lead told us how they helped families make memories by providing a pram to walk to the baby loss garden. They also secured funding for photo frames, and they make casts of babies' hands and feet for parents to frame and keep.

The lead told us of the recruitment of specialist pregnancy loss nurses for pregnancies below 16 weeks who were based in the early pregnancy assessment unit.

Staff in the early pregnancy advisory unit offered support and counselling to patients following a miscarriage. Information packs were offered to women/couples following a miscarriage.

Guidance was in place for the surrogate pregnancy journey to ensure that plans were in place for antenatal planning, labour, and the postnatal period. The safeguarding team were informed of changes to plans so the families achieved the best outcomes from the arrangements in place.

Understanding and involvement of women and those close to them

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

The maternity service at Doncaster and Bassetlaw Hospitals included a 'Maternity and Neonatal voices partnership' which was a group of women, birthing people and their families, healthcare professionals, commissioners and others who collaborated to make improvements to maternity services. Leaflets informed women and their families about this service and how they could become involved.

Women were also signposted to external information from the Royal College of Obstetricians and Gynaecologists, for example, coronavirus, pregnancy, and women's health and National Institute of Clinical Excellence guidance.

Women were also signposted to information provided through Tommy's pregnancy hub a midwife-led information hub which covered everything about having a safe and healthy pregnancy, from conception to birth. The information was presented in either written or video formats.

Staff made sure women and those close to them understood their care and treatment and supported women to make informed decisions about their care. Staff talked to women in a way they could understand, using communication aids where necessary. We observed clear communication of options discussed with a woman and the multidisciplinary team. The woman's understanding was checked throughout the discussion and questions answered.

Women received information and could access a wide selection of information leaflets through a variety of sources, for example, women who attended the pregnancy advisory service were given an information package.

Maternity

Weekly antenatal workshops advised women of the methods of induction of labour, informed consent and the other options women had should they not want an induction of labour. Staff said currently plans were not in place to present this information in alternative languages.

Women and their families could give feedback on the service and their treatment and staff supported them to do this.

Is the service responsive?

Good

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

Service delivery to meet the needs of local people.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. They monitored and took action to minimise missed appointments. Staff confirmed a 'do not attend' follow-up process was in place for women who did not attend outpatients' appointments.

To meet the national priorities to improve health the service implemented a local maternity network service equity and equality action plan schedule dated March 2023. Some key deliverables were specific to core groups, for example, identify local demographics of women that had complex social factors.

Changes to the service incident form allowed demographic information capture, for example, to add/capture peoples ethnicity, vulnerabilities, and protected characteristics as mandatory field (Deaf, Disability, Non-English Speaking, Decile of Deprivation). This evidence was presented as a blank form which did not confirm the agreement that this change had yet been actioned.

Maternity voices partnership (MVP) leaflets were displayed throughout the service to encourage parents to join the group to help shape maternity services in Doncaster and Bassetlaw. The January 2023 MVP 'Chairs Monthly Update' confirmed progress made in areas, which included community outreach initiatives.

The service included two maternity units which provided midwifery led care, with the option of a home birth service for low-risk pregnancies. Pregnant people who choose to give birth in hospital booked at either Doncaster Women's Hospital or Bassetlaw Hospital.

Antenatal care was provided in the community setting, in GP surgeries, at home or in one of the four hospitals.

The community midwives told us about the diverse communities they covered and gave examples of how they contacted language line to help with communication. They had an excellent understanding of the needs of all communities in their area.

The bereavement room was used for bereaved families to stay overnight and provided facilities to make drinks and snacks. A resuscitaire was stored in an unlocked store cupboard in the bereavement room. this was not sensitive to the needs of bereaved families if seen by them.

The nurse led early pregnancy assessment unit (EPAU) opened from 8am to 4.30pm Monday to Friday and saw women in the first 16 weeks of pregnancy. Referral to the service was by the GP community midwife or by self-referral. Scanning was available five days a week and emergency scans if needed were reported at Doncaster Royal Infirmary. The EPAU had a mobile ultrasound scanner; before its introduction women who suffered a miscarriage at Bassetlaw District General Hospital and required an ultrasound for a diagnosis, had to leave the EPAU and walk into a busy scan department shared with other patients waiting for either their standard 12 week or 20-week scans.

Staff could access emergency mental health support 24 hours a day seven days a week for women with mental health problems and learning disabilities.

Women who required critical care support were cared for on the adult critical care unit.

The midwife led maternity day assessment unit (MADU) operated from 8am to 5pm Monday to Friday. The unit comprised of a small waiting area and a clinical area with two beds. If confidential conversations were needed a room could be accessed on ward A2. Staff said as medical staff covered the unit, the delivery suite, and the ward this meant women in the MADU were subject to long waits if they needed a doctor review or prescription.

Meeting people's individual needs

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

Staff understood and applied the policy on meeting the information and communication needs of women with a disability or sensory loss.

Guidance was in place which related to the disposal of pregnancy remains.

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

Mobility assessments were completed on women with limited mobility to ensure the necessary aids were provided for those women. Women could use their wheelchairs to access the wards and delivery suite.

The summary report for divisional governance on maternity interpretation services (July 2023) identified several actions required to improve the patient experience in this area. Work was ongoing against some actions, whilst others were completed. Ongoing actions included working with maternity voices to seek service user feedback from targeted groups to understand needs and how this should inform service provisions.

The service had information leaflets available in languages spoken by the women and local community. Information leaflets could be requested in other languages or formats.

Managers made sure staff, women and their loved ones and carers could get help from big word face to face interpreters, telephone language interpreters or signers when needed. Staff described good access to translation services via language line.

A hearing induction loop and pictorial information was available which staff could access as communication aids to help women become partners in their care and treatment.

Staff made sure women living with mental health problems and learning disabilities, received the necessary care to meet all their needs. Women's individual needs such as learning disabilities, autism spectrum, communication or mental health needs were identified when they were first seen at antenatal clinic/early pregnancy advisory unit and were reassessed at each contact.

Staff could access emergency mental health support 24 hours a day 7 days a week for women with mental health problems and learning disabilities. If women showed signs of anxiety or depression staff referred women to the 'Improving Access to Psychological Therapies' (IAPT) services which provided evidence-based psychological therapies to people with anxiety disorders and depression.

Staff said the vulnerable women guideline had recently been updated.

Specialist midwives were available to support women who experienced substance abuse, mental health needs and domestic abuse. Flexible clinic times were given to women attending appointments with the substance misuse midwife and vulnerability midwife and if late they were still seen.

Specialist midwives provided teenage pregnancy support, bereavement support, infant feeding support, weight management and diabetes support. Antenatal and new-born screening midwives and clinical specialist midwives for labour and care during birth could be accessed.

Babies who required transitional care were cared for in ward A2.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.

Mothers self-referred by post, over the phone or online. Completed pregnancy registration forms automatically went to the maternity records department so the mother's details were added to the maternity system. The community midwifery team was notified and arranged booking appointments within two weeks; confirmed by an appointment letter sent to the mother-to-be.

Antenatal care through the midwifery services commenced at the woman's initial antenatal appointment which took place at under 10 weeks dependent on when the woman initially presented with pregnancy and women with complex medical needs were seen earlier

The booking midwife decided whether the woman was high or low risk against identified criteria which identified whether the women received consultant or midwife led care.

During the first booking appointment the community midwife discussed and offered a range of screening tests, including blood tests and ultrasound scans. Tests included blood pressure checks, urine and blood testing and the women's due date was confirmed. These were designed to check the mother's health and baby's health and wellbeing.

Maternity

Managers made sure women could access emergency services and ensured they received treatment. Staff supported women and babies who were referred or transferred between services.

Monitoring of women's and babies' conditions was via the modified early obstetric warning system, neonatal early warning system scoring and K2 electronic recording of observations.

Escalation processes and critical care support was provided through the adult intensive care unit.

Women who required an elective caesarean section were managed by the labour ward team. Currently, elective caesarean sections were performed by the registrar and senior house officer, whilst the consultant remained on labour ward. No concerns were raised by staff about this way of working.

Staff said one or two inductions were taken from Doncaster Royal Infirmary which meant inductions from Bassetlaw General District Hospital were delayed and resulted in these women becoming stressed.

Staff made referrals to tertiary centres for cardiac problems, cleft palate, and genetic conditions.

The outpatient midwife led antenatal clinics offered screening tests; at each visit a urine sample was tested and blood pressure measured. Consultant led clinics were available for women whose pregnancy was identified as a high risk.

Antenatal and postnatal clinics took place at weekends in GPs surgeries.

Learning from complaints and concerns

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

The service clearly displayed information about how to raise a concern in patient areas. Women, relatives, and carers knew how to complain or raise concerns. Patients and families were offered a face-to-face meeting to discuss their complaint.

Managers investigated complaints, identified themes, and shared feedback from complaints with staff and learning was used to improve the service. Staff understood the policy on complaints and knew how to handle them and told us that they tried to resolve patient concerns before they became a formal complaint. Staff said women received feedback from managers after the investigation into their complaint.

The women's and children's division report confirmed 41 obstetric complaints throughout 2022/23. Complaint themes included care, behaviours, and communication issues.

The first claims, complaints and incident data report was published in June 2023 and reviewed maternity service data to assist the service to direct resources to make the biggest impact in improving safety in maternity services. The complaints section of the report identified 41 complaints received in 2022; from 1 January 2023 – 30 June 2023 the service received 20 complaints across the service. The themes associated with these complaints were not identified.

Maternity

Is the service well-led?

Requires Improvement

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders understood and managed the priorities and issues the service faced. They were not always visible in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Maternity services were within the children and family's division. Clear lines of accountability existed within the maternity service. The lines of accountability included a divisional director, clinical directors, a divisional manager, business manager, director of midwifery, head of midwifery, equity, and equality lead and four midwifery matrons. The four clinical directors were split across the maternity, children, and community services. In addition, supporting services included education and clinical governance leads.

Midwifery matrons worked across site. The midwifery leads included the head of midwifery, community midwifery manager, quality and safety manager, labour ward managers and inpatient matrons.

Specialist midwives worked across the service.

Staff told us that they felt there was a disconnect between staff on the ground and senior leaders. They felt unsupported during times of high pressure and felt that escalations of heavy workload where not acted on by department leaders. Staff told us they felt well supported by immediate management but did not see the senior leaders much.

Leadership development for senior midwifery and obstetric staff was ongoing through the trust leadership course which staff confirmed presented opportunities for training and development into more senior roles.

The education lead worked closely with the Director of Midwifery to identify professional development needs based on the trusts strategic plan and succession planning requirements.

Some staff described development opportunities for all grades of staff, with funded courses available to allow for career progression. Staff were supported through Maths and English courses, this resulted in automatic progression to the higher pay band once completed. Staff told us they had not been allocated protected time to complete core competency packages.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Maternity

The trust vision was 'to be the safest trust in England, outstanding in all we do.' Four objectives originated from this vision, one of which included to provide outstanding care and improve patient experience. To deliver the four main objectives four breakthrough objectives were identified for 2022/23, for example, objective one was to maintain and improve CQC ratings by achieving improvements in quality and outcomes. The trust vision and values were displayed throughout the maternity service.

The draft maternity strategy (2023-2027) was confirmed by the service to be in line with the three-year delivery plan for maternity and neonatal services (March 2023) and aligned with the Doncaster and Bassetlaw Teaching Hospitals, nursing, midwifery, and allied health professionals' quality strategy 2023-2027. The maternity draft strategy identified six strategic themes which identified objectives and measures against each theme. Growing, retaining, and supporting our workforce also featured within the strategy.

Culture

Staff felt respected but did not always feel supported and valued. They focused on the needs of mothers and babies receiving care but recognised that they could not always accommodate all mother's needs. The service promoted equality and diversity in daily work. The service had an open culture where patients, their families and staff could raise concerns without fear.

Senior staff said the culture and working relationships had improved across the Doncaster and Bassetlaw maternity units over the last 12-years as staff now worked across both sites; band 7 staff worked together when escalation was required to ensure appropriate measures and support were in place. Senior staff said how proud they were of all the maternity staff across both maternity units and recognised the support staff provided by having worked additional hours.

We spoke with trained and untrained staff groups whilst at Bassetlaw District General Hospital maternity unit who said they were proud of their team; staff were brilliant and teamwork amazing. Health support workers were described as the glue on the ward that held the ward together.

Staff said staffing was challenging; staff morale was low; staff were stressed and going off sick. Staffing needed to improve, more so at Bassetlaw as it was a smaller unit. Staff described being on shifts with two midwives and the coordinator. The unit had got busier with less staff which meant they could not give the best care due to low staffing levels. For example, a post section woman asked for help feeding her baby, but the midwife does not have the time to feed the baby herself and passed the baby to mum to feed.

Staff made the following observation: 'It feels like there is an accident waiting to happen, staff are going of sick and are stressed. This is not what we signed up for, how long can we continue doing this if the staffing situation continues. You can have a 13-hour day with no break. The midwife in charge would escalate that staff have no breaks. Midwives are encouraged to take breaks however this would only leave one midwife on the ward.'

Staff spoke of the low visibility of management. One staff member said they had not seen higher management on the Bassetlaw site, they were more visible on the Doncaster site.

Most staff were aware of and said they could access freedom to speak up guardians, colleagues and/or managers to raise concerns. However, some medical staff were not aware of the freedom to speak up guardians.

The bereavement lead midwife told us that she was very well supported with her wellbeing and was able to access reiki and alternative therapies through the trust.

Maternity

Governance

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

We saw evidence of a local maternity and neonatal system which aimed to standardize and share good practice through weekly and monthly meetings.

The head of midwifery oversaw governance with the support of a divisional governance lead. Senior staff confirmed direct access to the trust board and named people were accountable for actions within the governance team.

The director of midwifery oversaw the effective implementation and application of all midwifery related trust policies, procedures, and standards within the division with professional responsibility for ensuring compliance with the policies. However, we observed not all policies and procedures were in date which the service had identified as an extreme risk on the Doncaster and Bassetlaw Teaching Hospitals (DBTH) Short Risk Register.

Staff confirmed the governance culture had started to embed within the midwifery team and understood their responsibility for service quality and patient safety and mechanisms to monitor patient safety, measure clinical outcomes and other quality measures were in place. Medical staff said they had been encouraged to attend governance meetings and participate in clinical audit. Cardiotocography (CTG) meetings took place twice weekly.

The monthly maternity clinical audit meeting reviewed local and national standards for maternity services and developed the annual audit programme. Medical staff said they were encouraged to undertake clinical audit.

There was trust board oversight of performance of antimicrobial prescribing and stewardship. Staff said the service was alerted by email and the alert discussed at the maternity governance and children's and families trust boards following which actions were relayed back to ward managers and teams.

Midwifery and medical staffing establishments were monitored closely through several committees including the children and families' board. Ongoing midwifery staffing updates were documented in the meeting minutes which included: the divisional clinical governance meeting held on the 12 May 2023, clinical governance committee of the 19 May 2023 and maternity and gynaecology services clinical governance committee minutes dated 23 June and 28 July 2023.

Staff said reporting of 'red flags' was through Birthrate Plus. Currently, the post-natal birthrate plus tool was being redeveloped by the manufacturer these flags were captured through the incident reporting framework.

The community matron attended the operational meetings where any committee issues were raised and later discussed at the maternity governance meeting.

Management of risk, issues, and performance

Leaders and teams had systems to manage risk and performance however, we were unable to ascertain whether all risks, issues and performance were managed effectively. Risk escalation processes were in place; risks and performance were discussed at trust board level and plans were in place to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Maternity

During the 2019 inspection of the maternity service, we found some area's performance was either not monitored or gaps in monitoring existed. At this inspection we inspected how the service managed risk, issues, and performance again and reviewed the previous gaps identified at the 2019 inspection to ascertain what progress had been made.

Previously, some risks to the service, were not included on the current risk register or recognised by the leadership. These risks included training shortfalls and equipment monitoring / calibration and maintenance shortfalls. At this inspection we saw some shortfalls in equipment maintenance as described in the environment and equipment section of the report.

At the 2019 inspection the patient group direction (PGD) paperwork did not clarify which midwives had completed competencies in this area and who were currently approved to carry out this task. At this inspection we received training records for those midwives across the service who had completed PGD competency training. The training documentation did not confirm whether the midwives were based at specific hospital locations. Following the inspection, the Trust confirmed that midwives worked between all sites, however, this was not identified on the training documentation.

Although, we saw improvements in how the service monitored risk and performance at this inspection some areas required ongoing improvement. These areas included mandatory training attendance, staff appraisal completion and staffing.

At this inspection ongoing risks were identified on the service and corporate risk registers however we also identified some areas of concern which related to the maternity day assessment unit (MADU) which was escalated to the inspection lead. In the MADU patients were seen in order of attendance and not prioritised based on risk or condition. Staff said up to 30 patients could be seen daily and sometimes 10 patients waited whilst the two beds were occupied. It was unclear how one staff member could monitor the patients' presenting risks on the unit and maintain oversight of all waiting patients. Escalation took place if the MADU was unmanageable for one midwife, however, the staff member was not supported with additional staff support. We were told that managers would try and pull midwives from elsewhere but due to pressures across the whole department, this rarely happened. Following the inspection, the Trust identified average daily attendances as 3 or 4. If attendances were higher than average attendances the escalation would be for the wards to provide support, this is an infrequent occurrence.

Medical staffing evidence requests were not received despite repeated requests. This meant we were unable to ascertain whether there were risks within these areas.

Risk Management:

The director of midwifery advised on risks that required escalation onto the trust risk register and advised on actions required to mitigate those risks.

Local and South Yorkshire agreed maternity services network escalation policies were in place.

Senior staff involved in the risk and safety agenda participated in the incident review process when clinical commitments allowed. They were unable to attend audit meetings as they clashed with divisional meetings. They did not directly supervise the audit programme and felt there were initially limited assurance processes, however, recognised this had improved. The clinical risk lead met with the chief medical officer for support and to escalate concerns. Currently, there were no immediate maternity concerns identified at the hospital.

Maternity

Risk management guidance was in place at trust level and within the maternity service. The maternity service document was the Maternity Services Risk Management Strategy (v8). The maternity and gynaecology risk register formed part of the specialty clinical governance group and was reviewed and updated monthly at the Maternity and Gynaecology Clinical Governance Forum.

Trust risk registers captured trust wide risks which scored 15 and over. The description, controls, risk level, description of work in place to reduce the risk, review date and risk owner were identified. The risk register was reviewed and updated monthly. Maternity risks identified on the children's and family division risk register were on the corporate risk register. The top three maternity risks identified on both risk registers were: lack of elective section slots at Bassetlaw District General Hospital, Midwifery staffing levels and out of date maternity guidance and policies. The current rating for these risks was 15, 16 and 20 were rated as extreme risks on the children's and family division risk register and high risks on the trust risk register.

Monitoring of policies was through committees and groups, for example, the clinical governance quality committee (CGQC) was responsible for the operational aspects of clinical risk, clinical governance, and patient safety risks. Divisional or corporate directors and managers had identified leads in risk and training within their respective areas.

Highlight reports confirmed the Quality and Effectiveness Committee were kept informed of progress made against the safety actions identified and how this impacted the trusts clinical negligence scheme for trusts (CNST) status. The Quality and Effectiveness Committee latest minutes dated the 7 August 2023 confirmed progress and compliance status against safety actions 1,5,6,7,8, 9 and 10. The milestones identified on the report were red, amber, green (RAG) risk rated.

Action notes confirmed the trust board of directors were kept informed through feedback from the maternity safety champions. Maternity safety champions meetings provided a forum for discussion of maternity and neonatal safety issues, agreed local actions, and escalated safety issues to the board of directors following the executive and non-executive director safety champions walk rounds. The maternity safety champion action notes dated 20 July 2023 recorded the concerns raised with actions and updates. One concern related to 'indications for induction of labour do not always follow the unit guidelines.' Part of the agreed action was to continue monthly induction of labour audits and share at governance meetings.

The maternity service reported into national reporting systems in the event of an adverse outcome meeting the set criteria; NHS Early Resolution Scheme (ERS), Perinatal Mortality Review Tool (PMRT), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE).

The perinatal mortality and morbidity group met to review incidents within the previous month where mortality or morbidity was highlighted.

Trust wide corporate business continuity, major incident, severe weather, and pandemic influenza plans were in place to advise staff should any of these events occur.

Staff handovers:

Safety huddles discussions which included safeguarding, incident reports, staffing (medical and midwifery) took place throughout the service twice daily. This was via a team's link for staff on the Bassetlaw site.

Information from these meetings informed the staff and senior teams of any potential risks and was used to inform the situation, background, assessment, and recommendation (SBAR) communication tool. SBAR was audited and we observed an improvement from the 2021 audit figures as compliance throughout 2022 was 100% for antenatal handovers.

Maternity Dashboard:

The maternity services dashboard was used to monitor performance. The dashboard contained a range of performance measures colour coded green, amber, and red dependant on progress made against the target. The current maternity services dashboard (July 2022 to July 2023 confirmed the RAG status and thresholds of 30 key indicators. We observed that 16 indicators were rated red either for the whole of the time or on specific months for that indicator. We looked at each hospital site to ascertain whether there was a trend for the indicators viewed and noted most red ratings at Bassetlaw District General Hospital (BDGH) related to following initiatives: Smoking and breast feeding at initiation. Induction rates for both maternity services were above the 32.8% threshold.

Assisted Birth - 3rd/4th degree birth tear – at BDGH the highest score was 15.4% (October 2022), following this scoring fluctuated between 6.3% (Dec 2022) to 9.1% in June 2023 for BDGH. The indicators red threshold was identified above 6.05%. Statistical information confirmed both maternity units performed similarly for red thresholds identified for this indicator. These statistics were discussed monthly at the governance meeting and recorded on the maternity key indicators dashboard. The trust confirmed a professional midwifery advocate led in this area since 2019. A part time pelvic health lead midwife had recently been appointed and their role was to lead change related to all pelvic health including 3rd & 4th degree tears.

The saving babies' lead midwife was responsible for progressing the saving baby's toolkit. Each element in the toolkit identified a specialist midwife who led on the action plan and delivered compliance for the area. Staff said the saving baby's toolkit was used as a dashboard and to-date the maternity service had achieved 50% of the key performance indicators. Midwifery matrons contributed to this through monthly tendable audits; audit leads completed weekly audits.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data was not consistently submitted to external organisations as required.

Medical staffing evidence requests were not received despite repeated requests. This meant we were unable to ascertain whether there were risks within these areas.

The Caldicott Guardian was responsible for ensuring that personal information about those who used its services was used legally, ethically, and appropriately, and confidentiality maintained.

The service submitted information to the NHS Resolution Early Notification Scheme. One incident was reported in the time-period 1 April 2022 to 31 August 2023. This incident will be investigated through the Healthcare Safety Investigation Branch.

K2 technology collected all the relevant patient details right from the start. In four of five records four cardiotocography (CTG) recordings although recorded were not stored on the K2 electronic maternity information system due to connectivity issues with the CTG equipment and K2 archiving. Staff identified this risk, and it was on the risk register; when we checked a moderate risk about the failure of CTG machines was identified. Cardiotocography is a technique used to monitor the fetal heartbeat and uterine contractions during pregnancy and labour.

The maternity service had not updated the K2 technology despite a national update being available. The Birmingham symptom specific obstetric triage system (BSOTS) a system based on established triage systems in emergency medicine and used an assessment with clinical prioritisation of the common reasons that present within maternity triage was not recorded on K2. Following the inspection, the Trust confirmed there was a problem with the software company and the risk was being mitigated by using a manual system until the update is provided.

Quarterly data was submitted to the Yorkshire & Humber Clinical Expert Group. The monthly dashboard used the K2 electronic record system which rated the key indicators via a colour coded (green/amber/red) traffic light approach.

The digital midwife monitored uploads to the maternity services data set (MSDS) and local maternity and neonatal system dashboards.

Information governance and duty of candour were covered within the statutory and mandatory training programme. Patients received a leaflet on duty of candour.

The trust information technology (IT) department supported IT needs. Safeguards were in place to ensure the security of patient information. Access to IT systems was password protected and following discharge women's notes sent to an off-site secure storage facility.

Currently, the figures which related to women undergoing induction of labour were recorded in a paper diary on labour ward which staff said was planned to be moved to an electronic process in the future.

Community midwives had no issues connecting to the internal computer systems when out in the community. Community midwives had mobile phones, dongles, and laptops. If the system failed completely the business continuity plan was to revert to paper, and upload retrospectively.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The Maternity and Neonatal voices partnership (MNVP) was a team of service users, service user representatives, midwives, doctors, and commissioners; a representative of which sat on the local maternity service steering group. MVNP met quarterly to review and contribute to the development of local maternity services, quality standards and clinical risk. The committee ensured women's views were considered in any decisions made about changes in local maternity service. Action plans from complaints and clinical incidents were a standing agenda items at this meeting.

Collaboration with local commissioners, stakeholders and local communities took place; the maternity neonatal partnership chair and co-chair were funded for 15 days a month. These meetings were well attended by some but not all local users. Antenatal education was available for all groups.

Maternity

The Picker 2022 Survey Response / Action Plan Update - August 2023 confirmed a response rate of 27% for Doncaster and Bassetlaw Teaching Hospitals (83 responses of a possible 307). For the top five scores the service scores had improved from the 2021 survey with scores that ranged from 73% to 100%. The bottom five scores included having enough information, partner involvement and being offered a choice of where to have the baby. The action plan following this survey was in development.

Friends and Family feedback was collected which confirmed satisfaction with the maternity service provided to women and their families.

The 2023 staff survey resulted in a report and action plans specific to the inpatient and community maternity teams; each team had a designated action plan in place. Both maternity teams identified morale concerns through their responses to the staff survey when asked questions about their job, for example relationships at work are strained. Both action plans were undated and identified no leads for the action areas. Staff said staff feedback sessions were given post survey.

The service had just completed the Safety, Communication, Operational, Reliability and engagement (SCORE) survey which was an internationally recognised way of measuring and understanding the culture that existed within the maternity teams. Following this the service would have structured action plans to inform them of how to proceed.

Meetings for day and night staff took place. We were told that night staff meetings took place before the morning handover whilst day staff meetings took place after handover. Teams' meetings were held for the Doncaster and Bassetlaw maternity units at 12am.

Additional staff meetings had recently taken place due to staff morale issues. Please refer to the detail in the culture section.

Staff said the Head of Midwifery walked around the service once or twice weekly; at Bassetlaw Hospital there had been limited visibility. Teams' meetings were to be introduced so that midwives could attend and speak with senior midwives.

Staff said the maternity safety champion completed monthly walkarounds of the service and the Chief Executive Officer was visible across the service.

Patients were encouraged to provide feedback on their experience of the service using a friends and family feedback form. The form asked patients what was good about their care and what could be improved.

Monthly friends and family tests results were displayed in clinical areas.

Positive feedback was displayed in clinical areas from women and their families.

The equality lead worked closely with travellers and hard to reach groups.

Learning, continuous improvement and innovation

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

Maternity

A new nursing role was introduced across the maternity service to support families with early pregnancy loss. The early pregnancy loss (EPL) role was covered one day per week by specialist nurses who worked closely with the bereavement midwives, patients and their families affected by early pregnancy loss up to 16 weeks. The role included signposting women and their families to emotional support and counselling, as well as practice advice and information on available services and resources.

Capital funding had provided monies for equipment replacement throughout the service.

Urgent and emergency services

Requires Improvement ↓

Is the service safe?

Requires Improvement →←

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

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff. However, managers did not ensure everyone completed it.

Nursing and medical staff received mandatory training. However, they did not always keep this up to date. We reviewed the latest compliance figures for UEC nursing and medical staff's mandatory training at Bassetlaw. The nursing staff's latest overall completion rate was 83.22% and medical staff's rate was 41.67%. These did not meet the trust's 90% target. The only UEC staff group to meet mandatory training compliance were paediatric nursing staff with 92.42%.

On our last inspection, we told the trust they must ensure all staff, particularly medical staff complete mandatory and safeguarding training sessions in line with trust policy and relevant to their role.

At this inspection we found the service had made some improvement, but compliance was still well below trust target, and this was a repeat breach of regulation.

Medical staff told us that they did not have protected time which made it more difficult to complete mandatory training.

Managers monitored mandatory training. However, they did not always alert staff when they needed to update their training.

Leaders told us that mandatory training was not a priority during the COVID-19 pandemic. However, they had since recruited two band 7 staff and one band 6 post to support staff with training. Twice weekly sessions covered safeguarding and other focused topics. Leads had introduced lunchtime and breakfast teaching within the department.

In response to medical staff's lack of training compliance, the divisional director (DD) held a 'hot area of discussion' with regular reminders for colleagues. They targeted the staff groups with the lowest compliance, and highlighted figures at every management board meeting. The DD wrote to medical staff individually if necessary. The DD reported compliance had improved.

The mandatory training was comprehensive and met the needs of patients and staff. New doctors told us this training was easy to access.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia. Staff were asked to complete the Health Education England (HEE) Oliver McGowan training package which was being rolled out across the trust.

Urgent and emergency services

Safeguarding

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

Nursing and medical staff received training specific for their role on how to recognise and report abuse. At the time of our inspection divisional compliance across all staff groups was 100%.

However, safeguarding leads identified their training was no longer sufficient content to meet the intercollegiate document recommendations. They had identified a more detailed safeguarding training package due to be adopted in early 2024 as part of the mental health training launch.

Work had been done around safeguarding training, to raise staff knowledge and awareness. Paediatric staff completed safeguarding adults and children training levels 1 and 2 online, and level 3 every two years was face to face. Additional sessions were available for staff to refresh their knowledge and skills.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. They worked with other agencies to protect them. Paediatric nursing staff documented and acted upon safeguarding concerns in patient notes, such as unexplained bruising for a looked after child.

We saw domestic violence and female genital mutilation (FGM) support was available, within the department which patients could access.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff could explain how they followed safeguarding processes or guidance.

Agency staff said they had to inform the nurse in charge about any safeguarding concerns. They could access the trust intranet to report these themselves.

Staff confirmed they had a safeguarding lead and knew how to contact them.

Staff followed safe procedures for children visiting the ward. The paediatric physical environment helped to keep children safe.

The children's assessment area pathway within the department meant they and their parents/carers had to navigate areas mixed with adults. However, all children in the children's area were always accompanied.

Cleanliness, infection control and hygiene

The service did not control infection risk well. Staff did not use equipment and control measures to protect patients, themselves and others from infection. They did not keep equipment and the premises visibly clean.

During the inspection we identified clinical areas that were not clean and did not have suitable furnishings which were well-maintained.

Several areas of the paediatric UEC were very cluttered due to a lack of storage space. This meant equipment was dusty and inaccessible for staff to clean properly.

We found several areas and equipment which staff could not clean effectively. For example, an ECG machine with stickers, residue and paint loss, damaged walls, a rusty cabinet and two broken consumables trolleys which had drawers repaired with surgical tape. We found dirty trolleys containing clinical patient equipment. For example, the Thomas splint trolley drawers and some consumables trolley drawers were unclean and smeared.

Trolleys and storage contained out of date items. We also found equipment unsuitably stored for optimal use or cleanliness. For example, consumables were stored on the floor.

Staff did not always clean equipment after patient contact and label equipment to show when it was last cleaned. Cleaning records were not always up to date to demonstrate areas were cleaned regularly. We reviewed daily cleaning checklists in the paediatric UEC and found 24 missed days in the six months from 24 February 2023 up to the date of our inspection. There were gaps in the weekly cleaning tasks on 5 and 12 June 2023 for UEC area 1. There were no signatures for the 12 June schedule over the seven days. There were only two signatures for two of the five elements for the week of 5 June. This meant we could not always ensure all areas were cleaned as often or thoroughly as needed.

Staff did not always follow infection control principles in line with trust policy. We observed some staff were non-compliant with bare arms below the elbow standards throughout the department. They did not adhere to best practice regarding regular hand washing, for example between episodes of direct patient contact.

We saw some UEC staff including senior nurses wore acrylic nail extensions on shift within clinical areas. This presented an infection risk and did not adhere to the trust's dress code and uniform policy.

However, all staff we saw were compliant with and wore appropriate personal protective equipment (PPE) which they correctly donned and doffed. The trust had also implemented the national 'gloves off' campaign which raised awareness of appropriate glove use and skin health.

We escalated our concerns during the inspection and the trust took prompt actions to make improvements. The estates team conducted a review of the damaged walls and took remedial action.

Staff placed patients with nosocomial infections inside rooms, for example if they were COVID-19 positive. Staff told us in the event of an outbreak they could inform the infection prevention and control (IPC) team. We saw records of COVID-19 tests for patients with the date and time of their swab, result and the ward the patient was being transferred to.

Staff were aware of potential risk of exposure to immunosuppressed or compromised patients. For example, paediatric UEC triage nurses did not leave unimmunised children in the waiting room when space allowed. However, due to overcrowding in the department, social distancing was difficult to achieve whilst space was limited.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. However, staff were trained to use equipment and managed clinical waste well.

The design of the environment did not always follow national guidance. On our last inspection in February 2020, we told the trust they should ensure the mental health assessment (MHA) room was furnished and brought into use.

On this inspection we found the department's designated MHA room was now furnished and used, but not entirely compliant with the royal college of psychiatrist's latest psychiatric liaison accreditation network (PLAN) standards. The standards provide a clear and comprehensive description of best practice in liaison psychiatry services. The room had

two wipe-clean weighted chairs, no ligature points and viewing windows in the two-way doors. However, staff we asked were unsure if the room had environmental risk assessments completed. This room also had closed circuit television (CCTV) but no signs informing patients and the public this was in use. We reviewed the trust's latest CCTV policy which did not mention patient or public consent. However, the policy stated under section 7 policy statement that 'warning signs are displayed as required by the information commissioner's office's (ICO) code of practice'. This meant the MHA room did not adhere to trust policy.

We reviewed the health and safety risk assessment for the MHA room. This included eight associated hazards with existing controls scored from 1 to 25. However, the form was not signed, dated or reviewed. This meant we were unsure when staff had completed the latest risk assessment.

The UEC environment became very hot, and we saw no ventilation in communal areas or any cubicles with fans or external windows. This meant patients wating for longer periods could potentially become uncomfortable. At the time of our inspection building work had started on the Bassetlaw Emergency Care Village (ECV) which would substantially improve the environment.

We found a 'leak diverter system' over one patient trolley in the resuscitation area. This drained moisture from an exposed ceiling section into a very dusty bucket through a dusty pipe with a wide funnel. Staff told us this system had been in place for at least a year. We returned to the resuscitation room later that day and found this had been removed and the ceiling tile replaced.

We saw some outdated signage in reception such as COVID-19 posters about restrictions. One patient relative told us signage between diagnostic imaging and the main UEC was poor so they could not find their way back.

Staff did not always carry out daily safety checks of specialist equipment. We reviewed resuscitation trolley checklists for adults and children. Trolleys were sealed with all equipment in date. The checklists however had not been fully completed during June and August on 10 occasions. In addition, there were gaps in ventilator checks in the paediatric area, and logbooks for some anaesthetics machines did not always have serial numbers recorded.

Staff told us if equipment broke it took a while to be repaired.

The service did not always have enough suitable equipment to help them to safely care for patients. Staff told us there were sometimes not enough Lucas pumps required during cardiac arrests because they had been sent for repair. In addition, there was a lack of splints to use when treating patients with neck of femur fractures which resulted in delays and a poor patient experience.

The fire door at the back of the Assessment and Treatment Centre did not have swipe access. In June 2022 we heard a confused patient tried to leave through this door and fell down the stairs. There had also been a previous incident where a patient managed to get down the stairs to B Floor. Service leads resolved and mitigated this risk by installing an alarm system on the door. The new Bassetlaw ECV building would resolve these estate and environmental issues.

The service had suitable facilities to meet the needs of patients' families. The department had provision to accommodate relatives or carers in a designated overnight room.

Staff disposed of clinical waste safely. Clinical waste was managed in a way that kept people safe. Sharps bins we checked were off the floor, clean, not above the fill line and labelled with a date and signature.

Urgent and emergency services

Patients could reach call bells and staff responded quickly when called. We found accessible working call bells in all patient cubicles. However, the paediatric UEC service toilet had no call bell.

Security support was available for the department 24 hours a day. Staff reported security staff responded promptly.

Assessing and responding to patient risk

Staff could identify and quickly act upon patients at risk of deterioration. Staff completed risk assessments for each patient. They removed or minimised risks and updated their assessments.

Staff identified and escalated deteriorating patients appropriately using a nationally recognised tool. The department used the national early warning score (NEWS2) which staff managed well. UEC used the navigation nurse model at the front door which triaged patients into the appropriate pathway.

Nursing staff used the Manchester triage tool during a patient's initial assessment. The clinical risk management tool was used by clinicians to enable them to safely manage patient flow when clinical need exceeded capacity.

Staff used screening tools for patients such as the sepsis six pathway. Service leads had access to electronic observations as per the trust's digital strategy 2021-2024. This ensured staff were immediately alerted when a patient's risk of sepsis was identified.

Staff completed risk assessments for each patient on admission and reviewed this regularly. UEC staff used paediatric advanced warning scores (PAWS) for the initial assessment of children and their clinical deterioration. This was a screening tool that evaluated the degree of illness and the likelihood of transfer to an external paediatric intensive care unit (PICU). Staff recorded follow up actions if warning scores were high.

Receptionists could alert the triage nurse or push an emergency alarm if patients became unwell.

The trust used the sepsis six pathway and care bundle. Paediatric staff followed a paediatric version of the same screening tool for children aged 5-11 years. Staff followed a flow chart to determine if patients were at low, moderate or high risk of sepsis using specific criteria.

At the time of our inspection, staff covered both sepsis recognition and NEWS in a training course with a deterioration element, but not as stand-alone training.

Staff completed a 25-point skin inspection for patients on admission. They ensured the pressure ulcer traffic light assessment was completed within a patient's first two hours in the department.

The service used falls kits for patients at high risk of falls which contained yellow socks and a blanket. We saw staff administering these and they worked well as a visual prompt. Signs asked staff to see yellow and think falls risk. Staff had access to a falls holistic care team and a therapy assistant practitioner.

The service had 24-hour access to mental health liaison and specialist mental health support. The service could access psychiatric liaison any time of day.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. At the time of our inspection the trust was rolling out a new MHA tool to staff.

Urgent and emergency services

The trust had worked with a local mental health and community services trust and a neighbouring healthcare trust on new urgent and emergency care tools in May 2023. They previously had no mental health risk assessment tool available.

Staff shared key information to keep patients safe when handing over their care to others.

Nurse staffing

The service had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. We reviewed the staffing establishments across all UEC areas including paediatrics for the six months from February to July 2023. We found numbers were filled on nearly all shifts.

On this inspection we found significant improvement around pediatric nurse requirements in line with Royal College of Pediatrics' and Child Health guidance. The children's UEC was fully staffed for all shifts on the day of our inspection. For example, two registered children's nurses were on the CAU from 9am to 9pm supported by healthcare assistants.

However, some staff told us UEC often had nursing staff shortages. They felt these impacted patients with delayed care and discharge, lack of flow, administering pain relief and timeliness of take-home medicines.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Staffing levels were adjusted daily according to the needs of patients. The service had received a staffing uplift shortly before our inspection. Leaders completed the Shelford 2014 safer nursing care tool (SNCT) supported by NHS England/Improvement, and then applied professional judgement. This is a staffing tool used widely across NHS organisations and independent health providers in England.

SNCT data was collected periodically, and at least bi-annually. The first UEC SNCT data collection occurred in August 2023 and would be repeated in November 2023. This would bring it back in line with trust establishment review timeframes.

The number of nurses and healthcare assistants matched the planned numbers. Managers said healthcare assistants (HCAs) would occasionally need to cover wards, but they were not left short-staffed. UEC staff could request support from the intensive care unit (ICU) if needed, and some theatre staff supported comfort rounds in the department.

The service had low and reducing vacancy rates. At the time of our inspection the service had low vacancies. Data showed for July 2023 there were 2.36 full time equivalent band 5 nurse vacancies.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience. The medical staff did not match the planned number.

However, they kept patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service did not have enough medical staff. However, they kept patients safe. The service was supported by 22 whole-time equivalent (WTE) consultants who provided cross-site services in both trust UEC departments. However, they needed 34 consultants and two were retiring soon after our inspection.

At the time of our inspection the department had 6 tier 4 WTE senior registrars in post and needed 20. The service had 20 WTE tier 3 or 4 senior house officers (SHOs) level and registrars in post which had increased from 7. However, overall, the service needed 54. For tier 2 junior SHOs the service had met its target of 30 WTE.

A paediatric consultant was based onsite in CAU from 9-6 weekdays, excluding bank holidays and 9-12 weekends and bank holidays. However, when they were on call a paediatric middle grade doctor was available onsite 24 hours a day, supported by tier 1 to 4 medical staff.

The service also had other recruitment programmes in place for medical staff to include new innovative roles such as clinical fellows, and a practice educator.

Medical staff submitted exception reports to flag work which varied from their agreed schedules. The main themes were extra hours worked and unpredictable emergency care which required junior doctors to stay late to ensure patient safety.

The service did not have low and reducing vacancy rates for medical staff. 29% of junior medical staffing posts, or a rate of 7.2 WTE were unfilled from March to June 2023.

The service did not have low and reducing turnover rates for medical staff. This had the highest long-term rate (LTR) full-time equivalent (FTE) percentage of 28.4%, and LTR headcount percentage with 28%.

Sickness rates for medical staff were not low and reducing. These had the most overall occurrences, with 202 but only the third highest FTE percentage of 2.67% of all divisions.

Managers could not always access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work. The service used a locum card to help orientate and familiarise new medical staff.

Service leads had put detailed operational planning to ensure pathways were staffed as safely as possible, and patient cancellations minimised during the industrial action by junior doctors. The service provided full emergency cover during the consultant strikes, as a minimum provision equal to Christmas day. The service's emergency planning response was led by the Chief Operating Officer and the division.

Managers made sure locums had a full induction to the service before they started work.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Urgent and emergency services

Patient notes were comprehensive, and all staff could access them easily. We reviewed six patient notes. This included two patients who had been in the department for over 12 hours. Staff had maintained detailed record keeping with timely baseline observations.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. Patient's medical records were kept locked in trolleys when not in use.

Medicines

The service did not use systems and processes to safely prescribe, administer, record and store medicines.

On our last inspection we told the trust they must ensure staff follow the proper and safe management of medicines. On this inspection we still found concerns relating to this area. We followed up and escalated these concerns as this was a repeat breach.

During the inspection we found in the paediatric UEC used medicine bottles with no opening dated recorded on the labels. Controlled drugs (CDs) were stored with other medicines in the resuscitation area. This did not meet the trust policy for the safe and secure handling of medicines policy Part B controlled drugs. This stated in section 4.2.7 'the CD cupboard is used only for the storage of CDs. No other items are stored in there'.

Staff did not always complete medicines records accurately and keep them up to date. We found gaps in drug fridge temperature checks; for example, no checks were done from 1 to 18 August 2023. The service took no action when temperatures exceeded the maximum range of 8 degrees.

Medical staff checked if patients wore wristbands or asked their details before administering medicines. Patients we asked told us staff always checked they had no allergies before administering any medicines.

The service held staff huddles three times a day where medicine management was reported. Staff learned from safety alerts and incidents to improve practice. We saw a standing medicines management agenda item on the division's monthly clinical governance agenda. Managers shared these minutes with all relevant UEC prescribing staff.

However, we were unsure if staff learned from medicine errors and omissions due to the concerns we found on inspection.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured actions from patient safety alerts were implemented and monitored. However, managers could not always recall shared key learning or actions from incidents.

Staff reported serious incidents and in line with trust policy. They knew what incidents to report and how to report them. We reviewed themes and trends from UEC incidents in the last 12 months. The most common incident was skin integrity.

Urgent and emergency services

We found some UEC incident themes and trends matched our findings during inspection, such as lack of checklist prompts for specialist equipment. One incident from May 2023 involved a patient overdose of insulin due to 'a delay in the assessment of a potentially life-threatening condition' and resulted in low harm. Staff could not complete blood sugar level assessments as the equipment required a daily quality assurance check. Since this incident staff had put equipment safeguard checks in place.

The service had one never event. This related to a retained guidewire. The service investigated and completed a 72-hour and root cause analysis report. Actions were taken to address the incident reports recommendations.

Nursing leads encouraged staff to raise incidents if they felt care was compromised. This was used as part of lead nurse's evidence to prove shifts were challenged and escalate as required. Where there was service impact, the incident was reported on the risk register and monitored.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. We asked managers about serious incidents resulting in the death of an absconded patient at the service's other main site from October 2022. They mentioned a mental health triage tool but were unaware of the full detail or any other shared key learning or actions from this incident.

We heard the UEC lead nurse cascaded learning from incidents. UEC staff teams had a closed social networking group to communicate information about incidents.

Staff met to discuss feedback from incidents and look at improvements to patient care. We saw learning from monthly serious incidents on the division's clinical governance agenda. There was evidence of learning, for example staff were reminded to do a full tendon examination after a theme of finger injuries.

Patients and their families were involved in incident investigations.

Is the service effective?

Requires Improvement

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

The trust had an emergency care intensive support team (ECIST) visit which gave 19 recommendations to provide a consistent UEC pathway. In response the service facilitated workshops to focus on the key issues considered in the ECIST

report. These would be taken forward through the UEC delivery board attended by all system partners. The actions would proceed to the trust's Delivery and Transformation Board. We saw in trust board meeting papers from November 2023 the service was using ECIST disaggregated data to support high-intensity UEC users and understand more about them. This meant service leads could consider what initiatives to implement for supporting these patients and demand management.

Staff protected the rights of patients subject to the Mental Health Act (MHA) and followed the Code of Practice. Security staff had completed training in minimising and managing violence and aggression (level 3 advanced physical intervention skills). This meant they were suitably trained to understand and appropriately respond in the event patients with mental health needs became aggressive or violent when in UEC. As a result, they could respond to all patients with mental health needs, including those detained under sections of the Mental Health Act.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed the medical staff board round in the majors area where the needs for patients were discussed.

Nutrition and hydration

Staff used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs. However, staff did not always give patients enough food and drink.

Staff did not always ensure patients had enough to eat and drink. Two patients waiting for a bed for four hours had not been offered food or drinks.

However, one patient told us staff considered their hydration and nutrition if they were kept waiting. Staff brought them cups of tea or snacks and they liked the food quality and choice.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Trust staff used the malnutrition universal screening tool (MUST) to monitor patients. This was a five-step nationally recognised and validated tool to identify adults at risk of malnutrition.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff completed MUST scores and fluid intake and output balance monitoring in patient's notes.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Nursing staff used the Manchester triage tool during the patient's initial assessment. This covered scores to assess patient's pain levels from 1-10.

Patients received pain relief soon after it was identified they needed it, or they requested it. One patient on ambulatory care told us staff responded immediately when they had any pain.

Staff prescribed, administered and recorded pain relief accurately. We saw paediatric UEC nursing staff documented analgesia with a clear plan in the notes.

Urgent and emergency services

Patient outcomes

Staff monitored the effectiveness of care and treatment. The service participated in relevant national clinical audits.

Outcomes for patients were positive, consistent, and met expectations, such as national standards.

Managers and staff used the results to improve patients' outcomes. Where expected standards for audits were not met, leads developed and implemented an improvement plan and monitored this in the relevant trust committees.

The service had a lower-than-expected risk of re-attendance than the England average. The trust's percentage of patients that reattended the UEC within seven days of a previous attendance was generally similar to the England and regional averages from March 2021 to February 2023.

In February 2023 the trust proportion was 8.1% compared to the England average of 8.4% and Midlands regional average of 8.8%.

Managers and staff carried out a programme of repeated audits to check improvement over time. At the time of our inspection the trust had recently rolled out a new audit and assurance system to strengthen actions and assurance. Managers planned to use information from the audits to improve care and treatment. They shared and ensured staff understood information from the audits. Trust and service leads were still refining the data sets questions, and reporting processes associated with this system.

We reviewed the service's average audit system scores across UEC areas from 1 March to 31 August 2023. It showed UEC achieved 100% in monthly medicines management and 93.5% for weekly assurance. However, we still found several issues around the proper and safe management of medicines, so the scores did not correlate with our findings on inspection.

A weekly assurance inspection in the assessment and treatment centre (ATC) on 11 August 2023 found medications were left unattended and on work surfaces not locked away in the treatment room. The audit lead issued guidance with actions and measurable outcomes shortly before our inspection. However, we still found these medication management and storage issues in the department.

Likewise, an audit of controlled drugs in UEC on 6 July 2023 found staff had only signed the 'received by' section of the requisition book less than half the time. They also found the quantity received in the register was specified in figures, not words on most receipts which contravened correct CD documentation. The audit lead had issued no guidance, actions or measurable outcomes as a result. This meant we could not ensure audit and assurance data led to UEC staff's sustained improvement.

We reviewed weekly assurance inspection reports, including from 16 April 2023. However, long-standing issues we found on inspection were not reflected in the compliance results. This meant we were unclear how robustly managers audited their environment and IPC. For example, the report stated UEC staff had checked resuscitation and airway trolley equipment daily, but we found several dates were missed.

Managers shared and made sure staff understood information from the audits. Every Friday the UEC lead nurse held a performance meeting and provided feedback to staff.

Urgent and emergency services

Competent staff

The service made sure staff were competent for their roles. Managers held supervision meetings with them to provide support and development. However, they did not always appraise staff's work performance, especially medical staff.

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

Since our last inspection, adult nurses covering the children's UEC had received training to ensure they had the relevant skills and competencies to care for infants, children and young people.

Managers gave all new nursing staff a full induction tailored to their role before they started work. At our last inspection in February 2020, we told the trust they must ensure managers consistently appraise work performance to ensure staff were competent for their roles and their development was supported appropriately. On this inspection we found UEC staff were sufficiently competent for their roles.

However, managers still did not support medical staff to develop through yearly, constructive appraisals of their work. We saw the division's latest appraisal rates for 2022-23. The division had the lowest total appraisal completion rate of the trust, with 65.18%. This did not meet trust target. Only two of nine medical staff's appraisal was complete. This was a completion rate of 22.22%.

The nursing staff appraisal completion rate was 61.9%, comprising 24 of 63 staff still being due an appraisal. This also did not meet trust target. Nursing staff we asked had appraisals and many were due shortly after our inspection in September 2023.

The clinical educators supported the learning and development needs of staff. Staff were complimentary and grateful about clinical education support.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We heard additional training was available for adult nurses in paediatric UEC and paediatric nurses could support them.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff told us their working relationships between nursing and medical staff were good.

Seven-day services

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

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

Urgent and emergency services

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support on units. For example, alcohol withdrawal and smoking cessation information was available for staff to give to patients,

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

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. The service did not follow their own CCTV policy so patients in the MHA room could fully consent to being monitored and recorded.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. All patients attending the UEC had a brief capacity assessment. If staff had any concerns the patient lacked capacity, they were escalated to the relevant team.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patients we asked said staff sought their consent before any care and treatment. Staff clearly recorded consent in the patients' records. One patient said staff ran through the consent process every visit and explained the risks involved.

However, patients with mental health needs could not consent to treatment based on all the information available. The service did not follow their own CCTV policy so patients in the MHA room could fully consent to being monitored and recorded.

Nursing and clinical staff received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). This was part of staff's adults safeguarding level 2 e-learning module.

Information was displayed in the main waiting areas or throughout the department promoting staff's awareness and understanding of the MCA and its key principles.

Is the service caring?

Good

Our rating of caring improved. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness. They took account of their individual needs. However, staff could not always respect patient's privacy and dignity.

Urgent and emergency services

Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff were discreet and responsive when caring for patients. Staff we saw closed cubicle curtains fully when they were providing personal care for patients. Patients told us staff pulled down window blinds before carrying out any treatment. We saw no staff providing care interventions and treatment to patients in communal public areas or on the back of ambulances.

However, staff could not always maintain patient's privacy and dignity. For example, people sat in the waiting area could overhear patients booking in with receptionists asking their personal details and health issues. This was due to the reconfigured layout with chairs close to the booth.

Patients said staff treated them well and with kindness. One patient in ambulatory care told us staff always asked how they felt, checked their bed position was comfortable and were approachable.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. A chapel and multi faith room was available for patients and visitors could use with access to a chaplaincy and prayer room.

Emotional support

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

Staff gave patients and those close to them help and could give emotional support and advice when they needed it. Nursing staff told us they could give patients enough emotional support.

Staff supported patients who became distressed in an open environment. We observed a patient with anxieties about their chest pains and saw triage nursing staff took extra time to reassure them with empathy and respect.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. For example, staff always considered the use of professional independent interpreters for breaking bad news to patients whose first language was not English. For example, when detailed and perhaps distressing results needed to be conveyed.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Appropriately trained and skilled staff gave care and treatment to children and young people which was integrated and coordinated around their particular individual needs and that of their families.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We spoke to the mother of a patient. They were very happy with the staff's attitude and information given and were clear about their planned care and treatment.

Staff talked to patients in a way they could understand, using communication aids where necessary. Staff told us sign language interpreters were available and could be utilised whenever the clinician felt they were necessary to ensure effective communication.

Urgent and emergency services

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. UEC had 'your opinion counts' for patients and families where their views or suggestions about the service was dealt with in confidence. Comments could be anonymous, but if patients wanted a reply, they were guaranteed within 14 days.

The service used the friends and family test (FFT) review to gain feedback. Staff gave patients the FFT form to complete just before they left the department. The trust achieved their target completion rate.

Staff supported patients to make advanced and informed decisions about their care. Patients told us staff respected their choices.

The feedback from the emergency department survey test was negative. CQC's urgent and emergency care survey 2022 showed the trust scored significantly worse than other trusts for two questions:

- Q20. If a family member, friend or carer wanted to talk to a health professional, did they have enough opportunity to do so? 5.4.
- Q34: Did a member of staff tell you who to contact if you were worried about your condition or treatment after you left the Urgent Treatment Centre? 6.5.

Is the service responsive?

Requires Improvement

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

Service delivery to meet the needs of local people.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. Flow and triage nursing staff knew the different communities and backgrounds in the region who presented in the department.

Facilities and premises were appropriate for the services being delivered. The paediatric assessment and waiting areas were separate from the main department so children had a different pathway to adult patients. The paediatric nurses had a reception window to monitor the children's waiting area which had some provision such as toys, books and games. However, this window was small and partly obscured by a poster.

The service had systems to help care for patients in need of additional support or specialist intervention. For example, CAU staff could access play and activity leaders to provide appropriate support to children and young people.

Managers monitored and took action to minimise missed appointments. They ensured that patients who did not attend appointments were contacted.

The service relieved pressure on other departments when they could treat patients in a day. From the service's project charter work, leads had increased the number of patients streamed into the same day emergency care (SDEC) from UEC. This stayed consistent at an average of 451 patients per month over the period from August 2022 to August 2023. UEC had also streamed 204 patients to SDEC direct from ambulances over the same period.

The children's UEC service could respond to peaks in demand. We reviewed paediatric attendances for all patients aged 0-15 from August 2022 to July 2023. Children's UEC's total for all paediatric attendances was 12,578 over the year. This was considerably less than the trust's other main UEC site as the service was smaller. Monthly attendance numbers peaked in December 2022, with the second highest monthly figure in November 2022. Most patients streamed were referred to Bassetlaw urgent care centre. This meant the service was working to reduce delays for children waiting to be seen.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Staff had access to specialist learning disabilities nurses. One learning disabilities liaison nurse had community involvement and could speak to families. The service had access to a learning disabilities service team, ambassadors with key responsibilities and leaflets for patients around what to expect when attending the department.

Wards were designed to meet the needs of patients living with dementia. There was a dementia-friendly link nurse to help offer patients with dementia or delirium suitable materials and activities. We saw provision in the department for patients with dementia. Staff could access a patient-centered care nurse to lead on dementia care. Staff completed dementia training.

In collaboration with an external training provider, a dementia tour bus experience had visited both trust UEC sites in July 2023 with further visits planned for autumn. This gave staff a unique insight and immersive perspective into the challenges faced by individuals living with dementia. This helped staff support colleagues with developing a deeper understanding of the condition, enhancing the care provided to patients.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. We saw 'this is me' forms in the department for staff to complete information to help them support patients with dementia in hospital. The trust was in support of John's campaign. This was a public declaration stating staff always welcomed carers to support patients living with dementia or experiencing delirium.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff could routinely record related information on the trust's patient clinical management system or using a passport.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. UEC staff could use 'the big word' telephone interpreting service for quick access. Staff we asked reported no delays or issues when they needed this service.

The service had information leaflets available in languages spoken by the patients and local community. Admitting clinicians were aware of associated risks with not obtaining all relevant information from patients upon admission. Staff provided as much information as possible to patients in their own language with planned admissions. However, as most admissions were over 45 minutes, staff prioritised face to face interpreters, or relatives or friends if the patient preferred. Staff would first ensure patient consent was gained and be vigilant for any potential signs of abuse.

Access and flow

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

The service made sure patients could access emergency services when needed, but they did not always receive treatment within agreed timeframes and national targets. However, managers monitored waiting times.

Trust wide ambulance handovers within 15 minutes deteriorated from 65.2% in May 2023 to 59.8% in June 2023. This did not meet the national average for June 2023 of 64%.

Trust wide ambulance handovers within 30 minutes deteriorated from 90.2% in May 2023 to 85.6% in June 2023. This did not meet the national average for June 2023 of 78.2%.

Trust wide ambulance handovers within 60 minutes deteriorated from 98.2% in May 2023 to 95% in June 2023. This met the national average for June 2023 of 91.8%.

Bassetlaw District General Hospital generally saw a much smaller proportion of ambulance handovers taking over 60 minutes over this period, compared to both its sister sites and the NHS ambulance service which served the hospital.

The service saw a considerable increase in ambulance handovers from 5.6% in August 2022, to 14.8% in December 2022. This was followed by a reduction to 0.5% in April 2023.

UEC nursing leads told us they held monthly meetings with their local ambulance services to review and discuss any issues. However, the department had no hospital ambulance liaison officer (HALO) or ambulance response coordinator (ARC) from the local ambulance service to help reduce their ambulance turnaround times.

Trust wide four-hour performance was 69.65% in June 2023 (against a standard of 95%). This was a reduction in performance from 74.16% in May 2023. The trust's performance was second in the region and remained in the second quartile nationally with a national performance of 72.8% for June 2023.

In June 2023 there were 17,094 attendances to the UECs, of which 5,188 were in the department over four hours before admission, discharge or transfer.

BDH UEC had 5,216 attendances in June 2023, of which 990 were in the department over four hours. This meant their performance metric of 81.02% was considerably better than the trust's other UEC, regional and national averages.

(Source: NHS England - A&E SitReps)

Time to initial assessment

Urgent and emergency services

The trust's median time from arrival to initial assessment was consistently longer than the England average from March 2021 to February 2023.

The trust median increased considerably from 19 minutes in July 2022 to 50 minutes in December 2022. This was followed by a reduction to 16 minutes in February 2023.

(Source: NHS England - A&E SitReps)

Time to treatment

The trust's median time from arrival to treatment was generally like the England average from March 2021 to February 2023. The only exception was December 2022, when the trust median temporarily increased to one hour 58 minutes (England median one hour 30 minutes).

UEC leads monitored their average nurse triage waiting times. We reviewed the minutes from July 2023 which averaged at 20 minutes. The lowest and highest daily triage times were 13 and 30 minutes respectively. Triage staff could request extra staff for support at peak times if they were available.

Total time in UEC

The trust's median total time in UEC was shorter (i.e., better) than the England average from February to November 2022. There was then a temporary increase, from two hours 57 minutes in November, to three hours 20 minutes in December. However, as of February 2023 the trust median had reduced to two hours 51 minutes. This was shorter than the England median of three hours four minutes.

(Source: NHS England - A&E SitReps)

Median total time in UEC per patient

The trust consistently reported a shorter 95th percentile total time in UEC compared to the England average from September 2021 to February 2023.

There was an increase from 10 hours 42 minutes in July 2022 to 16 hours 19 minutes in December 2022. This was followed by a reduction to six hours 37 minutes in February 2023.

The percentage of patients admitted, transferred or discharged within four hours of arrival at the trust was generally similar to the England and regional averages from April 2021 to March 2023.

The percentage of patients waiting more than four hours from the decision to admit to admission at the trust was consistently higher (i.e., worse) than the England and Northeast and Yorkshire regional averages from April 2022 to March 2023 (though for March 2023 the England average was not available).

The trust's performance peaked at 54.0% in December 2022, before reducing to 39.9% in March 2023. The Northeast and Yorkshire regional average for that month was 34.8%.

The number of the trust's patients waiting more than 12 hours from the decision to admit to admission increased from 24 in March 2022, to 501 in December. There was then a reduction to 116 in March.

Urgent and emergency services

Emergency access within 12 hours

Trust wide 12-hour performance was 2.64% in June 2023, a slight deterioration in performance from 2.59% in May 2023. The trust is in the first quartile nationally with a national performance of 10.3% for June 2023. In June 2023 there were 452 12-hour breaches (2.64% of all attendances).

The service saw 47 of these 12-hour breaches in June 2023 (0.90% of total attendances). We asked the UEC matron and service manager how they worked to reduce these breaches. They showed us Doncaster (and Bassetlaw) Electronic Reporting Information Centre of Knowledge (DERICK); a real-time live dashboard and compliance platform which helped them monitor beds, waiting times, ambulances, and patient numbers when not directly in the department.

Managers reviewed all breaches and checked for harm.

Managers and staff could not always work to make sure patients did not stay longer than they needed to.

On our last inspection in February 2020, we told the trust they must ensure long waits were not experienced by patients at Bassetlaw District General Hospital (BDGH) requiring assessment by mental health services or by surgical patients waiting to be transferred to Doncaster Royal Infirmary.

On this inspection we found limited improvement, as both these patient cohorts still experienced long waits.

The number of patients leaving the service before being seen for treatments was low. As of February 2023, the trust percentage was 4.5% compared to the England average of 4.8% and Midlands regional average of 5.3%. The service's percentage of patients who left before being seen by UEC staff was 5.3% in March 2023. This had reduced slightly from 6% in March 2022. This meant the service's rate of patients who left before being seen had reduced and was consistently lower than average.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. The service had plans in place for repeat attendances such as flags on the patient clinical management system. Some of these processes had been tightened with more safeguards since the death of a repeat patient absconding incident in October 2022.

Leads held discussions about transfers between the hospital departments and the limited resources UEC had available to facilitate this. At times UEC had to provide staffing to support a transfer. However, staff were usually not transfer trained, and it also left a staffing deficit in the department.

Staffing and skill mix was reviewed to see if they could better support these transfer problems. As a result, UEC gained an informal transfer team which included an operating department practitioner, senior nurse and doctor from an anaesthetic or ITU background. Some staff had attended transfer courses to improve their skillset. At the time of our inspection, a transfer team which used the local ambulance service fleet had improved cross-site waiting times.

Managers monitored patient transfers and followed national standards. Trust leads told us they had a good working relationship with their local NHS ambulance service, and teams frequently liaised with the department's streaming nurse.

There was orthopaedic provision out of hours for review with direct access to senior clinicians.

However, consultant staff expressed concerns around integration with other specialities. We heard this could cause a lack of bed availability that directly impacted flow. For example, the hospital had an orthopaedic registrar or surgical advanced care practitioner (ACP) from 8am to 8pm but no beds for this specialty to accommodate patients. This meant UEC staff could not always transfer patients to Doncaster.

We heard UEC had been under pressure due to the volume of computerised tomography (CT) scans undertaken. Common causes of CT scans were for seizures, or transient ischemic attacks (TIAs) when there was no indication for imaging. Service leads held discussions at Bassetlaw UEC and acute medicine clinical governance meetings. This led to actions to reinforce the pathway which reduced their CT demand.

Learning from complaints and concerns

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

Staff understood the policy on complaints and knew how to handle them. Patients, relatives and carers we asked knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas. The trust's patient advice liaison service (PALS) and formal complaints team contact details were visible in numerous places throughout the department.

Managers investigated complaints and identified themes.

Nursing staff told us their most common complaints were about waiting times and patient expectations not being met.

At the time of our inspection the service had no Parliamentary and Health Service Ombudsman (PHSO) complaints in progress.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Requires Improvement

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

Leadership

Leaders had the skills and abilities to run the service. They were visible in the service for patients. Leads understood the priorities and issues the service faced, however, they did not always manage them. Leaders were not always approachable to all staff groups.

The divisional structure was a triumvirate of director, nurse, and general manager. They were supported by two emergency and acute medicine clinical director posts, the latter of which was vacant at the time of our inspection.

Urgent and emergency services

At the time of our inspection the service had appointed a new divisional nurse who would commence their role from early October 2023. The divisional director had covered both divisions until UEC formed a new separate division.

Leaders had the skills, knowledge, experience, and integrity they needed. Leads knew what service improvements were needed, and which priorities were outstanding from their revised development plan.

Divisional leads felt they were sufficiently focused on patient care and experience. They attended accountability meetings with senior executives so felt they had a voice and the chance to have important and necessary conversations. Medical staff said their triumvirate were approachable and understanding of their challenges.

Nursing staff told us the senior leadership team and site manager were visible and approachable for staff. For example, the lead nurse always had an open door and was contactable. If their line manager was cross-site or based at the trust's other UEC, staff had a supportive equivalent leader onsite.

The service had clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership.

There was a development programme, which included succession planning. For example, the service worked to address sustainability amongst the medical workforce through the trust's hybrid international emergency medicine programme.

However, some UEC consultants told us the hospital's UEC felt like an afterthought, as more attention was placed at Doncaster. They felt the management approach was not collaborative with their staff. For example, paediatric UEC nurses were moved to a paediatric nursing structure without being fully consulted.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. Service recovery and a consistent strategy were delayed due to a high turnover of senior and lead staff.

The trust's vision was 'to be the safest trust in England, outstanding in all that we do'.

The service had a trustwide improvement plan in place which reported through the Transformation Board. This included metrics and national standards. A service leads meeting on 1 March 2023 discussed the next 12-month programme which began in April 2023. The plan included five key areas;

- UEC improvement plan redesign
- Data and information to consider a trustwide strategy approach to patient data
- Board and ward round processes and ensure delays were highlighted and escalation plans developed
- Whole system discharge planning to develop and improve the alignment to home first principles and best practice
- The people, to build trust among the clinical teams through organisational development processes

Patient flow measurements were highlighted within the report and were another area of focus over the 12 months. A senior responsible officer was assigned to the individual elements of the improvement programme. Progress against the plan would be monitored through the trust's internal governance structure and reported to the Transformation Board.

Urgent and emergency services

The service's strategy included plans for a new Bassetlaw emergency care village to expand and enhance the hospital's UEC. It was aligned to the wider health economy and would support the Bassetlaw community's needs long-term. This meant the service would be better equipped to provide same day accessible services, including 24/7 urgent and emergency paediatric care for children reducing patient transfer to Doncaster.

The project began detailed work in 2021 with an internal team of clinicians and trust leads working together with external specialist advisers and construction partners. The project team engaged with internal and external stakeholders to ensure the new build met clinical requirements.

Culture

The service had an open culture where patients, their families and staff could raise concerns without fear. Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. However, not all staff felt respected, supported or valued.

Not all staff felt supported, respected, and valued. Some staff described a lack of respect, listening and 'compassionate leadership' from the trust. Medical staff told us they felt disenfranchised from higher management and felt pressure from them to meet performance targets. CQC had received 5 whistleblowing's since June 2022. We followed up these themes at this inspection.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and appropriate learning and action was taken because of concerns raised. For example, the service had undertaken a freedom to speak up (FTSU) review in response to whistle blowing concerns to the CQC with an action plan implemented.

The service had also completed a cultural change programme supported by organisation development partners. This was to address one of the division's top risks around workforce challenges impacting upon safe care.

The service had mechanisms for providing staff at most levels with the development they need. However, this did not always include appraisal and career development conversations. Both medical and nursing staff appraisal rates missed trust target. The division had the lowest total appraisal completion rate of the trust.

Staff did not always feel positive and proud to work in the organisation. There was not always a strong emphasis on the safety and well-being of staff. The latest NHS staff survey 2022 results showed the UEC department's three lowest scores out of a possible ten were 'we are recognised and rewarded' with 4.6, 'morale' with 4.7 and 'we are safe and healthy' with 4.8. These three and their six other metrics all scored at least 0.5 below trust average.

Governance

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Leaders worked with partner organisations. However, leaders did not always operate effective governance processes throughout the service to address breaches from our last inspection.

There were effective structures to support the delivery of the strategy and good quality, sustainable services. These were regularly reviewed and improved. Service leads held divisional clinical governance meetings on the last Friday of every month. Any staff could join or dial in from home. Minutes and themes were written on staff room noticeboards.

However, on this inspection we found two repeat breaches from our last inspection. The service had only made limited improvement around staff's mandatory training compliance. We found no improvements relating to staff's proper and safe management of medicines. This meant we could not ensure governance processes and systems of accountability were effective.

We reviewed clinical governance meeting minutes from June, July, and August 2023. Agenda items included mental health triage and sepsis tool updates as well as paediatric transfer process and observation.

Senior sisters' meetings chaired by the lead nurse were held every other month as a communication forum to keep staff informed.

Arrangements with partners and third-party providers were governed and managed effectively to encourage appropriate interaction and promoted coordinated, person-centred care. Divisional leads worked closely with their external partners on models to improve patient streaming. For example, they had coordinated six sessions with their urgent treatment centre provider supported by ECIST to test and support pathways to reduce delays. Leads had undertaken other specialties work in gynaecology and oncology with external partners to divert patients out of UEC.

Divisional leads maintained strong links with their local integrated care partnerships in Bassetlaw, system partners in Nottinghamshire and regional and national organisations. For example, leads engaged in specific collaborative work on UEC recovery to deliver a winter plan to reduce the known and reasonably foreseeable associated risks. The division's winter plan reflected NHS England guidance issued in July 2023 to identify a national approach.

Staff were clear about their roles and understood what they were accountable for, and to whom.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact. Staff contributed to decision-making but could not always avoid financial pressures compromising the quality of care. Service leads could not always provide sufficient assurance about risks they faced.

There were not always effective systems for identifying, recording, and managing risks, issues and mitigating actions. During the inspection we found risks relating to infection control, environment, equipment, and management of medicines which had not been identified and actioned effectively.

The service had a risk register and there was alignment between the recorded risks and what staff said was 'on their worry list'. We reviewed the latest divisional risk register. The main risks were long waiting times to access care, workforce challenges and delays in patient assessment and treatment. There were mitigating actions in place, for example staff were completing clinical harm reviews for all patients waiting in UEC over 12 hours. All risks had controls in place and leads reviewed them quarterly.

There was a programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. However, the audit programme was not systematic or fully embedded.

The trust had rolled out a new trust wide audit and assurance system, to strengthen actions and assurance. However, the trust was still refining the data sets questions, and the reporting processes. Some internal audit areas had not yet commenced such as NEWS2 or deteriorating patient.

Potential risks were taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. However, staff said the service's winter and escalation plans for 2023/24 had not yet been released or shared with them.

We followed this up with divisional leads who said these plans were still in the planning phase and going through governance processes. They had held two workshops for staff to discuss issues and felt plans were progressing well and being put in place much earlier this year.

There were processes to manage current and future performance. These were regularly reviewed and improved. The service had performance targets as part of the UEC improvement programme to see 76% of patients within four hours by March 2024. They planned to achieve this by targeting three areas for patient performance standards and working closely with a third partner provider.

Performance issues were escalated appropriately. The service had ongoing work to improve performance and patient flow through the UECs, and into and out of the trust hospitals. In 2023/24 they planned to reorganise their divisional structure to create a new division of UEC composed of emergency and acute medicine. At the time of our inspection this had been led by their divisional director for 12 months since April 2023.

Divisional leads assessed and monitored the impact on quality and sustainability when considering developments to services or efficiency changes. At the time of our inspection divisional leads had been in post for between 18 months to two years. During that time, they explained from a state of flux they became able to drive required changes despite COVID-19 and other disruptions.

Information Management

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

Information technology systems were used effectively to monitor and improve the quality of care. The trust's main patient records management system worked well and included all relevant patient observations and results on one system. This kept patient records paper-light and gave staff good oversight of patient care.

The service had built in IT safeguards, such as the red, amber, green (RAG) rated 'footsteps' system to support clinical prioritisation of patients.

The service planned to use consultant connect technology to unlock UEC capacity by connecting paramedics to specialist consultants in SDEC for advice and guidance.

There were arrangements to ensure data or notifications were submitted to external bodies as required.

Divisional leads told us e-referrals had been piloted for four weeks, which had seen a positive impact on waiting times. They planned to roll this out imminently as part of a pre-winter piloting system.

Urgent and emergency services

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. However, medical staff told us leads did not always openly engage with them.

People's views and experiences were gathered and acted on to shape and improve the service. The trust performed within the expected range for all nine sections in the CQC Urgent and Emergency Care Survey 2022.

People who used services, those close to them and their representatives actively engaged and were involved in decision-making to shape services and culture. This included people in a range of equality groups.

Patient groups were invited to walk around the site to gain insights on the difficulties of finding their way to where they needed to go. This fed into the patient environment group work to improve signage across the trust.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. The division was part of a South Yorkshire UEC alliance which focused on service developments, and system wide areas of focus to local populations.

Service leads had helped develop direct pathways from ambulance services to SDEC medical and surgical pathways.

Divisional leads had undertaken UEC work around meeting the needs of local communities and demographics. The service had a 'high intensity users' group' (HIUG), where mental health and local authority advocates came to discuss patient needs with UEC staff.

The staff engagement score in the latest NHS staff survey was 6.1 out of 10. This was 0.7 lower than the trust overall's score.

Staff routinely thanked each other through a private messaging function. They gave reward and recognition to their colleagues,

Learning, continuous improvement and innovation

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

There were standardised improvement tools and methods, and staff had the skills to use them. The service had completed quality improvement projects including patient-led redesign of pathways. Another QI project had resulted in improved ambulance handover times during April to August 2023 which had resulted in positive outcomes. Data showed that 63-72% of patients were handed over in under 15 minutes, and 94% of patients handed over within an hour.

There were systems to support improvement and innovation work, including objectives for staff, data systems, and processes for sharing the results of improvement work. There was a public health consultant for health inequalities based onsite undertaking work around training and awareness for staff. For example, one training provider had supported quality improvement work with a focus on health inequalities. At the time of our inspection leads were discussing how to link this internal work with their system partners.

Urgent and emergency services

The service participated effectively in and learnt from internal and external reviews, including those related to mortality. Learning was shared and used to make improvements. The division fed any relevant incident learning from patient deaths into the trust's mortality and morbidity group. They contributed to the learning disabilities mortality review (LeDeR) programme to learn from the deaths of people with a learning disability.

Leaders and staff strived for continuous learning, improvement, and innovation. This included participating in appropriate research projects and recognised accreditation schemes. The trust had been recognised nationally for recruitment of specialist registrars to consultant posts under the certificate of eligibility for specialist registration (CESR) programme, having promoted one new consultant consistently for the last ten years through this route. As a result, the trust was used as an RCEM case study for good implementation.

Trust and senior medical staff were proud of the trust's innovative and international long-term recruitment workforce planning to better facilitate clinical capacity and development in UEC. Nationally the trust had the highest consultant production under the CESR programme, to which clinical leads had recruited ten new consultants over ten years. Their current clinical director came through this route. The trust's hybrid international emergency medicine (HIEM) programme recruited tier 2 and 3 doctors from Nepal and India on a four-year scheme with two years in the United Kingdom. They planned to achieve sufficient tier 4 doctors within 12-18 months of our inspection.

Diagnostic imaging

Good ↑

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff but did not always make sure everyone completed it. Training for autism had not been received by staff at the time of the inspection.

Staff received but did not always keep up-to-date with their mandatory training, with compliance rates at an average of 87% against a trust target of 90%.

The mandatory training was comprehensive and met the needs of patients and staff. Staff were provided with training specific to their job role, this meant they received the required training relevant to their role.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, and dementia. The trust had appointed learning disabilities ambassadors into each area, these staff received enhanced levels of training and delivered learning sessions in their own teams. They attended overall trust meetings with ambassadors from other parts of the trust. The autism training for staff had not been held yet but was planned to be rolled out later in 2023 for all staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers told us they can view this on a dashboard to see overall compliance in training as well as individual results and due dates.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it, but this was not always kept up to date and was below the Trust training target.

Staff received but did not always keep up to date with training specific for their role on how to recognise and report abuse. The compliance for training across the trust in diagnostic imaging was at 87.5% completion in safeguarding training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust had a specific safeguarding team that staff could contact at any time for concerns and referrals.

Diagnostic imaging

Staff could access safeguarding advice via the trust's lead nurse for safeguarding. Staff explained some vulnerable patients may come to the department with a signed consent form from the referrer if they were unable to give consent themselves. There were a small number of children referred to diagnostic imaging for suspected physical abuse checks. If these patients did not attend (DNA) staff would send a DNA report back to the referrer.

Staff attended paediatric multidisciplinary meetings to discuss referrals, images and reports relating to children.

We reviewed the trust's safeguarding adults at risk of abuse and neglect policy which was in date (April 2022), version controlled and had a review date of Feb 2025.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Staff provided records to show cleanliness of equipment had been checked. All rooms and public areas were cleaned daily by hospital domestic staff, and cleaning checklists were available to staff.

Clinical area cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

The service generally performed well for cleanliness. Recent PLACE scores for the hospital shows achieving higher than national average scores in most areas. The latest (2022) Patient-Led Assessments of the Care Environment (PLACE) score was 98.4% for cleanliness.

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

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff disposed of ultrasound gels in bottles at the end of every day. Sonographers cleaned and disinfected ultrasound probes before use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could not always reach call bells although staff responded quickly when called. We did observe one patient who was brought from a ward asleep and then left alone, this patient was also left in a position where they were out of reach of a call bell. We raised this whilst on site during the inspection and were told this was an unusual occurrence and that patients are always able to reach a call bell.

The design of the environment followed national guidance. There was clear signage throughout the departments where ionising radiation or magnetic resonance imaging (MRI) equipment was used and there were controls to restrict access to patients and staff. Equipment used in MRI environments were suitable for use and labelled as MR safe. There was appropriate PPE available including lead aprons and coverings.

We saw radiation protection supervisor reports showing reviews undertaken against IR(ME)R and learning shared with staff through team meetings and training.

Diagnostic imaging

Staff carried out daily safety checks of specialist equipment. Staff provided servicing and maintenance documents for all equipment. Staff were able to raise any immediate concerns to managers who took action to rectify faults quickly.

Staff completed quality assurance (QA) checks on all equipment. These were mandatory (must do) checks based on the Ionising Radiation Regulations 2017 and IR(ME)R 2017 regulations. These protect patients against unnecessary exposure to harmful radiation. All x-ray equipment had been measured by the regional medical physics advisor and had been found to be safe.

The service had suitable facilities to meet the needs of patients' families. The waiting area was large and airy.

The service had enough suitable equipment to help them to safely care for patients.

There were temperature controls in areas where radiological contrast was stored. Inspectors found contrast stock was well managed and all packages of contrast were within date. MRI safety was monitored and managed by a medical physics expert based at a local NHS trust and a specialist radiologist within the trust.

There was guidance for quality assurance and diagnostic reference levels (DRL) for equipment. DRLs were present in main x-ray rooms. Each piece of equipment should have had separate and specific DRLs, and the manager informed us they would contact their medical physics expert for advice.

The adult and paediatric resuscitation trolleys were well stocked, locked, and tagged. Equipment including suction and oxygen lines were clean. There were anaphylaxis and cardiac arrest kits kept with the trolleys. The checklists for resuscitation trolleys were up to date for the 3 months prior to our inspection visit. Trolleys were due to be checked daily and we saw this was happening.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff responded promptly to any sudden deterioration in a patient's health. The trust had clear policies and guidance in place for managing medical emergencies. Staff received basic life support training as a minimum and there was an emergency crash team who could be called to assist.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used a standard document for all examinations consistently across all sites. This document was uploaded to the patient record and there was a standardised process to check patient identification, contrast safety and World Health Organisation (WHO) safer steps to surgery checks.

Staff knew about and dealt with any specific risk issues. Radiology equipment had been risk-assessed and portable equipment tested to ensure the safety of staff and patients. Specific testing and reporting on equipment included radiographic tubes and generators and ultrasound machines.

Staff asked patients if they were or may be pregnant. There were signs in the department asking patients to let staff know if they may be pregnant. If patients could not be sure, staff ensured a pregnancy test was completed before

carrying out any examination involving exposure to radiation. This met with the radiation protection requirements and identified risks to an unborn foetus. Staff followed different procedures for patients who were pregnant and those who were not. For example, patients who were pregnant underwent extra checks and staff completed checklists to record them.

Staff shared key information to keep patients safe when handing over their care to others. Images and reports were made immediately available to all referrers and clinicians. Previous images and reports were also available to help staff check previous findings for clinical checks and comparison.

Shift changes and handovers included all necessary key information to keep patients safe. Staff attended a "huddle" every morning before the main shift began to exchange information on equipment, expected patients, any identified risks, and to prepare for the day ahead.

Diagnostic imaging policies and procedures were written in line with the Ionising Radiation (Medical Exposure) 2000 regulations. The trust had named and certified radiation protection supervisors and liaised with the radiation protection advisor (RPA). Local rules are the way diagnostics and diagnostic imaging work to national guidance and vary depending on the setting. Staff had written and agreed policies and processes to identify and deal with risks. This met with IR(ME)R 2017.

Staffing

Allied health professional (AHP) staffing

The service had enough nursing and support staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The service had low vacancy rates with 1 WTE band 5 vacancy which was being recruited into during the inspection.

The service was reviewing the job descriptions of the experienced band 5 staff nurses to recognise the skill set required as a band 6 staff nurse, as they recognised this as a national skills progression.

Managers made sure all bank and agency staff had a full induction and understood the service. We saw examples of the this during our inspection on site, with information provided to all staff to ensure they understood the service.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. Medical staff matched the planned numbers on rotas we reviewed for the three months prior to inspection.

Diagnostic imaging

The service had low vacancy rates for medical staff.

The service had low turnover rates for medical staff at 1.41%.

Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work.

The service always had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records. The record system was accessible and reliable, and images could be viewed and reported on remotely by all registered clinicians. We reviewed 10 patients records and these were completed appropriately and in line with service and national guidelines.

Records were stored securely. Staff accessed records using their own login and password.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. This matched the incident policy that the provider had in place.

The service had no never events.

Staff reported all incidents of repeated or excessive radiation dose to the RPA who advised if any reached a notifiable dose. All patient incidents reported on datix from Bassetlaw Hospital over the previous 12 months were all no or low harm outcomes.

Managers shared learning with their staff about never events that happened elsewhere. Staff attended meetings and discussed learning from incidents across the region.

Staff reported serious incidents clearly and in line with trust policy. We reviewed the incident log and can see appropriate action had been taken and correct reporting followed.

Staff understood the duty of candour. Staff we spoke with described the duty of candour during the inspection well and understood the importance of putting it into practice.

Diagnostic imaging

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

Radiologists and reporting radiographers attended monthly discrepancy meetings where findings were discussed, actions agreed, and learning was shared. Reporting radiographers liaised with staff regarding poor image quality, identified trends, and led workshops on making improvements.

Managers investigated incidents thoroughly. We reviewed the radiology incident log which was all datix incidents and all action taken clearly recorded.

Is the service effective?

Inspected but not rated

We do not rate effective in diagnostic imaging, however we found:

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. All policies and guidelines were stored on the trust intranet. As staff received new guidance and directives, the department managers ensured updates to clinical practice.

The departments were adhering to local policies and procedures. The local rules were not displayed in all rooms with latest version of the rules at the beginning of our inspection, but these were changed to the current version in all rooms during our time on site.

We saw reviews against IR(ME)R and learning shared to staff through team meetings and training. The trust had a radiation safety policy, which met with national guidance and legislation. The purpose of the policy was to set down the responsibilities and duties of designated committees and individuals. This was to ensure the work with Ionising Radiation undertaken in the Trust was safe as reasonably practicable.

Radiation protection supervisors (RPS) for each modality led on the development, implementation, monitoring, and review of the policy and procedures to comply with IR(ME)R.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Staff made sure patients had enough to eat and drink. Including those with specialist nutrition and hydration needs. There were water machines for patients and their relatives to use when waiting to be seen.

Staff ensured patients requiring CT examination using contrast were sufficiently hydrated prior to their procedure.

Diagnostic imaging

Patient outcomes

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

The service participated in relevant national clinical audits. We saw an audit had been conducted in March 2023 on the amount of Antero-Posterior' (AP) chest x-rays and postero-anterior (PA) chest x-rays being performed at the Trust. The quality of chest x-rays audit outlined by the Royal College of Radiologists (RCR) published in 2016 and reviewed in 2022 states "Every effort should be made to perform a PA erect chest x-ray". The targets set for this were 75% PA for inpatients and emergency department patients, and 95% AP for outpatients and general practice patients. It was found that radiology was operating below the expected standard suggested by RCR, with 47% of adult emergency department chest x-rays performed PA instead of the recommended target of 75%. We saw this information being shared with staff through the radiology newsletter in May 2023 and a request for staff to change the x-rays performed unless not possible, in which case this was expected to be recorded on the patient records.

Managers and staff used the results to improve patients' outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Staff told us they participated in regular audits and that these were shared in team meetings with actions for improvements. An example of this is quality assurance (QA) annual audit reports completed for each location in the trust. We saw that the tests were carried out daily and the results from each test were held electronically on each scanner. These results also identified any results that were out of tolerance (quality noise and homogeneity).

We saw examples of audits within CT, DEXA, fluoroscopy, MRI, Ultrasound, X-Ray, and nuclear medicine. We also saw examples of the audit results being discussed at the radiation safety meeting.

Annual Medical Physics QA were undertaken by Sheffield Teaching Hospitals in March of every year.

The reports we saw were February 2022 to February 2023 to coincide with the Radiation Protection Annual cycle.

We reviewed the annual dosage audits which showed the values monitored and compared to the previous year's results.

Managers used information from the audits to improve care and treatment.

Managers shared and made sure staff understood information from the audits.

Improvement is checked and monitored.

Competent staff

The service made sure staff were competent for their roles. Managers appraised some staff's work performance and held supervision meetings with them to provide support and development, but this was not always every year.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. All new staff followed the trust competency framework where staff must perform several observed procedures to gain competency in that area. Designated supervisors approved and signed off the competency framework. Radiographers and sonographers told us the department supported them to complete competencies.

Diagnostic imaging

The service was committed to developing the skills, knowledge and competence of its students, staff, and managers. Students enjoyed their placements and took up permanent posts once trained. All staff were able to make use of opportunities to learn, develop, and share good practice.

Managers gave all new staff a full induction tailored to their role before they started work. We saw examples from the Head of Imaging of welcome emails sent to new staff. These included a full welcome PowerPoint, including details of the radiology senior management team and the local rules for them to read prior to commencement in their role.

Newly qualified staff told us the department had offered them a good level of competency training.

Managers supported staff to develop through yearly, constructive appraisals of their work, although compliance rates for appraisals were at 71.04% for the Trust overall within diagnostic imaging.

Managers supported staff to develop through regular, constructive clinical supervision of their work.

The clinical educators supported the learning and development needs of staff.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. There were multiple opportunities to attend team meetings including through Teams. Notes were always available and shared following these meetings.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Mandatory training had to be up to date for staff before additional training could be undertaken.

Managers made sure staff received any specialist training for their role. Staff told us about continued professional development (CPD) opportunities they had requested and had approved. This was across the diagnostic imaging department. Staff were proud to have ensured they can continue in CPD training and that this was supported.

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

Multidisciplinary working

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

Medical staff could contact a duty Radiologist any time to discuss issues and to provide support to other doctors and staff throughout the trust.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Seven-day services

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

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests.

Diagnostic imaging

There were clear arrangements in place for urgent scans and these would be managed at Doncaster Royal Infirmary within the Trust.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas. For example, we saw 'stop smoking' information, dementia awareness displays and information on being active.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained verbal consent from patients for their care and treatment in line with legislation and guidance. Diagnostic imaging, and medical staff understood their roles and responsibilities and knew how to obtain consent from patients. They could describe to us the various ways they would do so. Staff told us they usually obtained verbal consent from patients for simple procedures such as plain x-rays. In some general cases this was inferred consent. Specialty medical staff obtained consent for any interventional procedures in writing before attending departments and for biopsy procedures.

Staff made sure patients consented to treatment based on all the information available.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Mental Capacity Act and Deprivation of Liberty Safeguards training was part of the Safeguarding Level 2 e-learning module for all staff. The Trust were in the process of changing this to become part of the mental health training being launched under 'SET+' and this was in the process of being adopted.

Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Good

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

Compassionate care

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

Diagnostic imaging

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. All staff including reception staff, were observed to be compassionate and respectful to every patient who used the service. Patients told us that staff were friendly, and we observed this in action during the inspection. We observed that all staff introduced themselves when patients were called from the waiting area, for their appointment.

Patients said staff treated them well and with kindness. We spoke with four patients, and they all felt staff provided caring treatment towards them saying “I felt comfortable and found where I was going easily.”

Staff followed policy to keep patient care and treatment confidential. Patient records were kept safe and in line with policy. Conversations were held with patients in private consultation rooms with the door closed. This meant the information regarding the patient was confidential.

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

Staff collected patients from waiting areas and took them to private changing facilities.

Staff spent time with patients and those close to them to give explanations about their care and encouraged them to ask questions.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff giving reassurance to patients in a calm and relaxed manner.

Staff understood the emotional and social impact that a person’s care, treatment, or condition had on their wellbeing and on those close to them. We observed staff providing care before, during, and after procedures and showing consideration to patient’s emotions, allowing them time to ask questions or comply with requests. Staff were aware some positioning could be uncomfortable and allowed patients to be independent or made adjustments where possible.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families, and carers in a way they could understand, using communication aids where necessary. Staff shared with us examples of alternative communication methods such as drawing for ease of understanding in certain patients when needed.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Diagnostic imaging

Patients gave mainly positive feedback about the service. We saw the results of the most recent patient survey broken down by speciality. The completion rates for August 2023 look to be very low numbers from patients with 0 received in MRI, 1 in CT and 12 within radiology. Although results were mainly all either good or very good in the responses received. There was 1 response received in August 2023 with poor feedback in radiology.

Is the service responsive?

Good

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

Service delivery to meet the needs of local people.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. There was a new role to the service of a 'cancer pathway navigator', this post had been created in January 2022. There had just been recruitment to expand this to include a second position for this role who was due to start imminently. The cancer pathway navigators looked for any cancellations on a daily basis and contacted any patients waiting to be seen at short notice to aim to ensure any cancellations were filled. The demand in the local area has increased over the last year, so the service has appointed a second person for this role due to demand.

The departments were accessible for people with limited mobility and people who used a wheelchair.

Diagnostic imaging reporting was electronic, and the department used paperless methods to reduce time and administration.

Managers monitored all targets and reported to the trust board through their overall performance reports.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion.

Facilities and premises were appropriate for the services being delivered.

The service had systems to help care for patients in need of additional support or specialist intervention. There were sufficient facilities to meet the needs of inpatients rooms large enough to wheelchairs and staff accompanied patients from wards.

Managers monitored and took action to minimise missed appointments. Staff respected inpatient mealtimes and, where possible, organised inpatient imaging to avoid them.

Managers ensured that families of children or vulnerable patients who did not attend appointments were contacted.

Diagnostic imaging

The service relieved pressure on other departments when they could treat patients in a day. Reporting radiographers checked suspected fractures straight away and provided results back to the minor injuries department to ensure efficient patient care or discharge.

There was a free bus service provided for patients between hospital locations where needed and this was pre-bookable.

Meeting people's individual needs

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

The main waiting area was large and airy. Patients attending the department had access to drinks and snack facilities, a café, and a shop.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff were not able to tell us of any particular documents they were aware of during inspection when patients attending may need support with any individual needs.

There was dementia awareness information displayed on the x ray waiting area wall.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. These were arranged in advance when the requirement was known about, but staff knew how to access this for any requirements on the day.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Referral to treatment (RTT) rates were measured against national targets for all patients on cancer pathways, two week waits, urgent and planned care, and routine images.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. CT scan figures showed significant reductions in waiting times for patients over the last 12 months. August 2023 showed 91.2% of patients were seen for CT scans within 14 days. MRI scan data showed 80.5% of patients were seen for urgent referrals within 14 days.

Diagnostic waiting times in the service showed patients waiting longer than national targets set in these areas. For MRI services, there was a waiting list initiative in progress to aim to improve wait times and the service was currently performing at 62.57% and were aiming to perform at 95% by 31 March 2024. For CT scanning services, there was also a waiting list initiative in progress. The service was currently performing at 68.88% performance and aimed for 70%

performance by 31 March 2024. Non-Obstetric Ultrasound (NOUS) was performing at 93.99% of its 95% target. DEXA scanning had showed steady improvement in performance, and this was expected to continue throughout 2023/2024. DEXA was currently performing at 48.18% of its 90% target. Nerve conduction tests were performing at 87.12% and additional sessions have been scheduled in the service with 95% performance expected from this by 31 March 2024.

Managers worked to keep the number of cancelled appointments to a minimum and there were plans in place to improve these performances.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Learning from complaints and concerns

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

Patients, relatives, and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. The hospital had a complaints policy, which staff accessed on the intranet.

Managers investigated complaints and identified themes. Learning was shared across the hospital in the daily morning huddle, monthly head of departments meeting, clinical governance meetings, quarterly medical advisory committee, and quarterly departmental team meetings.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Staff described managers as being approachable and available. Staff knew how to contact managers at any point when they needed too and felt able to do this.

Diagnostic imaging

Managers provided clear leadership and were highly valued by staff we spoke with. Managers were keen to retain staff and invested in education for staff to progress. There was a radiology manager in post who staff felt supported by and who told us they were keen to support staff progression. An example of this was for the apprenticeships in place in the department, these have been expanded and staff on these programmes have had training opportunities for progression. These staff described to us that they felt confident in their roles and were keen to stay within the trust due to this.

The leadership team understood the current challenges and pressures impacting upon service delivery and patient care.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust vision was 'to be the safest trust in England, outstanding in all we do.' Four objectives originated from this vision, one of which included to provide outstanding care and improve patient experience. To deliver the four main objectives four breakthrough objectives were identified for 2022/23, for example, objective one was to maintain and improve CQC ratings by achieving improvements in quality and outcomes.

There was a vision for what leaders want to achieve and this was in line with the trust vision. The service promoted training, and staff were aware of the vision for diagnostics and were able to share this with us during inspection. Staff told us about the focus on reduction in waiting times for patients, and also a focus on improving the patient experience in the department.

Staff told us they provided patients with person-centred care and that working well in a team was key to achieving their vision and strategy.

The management team shared they were dedicated to workforce retention and prioritising wellbeing and development across staff groups.

Culture

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

Staff were proud to work at the trust and within their departments. Staff, from students to senior staff were loyal to the trust and chose to develop and progress within the service and across modalities.

All staff we spoke with said they felt able to raise any concerns to colleagues or managers and were aware of how to contact the Freedom to Speak up Guardian.

Managers described how they supported serious incident investigations with specialty colleagues and followed Duty of Candour where appropriate.

Equality and diversity was clearly promoted to patients, students, and staff throughout the service. There were no barriers to progression or development and staff received training in equality, diversity, and inclusion.

Diagnostic imaging

Staff were positive and caring towards patients and their relatives who used the service. In addition, we also noted caring and respectful interactions between staff of all grades and disciplines.

Governance

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

We examined various minutes of meetings for the operational governance, clinical governance, and radiation safety committee group. These minutes showed that these meetings were well attended by a wide range of staff and a variety of issues were discussed such as radiation incidents, CT new building update and home reporting.

The radiation safety committee produced an annual report and met twice each year. They linked in with specific subgroups which made them able to work more effectively, these included the radiology clinical governance group who meet monthly and the optical radiation health and safety committee.

All modality areas had a robust quality assurance (QA) programme in place, and this had been brought in since the last inspection and was firmly embedded as business as usual. Each modality area created a full QA report, and we could see these reports were reviewed as standard.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Staff described good IT support and no recent breakdowns or failures in the picture archiving and communications system. Images were always available to all relevant professionals.

Service leads and managers worked together to provide information to the executive performance meeting. They monitored performance and provided information to the divisional leads, along with identified risks and issues for escalation. Service leads reported a good level of support in planning for the future including finance and workforce planning.

Managers monitored all targets and reported to the trust board through their overall performance reports.

The service had a systematic process, involving staff of all roles and grades, in reviewing and improving the service. This included identifying risks and planning to reduce the level of risk. There was a rolling agenda of meetings to improve quality and patient safety.

There was a robust governance process related to risk with monthly risk meetings. The risks were escalated via the governance meetings and the divisional meetings.

Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact giving a red, amber, green (RAG) rating.

Diagnostic wait times were monitored with initiatives in progress to improve performance for 2023/2024, we could see these wait times were improving and monitored.

Diagnostic imaging

There were systems to flag up urgent unexpected findings to GPs and medical staff. This met the Royal College of Radiologist guidelines.

Information Management

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

Staff could find all patient information such as diagnostic imaging records including previous images, and reports, medical records, and referral letters through electronic records.

All staff had access to the trust intranet to gain information on policies, procedures, National Institute for Health and Care Excellence guidance, and e-learning. Some policies we reviewed for staff had not had their review date as recommended in the policy itself, examples of this include the guidance for staff in the use of chaperones and also the employers' procedures under IR(ME)R.

Information governance systems were in place and ensured the confidentiality of patient records.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

We saw the staff engagement group met monthly and this covered a wide variety of agenda topics in recent minutes we reviewed. We saw that staff survey questions had been updated to align with the NHS People Promise and that the Trust had asked additional questions regarding the awareness of Trust values. The initial staff survey results showed an encouraging and improving picture in relation to feedback. Work was being undertaken in relation to communication of the results and engagement with local teams, to embed a cycle of year-round engagement.

There was a clear focus on engagement activities to develop a culture of inclusion. The Trust held events for staff from ethnic minority groups. Diagnostic imaging was included in this, and the manager shared this with us.

Learning, continuous improvement and innovation

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

Staff met regularly with all colleagues across the Trust sites to share learning and provide peer support. The service had continued professional development (CPD) lunch and learn sessions, online evening learning sessions and these were based on what was needed following audit results, staff learning, and from staff requests.

The trust logged all compliments and positive praise received in each area and for each location. This was shared with staff and the wider team for learning.

There was a monthly publication of 'General Radiology Newsletter' for staff. This featured 'image of the month' which showed a different x-ray image each month and focus on how to perform this well and potential challenges. This was to improve learning and continuous improvement in staff.

Diagnostic imaging

Staff we spoke with told us they felt supported to develop their career. There were apprenticeship training places available that were being expanded year on year for the number of places available on these.

Medical care (including older people's care)

Requires Improvement ↓

Is the service safe?

Requires Improvement ↓

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

Mandatory Training

The service provided mandatory training in key skills to all staff, however compliance was below trust target.

Training compliance trust wide for medicine was 87% for nursing staff, which was below the trust target of 90%. Training compliance trust wide for medical staff was 57%, which was below the trust target of 90%. However, there was vast variation between wards with some compliance levels at 22% and others at 100%, this was division wide across all sites.

However, the mandatory training was comprehensive and met the needs of patients and staff. Managers monitored mandatory training on the electronic staff record system and prompted staff when they needed to update their training. Staff confirmed this and we saw red/amber/green (RAG) rated training compliance sheets displayed in some ward manager offices as a visual prompt for nursing staff. Managers we spoke with were aware some staff were behind target and had a plan in place to make sure staff accessed mandatory training in the near future.

There was a clinical practice educator who delivered face to face practical training. For example, staff we spoke with described simulation training designed to develop skills in management of deteriorating patients. Staff told us that training was a mixture of face to face and online. Staff told us they get protected time for training.

Staff told us there was training available to develop skills further, and they were supported to complete extended role training. For example, some nurses we spoke with completed extended training in male catheterisation.

Safeguarding

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

Staff we spoke with knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff received adult and children safeguarding training. They were compliant for level 1 and 2 training which meant service met the trust target.

We saw patients at risk identified in clinical records with an alert icon, which you could then expand to read the safeguarding referral.

Staff we spoke with knew how to make a safeguarding referral and who to inform if they had concerns. For example, the trust named safeguarding lead and local authority safeguarding teams. Out of hours, staff escalated safeguarding concerns to the duty cover. Staff gave specific examples of safeguarding concerns they had raised. Ward staff knew where safeguarding policies were and how to access them. They used online forms to refer safeguarding notifications or queries to the local authority.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

Wards had housekeepers to support staff in maintaining levels of infection control. Environmental cleaning schedules for domestic staff to follow were displayed in some areas, such as sluices.

We saw evidence of cleaning schedules in wards. Ward areas were mainly visibly clean and had suitable furnishings which were clean, wipeable, and well-maintained.

Some wards we visited displayed audits indicating high compliance with environmental cleanliness. However, clinical staff cleaned clinical equipment. Not all cleaned equipment we saw such as stored commodes and toileting aids were labelled with the date when cleaned.

Side rooms were available on all wards. We saw notices displayed on doors where patients with infections were being cared for and doors were closed in line with policy for managing infectious patients.

We observed that staff adhered to ‘bare below the elbow’ guidance and adhered to infection control policy.

We saw posters displayed around the wards we visited about infection prevention and handwashing. Hand washing facilities were available and antibacterial gel dispensers were situated at the entrance of the wards and on corridors. We saw 5-moments of hand hygiene posters displayed.

Patients we spoke with confirmed staff washed their hands before and after treating them. We observed hand hygiene practice. On the wards we saw that staff mostly either washed their hands before and after each patient contact or used hand gel, as recommended in trust and national policy.

The infection prevention reports were discussed at the infection, prevention and control committee and reported to board.

The trust submitted data as part of the Commissioning for Quality and Innovation (CQUIN) scheme for quarter 4 (January to March 2023). However, there was poor compliance with the uptake of flu vaccinations for front line healthcare workers (47%).

Environment and equipment

The design, and use of facilities and premises kept people safe. Staff were trained to use the equipment. However, equipment was not always maintained, and safety checked in line with trust policy. Substances hazardous to health were not always stored in accordance with regulations.

Access to all wards was via a secure buzzer and camera entry system. All fire exits were free of obstructions. Fire appliances were signposted and tested. The fire alarm was tested weekly.

Patients could reach call bells and staff mostly responded quickly when called.

Equipment was subject to routine planned preventative maintenance as defined by the equipment manufacturer and we saw that portable electrical equipment was not always maintained and safety checked. The trust had systems in place for recording the service and maintenance of equipment, identified through compliance stickers. Most equipment we looked at had been serviced in accordance with trust policy, however some were out of date.

Staff carried out daily safety checks of specialist equipment. For example, records we reviewed for checks of the emergency resuscitation trolleys had no gaps. Staff told us that resuscitation trolleys were checked and stocked by theatre staff and delivered to the ward.

Staff we spoke with said they had enough suitable equipment to help them to safely care for patients. For example, staff told us they had access to the correct equipment for the care of and moving and handling of bariatric patients.

Staff disposed of clinical waste safely. We saw all clinical waste sharps bins were used and stored in accordance with national guidance.

Substances hazardous to health were not always stored in accordance with Control of Substances Hazardous to Health (COSHH) Regulations (2002). For example, on one ward, in the dirty utility room, we saw cleaning solutions left around the ward on desks and in unlocked sluice rooms. This meant there was a risk vulnerable people could access potentially hazardous substances. We made staff aware at the time and it was rectified.

We found multiple examples across all wards of out-of-date equipment, this included cannulas, blood sample vials and oropharyngeal airways. This was escalated on day one however we found more examples across the following days on all wards we visited.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients (NEWS2). This helped staff to identify and escalate deterioration in a patient's condition. The NEWS2 alert system was embedded into practice with individual electronic ward boards providing oversight of the clinical area. In all records we reviewed NEWS charts were completed correctly, and there was clear evidence of escalation with deteriorating patients.

Staff we spoke with told us they accessed the recognition and management of the acutely ill and deteriorating patient policy via the intranet.

The trust took part in the Commissioning for Quality and Innovation (CQUIN) scheme and the audit results for 2022-2023 showed an increase in compliance with recording of NEWS2 score, escalation time and response time for unplanned critical care admission from 50% in quarter 1 to 100% in quarters 2, 3 and 4.

Staff we spoke with told us that doctors responded quickly when patients were escalated and there was a critical care outreach team out of hours to support the medical on-call team.

We requested evidence of compliance with VTE assessments and audits, the trust told us that an electronic assessment pilot was being undertaken on 1 ward at Doncaster Royal Infirmary.

We saw multiple examples of how staff dealt with specific risk issues such as patients at risk of falls. We saw patient falls risk assessments were completed on admission and falls risk was managed by cohorting patients, with a staff member allocated to each area when staffing allowed. In addition, patients were provided with non-slip socks. The trusts most recent data showed in the last quarter there were two falls with severe harm and three falls with moderate harm within the division of medicine.

Shift changes and handovers included all necessary key information to keep patients safe. Staff received a printed handover sheet which included any specific patient risks, for example, falls risk, resuscitation status and identified patients that required assistance with diet and fluids.

We observed staff attending multidisciplinary safety huddles. These were attended by physiotherapists, speech and language therapists, occupational therapists, discharge coordinator in addition to medical and nursing staff.

Nurse staffing

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

Staffing requirements were calculated by ward managers using a recognised safer care process. However, the service did not always have enough nursing and support staff to keep patients safe. For example, on the wards we visited we saw that planned and actual staffing did not always match.

Staff we spoke with told us this was a regular occurrence. There was a staffing escalation process in place. Staff we spoke with explained, when staffing was suboptimal, they reported to the manager on call for medicine. The on-call bleep holder redeployed staff from other wards, requested bank staff and unfilled shifts were offered to staff via a closed social media group. Agency staff were used and allocated where needed on arrival. Staff we spoke with told us they had sufficient rest and meal breaks and usually left duty on time.

The vacancy rate for nursing within the division of medicine was 177.51 WTE as of March 2023.

The absence rate for nursing within the division of medicine was 6.11% FTE at the time of inspection.

The vacancy rate for support staff within the division of medicine was 101.60 WTE as of March 2023.

Managers we spoke with explained the trust was actively recruiting registered nurses and had an extensive preceptorship programme to support staffing entering the organisation.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training, and experience. However, they kept patients safe from avoidable harm and provided the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service did not always have enough medical staff.

Managers could access locums when they needed additional medical staff. Rotas we reviewed had few gaps in medical cover. Managers made sure doctors had a full induction to the service before they started work. Staff we spoke with said they felt supported by senior medics and felt the support and training they received was appropriate to their roles and responsibilities.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings and weekends. Staff we spoke with said that on-call senior medics were contactable when required. Staff we spoke to had good understanding of the long-term workforce plans and improving staffing numbers, they told us that things had improved more recently with staffing levels.

Staff we spoke with told us they had sufficient rest and meal breaks but did not always leave duty on time.

The vacancy rate for medical staff within the division of medicine was 36 WTE as of March 2023.

The absence rate for medics within the division of medicine was 2.39% FTE at the time of inspection.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care. However, records were not always stored securely.

Records were held in paper and electronic formats. Records were comprehensive and contemporaneous. We reviewed 20 sets of patient records across medical wards from all 3 sites and found these were clear and comprehensive. The trust had a system in place to identify and alert staff members as to when risk assessments were due.

The trust had implemented audits of patient records which were uploaded on to an electronic system which could be benchmarked across the division.

Electronic systems for record keeping were used on all wards we visited and these recorded key information about patient risks and treatment, including alert icons for patients living with dementia, learning disabilities, patient acuity and discharge plans. The boards ensured that staff had easy access to key information, such as reviews by other members of the multidisciplinary team and clinical observations.

Records were not always stored securely. We saw examples of paper notes left open and unsecure. We also saw examples of electronic systems being left unattended for long periods of time with patient information on display.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, some medicines were out of date.

Patients did not always have wrist bands in place, this was escalated at the time of inspection and resolved.

We found examples across multiple wards of medicine items which were out of date. This was escalated on day one of the inspection, however we found further examples of this across the three days. At Bassetlaw Hospital we found 2 packs of a controlled drug out of date on 1 ward.

We observed medication rounds in which staff checked patients name and date of birth. We observed the electronic prescribing system that had been introduced which prompted staff when medicines were due to be administered.

Records we looked at assured us most medicines were being given as prescribed and where medicines were omitted, we saw evidence of reasoning why. However, Oxygen prescribing was not always completed consistently.

We saw evidence of prompt action by the medical team where changes were made to medicines via specialist teams. Medicine reconciliation was carried out by the pharmacy team.

Patient's own controlled drugs were recorded in a separate register. Most were returned upon discharge. However, we found three instances on two wards where patient's own medicines were not returned on discharge and still stored on the ward.

There was not an effective process to manage and monitor the ambient temperature of rooms which stored medication. This meant some medicines may be less effective and have to be disposed of which could lead to delays for patients to receive medications.

Medicines required to take home out of hours was dispensed in over labelled packaging from the wards. There was a robust checking system in place for discharge medication, we observed two nurses checking medicines were correct for a patient discharge.

Ward staff told us they were supported by pharmacists Monday to Friday. Pharmacists were contactable out of hours.

Incidents

The service did not always manage patient safety incidents in a timely manner. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff accessed the incident reporting and investigation policy on the intranet. All staff we spoke with knew what incidents to report and how to report them. All managers we spoke with knew their ward's most recurring top three incidents and gave examples of how these were being addressed and monitored. Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff we spoke with were familiar with the electronic incident reporting system and provided clear examples of incidents and near miss incidents they had reported recently. Managers shared learning about never events with their staff and across the trust.

Staff told us managers explained learning from incidents and these were shared via email or informal discussion.

Staff told us that the division leadership team supported several quality improvement projects to help improve services, for example there was a quality improvement project for falls and pressure ulcer reduction. There were 47 falls during 2022/2023 with severe or moderate harm, whilst this did not meet the trust target, there was a reduction in the number of falls resulting in harm.

The medicine division had 22 serious incident actions which were more than 1 month overdue and 31 SI actions overdue in August 2023. There were 264 open overdue incidents greater than 3 months in the incident reporting system. The trust was aware of the backlog for serious incidents and had put plans in place to improve this.

Medical care (including older people's care)

All staff we spoke with understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

We saw recent patient safety alerts displayed and managers we spoke with explained how these were implemented and monitored. This signposted staff to further information and covered key topics each month, such as learning from falls, prevention of pressure ulcers and incident reporting. Managers also told us of some quality improvement projects their wards were involved in to improve themes of incidents.

Is the service effective?

Good

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Staff we spoke with had a good understanding of the Mental Health Act, they followed guidance and could access support if required. Managers we spoke with had oversight on care and treatment and told us they ensured that staff were following guidance. We were told there was extra support available for staff to ensure they were up to date with evidence-based practice in the form of a practice development team.

Staff we spoke with explained how they accessed the most current best practice guidance online and trust intranet, for example NICE guidance.

Compliance against policy was monitored throughout the year using an annual trust audit schedule.

The trust submitted data as part of the Commissioning for Quality and Innovation (CQUIN) scheme for quarter 4 (January to March 2023). The results showed high compliance for the recording of the NEWS2 score, escalation time and response time for unplanned critical care admissions. This compliance had increased from 50% in Quarter 1.

There was also improved compliance with cirrhosis and fibrosis tests for alcohol dependent patients and was now 98% from 6.6% in quarter 1.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural, and other needs. Staff did not always complete fluid balance documentation when needed.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. For example, staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Where modified diets were required, assessments of a patient's requirements were detailed above their beds and on a whiteboard at the nurse's station. The service provided a wide choice of meals that catered for patient preferences.

We observed staff ensuring patients comfortable and ready to have their meals at a protected time. For patients in need of extra assistance, families and carers were encouraged to come in to help. We observed family members being welcomed at lunch time.

We observed mealtimes on various wards and noted that all staff were involved in serving meals to patients, including senior staff. Patients that needed support with eating their meals were given it.

We observed additional comfort rounds taking place with options for biscuits, juice, tea, and coffee. Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

Staff monitored patients' fluid intake throughout the day. However, fluid balance charts in the records we reviewed did not always accurately capture fluid input and output where this was required.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain assessment was recorded routinely as part of electronic physiological observation recording. The system ensured completion of the assessment was mandatory.

The trust audited pain scores following analgesia to monitor effectiveness. The trust also had plans to review and add to their pain audits to expand on their scope of oversight.

Patients we spoke with told us they received pain relief soon after requesting it. Staff prescribed, administered, and recorded pain relief accurately.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment. They were not able to use these findings to make improvements and achieve good outcomes for patients.

The service participated in some relevant national clinical audits. They submitted data to the National Audit of Care at the End of Life.

The National Audit of Care at End of Life for 2020/ 2021 showed medium compliance for key themes such as staff confidence, staff support, care, and culture which within expected range.

The service had not submitted data to the National Audit of Dementia audit since 2018/2019. The results at that time showed within expected range for all four metrics.

The service did not submit data to a number of national clinical audits such as the National Inpatient Diabetes Audit, National Early Inflammatory Arthritis Audit, and the National renal audits.

Medical care (including older people's care)

It was noted in the clinical governance meeting minutes from May 2023 that the trust was one of the worst performing trusts for the early inflammatory arthritis service. This was due to lack of medical staff, delays in waiting times and not able to follow up patients in a timely manner.

The service were hoping to start participating in a number of audits. This included the respiratory audit because they were undertaking pilots and hoped to start submitting data in 2024. They had just started collecting data for Falls and Frailty Fracture Audit. They did not have a patient data base to submit information to the Inflammatory bowel disease audit.

We were told that all outcomes from national audit reports and the resulting action plans are monitored via the audit and effective committee and discussed at the speciality governance meetings. We were told any issues identified are escalated to divisional governance meetings.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers told us that local scheduled audits of different sets of notes on each ward each month, were recorded on an electronic system and uploaded onto the trust computer system. These included medical records audits, hand hygiene observation, sepsis documentation, falls, pressure ulcers (category 3 and above) and venous thromboembolism (VTE) risk assessments. We were told that peer review of ward audits was being introduced across the medical division,

The trust developed action plans to improve outcomes. For example, the falls action plan and quality improvement project we were told about was developed in response to the findings from the audit of inpatient falls. In addition, other audits undertaken such as medication and risk assessment audits were used to extract emerging themes alongside incident reports, patient feedback and complaints.

We saw audit quality metrics displayed on wards indicated high compliance. The audit results were reflective of our observations of records.

Managers told us the implementation of electronic prescribing with mandatory fields had improved compliance and the trust had seen an overall improvement in accurate prescribing and administering of medications.

The trust held mortality and morbidity meetings to discuss learning from deaths. In July 2023 100% of all deaths for patients over the age of 18 were scrutinised by the medical examiner team.

The services sentinel stroke national audit programme (SSNAP) score overall had stayed the same as a rating of B.

The trust was JAG accredited for endoscopy.

Competent staff

The service made sure staff were competent for their roles. There were systems for managers to appraise work performance, but appraisal rates were below the trust target. Managers held supervision meetings with staff to provide support and development.

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

Managers gave all new staff a full induction tailored to their role before they started work. Staff we spoke with who were new to post, told us they felt well supported by their managers and peers. For example, they were allocated a 'buddy' and shadowed colleagues on supernumerary shifts. We were told there was an extensive preceptorship programme and additional support if required from practice development nurses.

However, staff told us they did not always have one to one meetings. Staff we spoke with told us managers supported nursing staff to develop through regular, constructive clinical supervision of their work, though this was informal and not always recorded. Established staff also told us they did not regularly have one to one meetings with their managers.

Appraisal rates varied between hospital sites. The overall appraisal rate within the medical division for medics, nursing and support staff and allied healthcare professionals was 67% which was below the trust target of 90%. In July 2023, the service did not meet the trust target of 90% as 70% of consultants had their job plans signed off.

Managers told us that they were confident poor performance was identified promptly and there were mechanisms in place to support staff to improve.

The clinical educators supported the learning and development needs of staff.

Managers told us that team meetings did not happen regularly, however information on development and training was disseminated in other less formal ways.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. For example, we observed MDT board rounds which included consultants, junior doctors, physiotherapists, and nurses. We saw good communication, and a methodical approach through physical, mental, and social needs of patients.

Patients had their care pathway reviewed by relevant consultants. For example, when patients that were on general medical wards required review or input from specialist consultants liaised with each other effectively.

Nursing and medical staff we spoke with told us there was good teamwork across all disciplines and managers were approachable. Staff said they felt empowered to challenge colleagues' practice if they were concerned.

Staff liaised with the multidisciplinary team directly. For example, they referred to diabetes specialist nurses, dietitians, learning disability staff, elderly care psychiatric team and therapies colleagues.

Seven-day services

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

Consultants led twice weekly ward rounds on all wards, and daily board rounds. However, there was consultant presence every day, including weekends.

Patients were reviewed by consultants depending on the care pathway. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Medical care (including older people's care)

Managers we spoke with told us they received support from clinical in-reach services, for example, speech and language therapy, however, this was not available 7 days a week.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards. For example, we saw leaflets containing information on chronic diseases such as diabetes in patient areas. There were posters displayed to raising awareness of mental health which signposted families and carers to sources of practical help.

The trust website patient and visitors section had links to health promotion information, including leaflets in easy-read format.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

People who used the service were supported to make decisions in line with relevant legislation and guidance.

Staff we spoke with told us they received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) incorporated within mandatory adults safeguarding training. However, the content was no longer sufficient to meet the recommendations within the intercollegiate guidance. The trust was taking action to address this.

There was a policy for enhanced observation of patients. Staff we spoke with described a multidisciplinary team approach to making best interests decisions. For example, they involved clinicians, safeguarding team, patients, and their family/carers.

Staff we spoke with knew how to access the policy and get accurate advice on MCA and DoLS.

Is the service caring?

Good

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients we spoke with said staff treated them well and with kindness. Staff followed policy to keep patient care and treatment confidential.

Medical care (including older people's care)

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. Staff we spoke with gave examples of adapting care to meet the needs of people with religious beliefs.

We observed patients sitting out of bed, and staff told us they encourage families and carers to bring in patients own clothes.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

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

Wards had visiting times however were flexible with these for patients who required extra family support. Staff told us these improved patients eating and drinking and also their morale.

Understanding and involvement of patients and those close to them

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

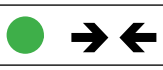
Staff made sure patients and those close to them understood their care and treatment. Staff talked with patients, families, and carers in a way they could understand.

Patients and their families gave positive feedback on the service and their treatment. Staff we spoke with told us they received positive feedback from patients and their carers.

We requested the most recent friends and family feedback for medicine. The trust provided us with data. The collection response rate was low for medicine with some wards collecting zero feedback in the format. Wards which had collected friends and family feedback were generally positive.

Staff we spoke with described how families and carers were encouraged to participate in care if they and the patient wished to. Staff now utilised therapeutic care staff to sit and ensure patients nearing end of life or patients in need of additional supervision were not left alone if their carers were away.

Is the service responsive?

Good 

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

Medical care (including older people's care)

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

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

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

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Facilities and premises were a challenge for the services being delivered. Investment in the estate was ongoing, but senior leaders were aware of the estate challenges currently.

The service had systems to help care for patients in need of additional support or specialist intervention. The service relieved pressure on other departments when they could treat patients in a day.

The service had systems to help care for patients in need of additional support or specialist intervention. Due to staffing shortages, additional one to one care was not always fulfilled; however, staff took action to mitigate against potential risks by cohorting patients. We saw several examples of this system happening during our visit.

We saw that staff had access to additional specialist equipment such as bariatric hoists and chairs.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet their needs.

Staff told us they accessed advice from a learning disabilities and dementia specialists when required. Staff supported patients living with dementia.

Patients were identified on the electronic white board. Patients identified as requiring 1 to 1 supervision were allocated this when staffing allowed.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff accessed interpreters when required.

Staff had access to information leaflets available in languages spoken by the patients and local community.

Patients were given a choice of food and drink to meet their cultural and religious preferences. We observed a meal service during inspection and saw examples of different food options available.

Access and flow

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

Medical care (including older people's care)

Managers monitored patient transfers and followed national standards. Managers worked to minimise the number of medical patients on non-medical wards and made sure they had arrangements for medical staff to review any medical patients on non-medical wards. However, given the significant strain on capacity in services it was not always possible to do this.

There were differing pathway options available within the medicine speciality. The hospital had capacity and flow problems due to the high number of patients with no care package immediately available for discharge to be carried out safely. This was outside of the trust's control.

The service's performance in July 2023 showed that 71% of patients received medical treatment within 18 weeks. This meant they did not meet the trust target of 92% or national NHS targets. The lowest performing services (under 70%) included cardiology, dermatology, endocrinology, gastroenterology, and respiratory medicine. There were at least 57 medical patients waiting over 52 weeks for treatment. There was also increased waiting times of over 21 weeks for a first appointment within gastroenterology and managers were working on this as a priority.

Senior leaders were making good progress against the risks associated with these long waiting times. They had exceeded their target for delivering 28% of outpatient appointments virtually by video or telephone.

The trust submitted data as part of the Commissioning for Quality and Innovation (CQUIN) scheme for quarter 4 (January to March 2023). The results showed an improved compliance for timed diagnostic pathways for cancer services from 1.4% in quarter 1 to 71%. In July 2023 97% of patients waited less than 6 weeks from referral for a diagnostics test.

The trust at the time of our inspection had 100% compliance rate with treating lung, haematology, skin, and upper gastrointestinal cancers within the 31-day target. However skin and upper gastrointestinal cancer were below target for 2 week waits at 88%.

The service did not have a triage process for triaging dermatology referrals due to the volume of referrals and the time required to support this process. The integrated care board had provided funding for the triage of 4000 referrals, but this has since expired. This was outside of the trust's control. The service had listed this as high risk on the risk register as this could have significant consequences for patients.

The services risk register listed an extreme risk that the community diabetes teams were no longer able to see patients with Type 1 diabetes who had been referred to them from outpatients. This meant that patients did not receive additional support for example with their insulin pumps, changes to treatment or psychological support.

Managers and staff worked to make sure patients did not stay longer than they needed to. In July 2023, the service met the trust target for reducing the length of stay for all patients who had been in hospital for more than 21 days. Senior leaders were aware of the pressures within the service. Managers and clinical leaders participated in site meetings held regularly throughout the day, every day. We were told during these meetings managers discussed the number of patients waiting to be provided with beds within the service, the number of discharges planned for patients, and plans on how to manage shortfalls between the 2.

They also monitored the number of delayed discharges and reviewed how to manage these effectively.

Medical care (including older people's care)

For the period of May to June, the trust's general and acute bed occupancy data showed the service was performing worse than their target and above the regional and national averages. Of these June was the worst performing month, seeing the trust at the 30th highest of 123 trusts, however this was the only month of the last three where the trust was in the worst performing quartile.

Managers monitored and took action to minimise missed appointments. The service had created an action plan to see what work was needed to achieve the trust target of 8% for 'did not attend' (DNA) rate and were focussing on the clinics which had a high DNA rates. In July 2023, the overall DNA rate for a first appointment was 11% and geriatric medicine was 24% and diabetic medicine and endocrinology were 14%. The overall DNA rate for a follow up appointment was 9%. Senior leaders were also reviewing the text reminder service because this was not available for all clinics.

Learning from complaints and concerns

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

Patients, relatives, and carers knew how to complain or raise concerns. For example, they discussed with staff directly and contacted the trust patient advice and liaison service (PALs).

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

The division of medicine had the most complaints in the trust with 267 complaints in 2022-2023, making up 44% of the total complaints for Doncaster Royal Infirmary.

Data showed in the last 12 months complaint responses completed against the agreed trust target showed medicine had been consistently falling short of the target. For the month of June 2023, 33% of complaints had been closed in the timescale agreed by the complainant.

Work was ongoing to complete complaints. There were plans to prioritise completion of complaints unresolved over 3 months. The trust reported in July 2023 that there were no complaints open longer than 6 months.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Staff we spoke with understood the policy on patient and carer experience (complaints) and knew how to handle them. Managers and staff, we spoke with said most complaints were about poor communication between staff and family members and carers.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, we saw displays containing details of compliments and suggestions for improvement following thematic reviews of complaints.

Staff could give examples of how they used patient feedback to improve daily practice.

Medical care (including older people's care)

Is the service well-led?

Requires Improvement

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

Leadership

Leaders had the skills and abilities to run the service. However, they did not always manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The divisional structure was a triumvirate of divisional director, divisional nurse, and divisional general manager. They were supported by two emergency and acute medicine clinical director posts, the latter of which was vacant at the time of our inspection. The service had appointed a new divisional nurse, their role would start from early October 2023

Managers had the right skills and abilities to run the service.

Staff spoke positively about their leaders and felt respected. Staff we spoke with told us the senior nurses within the organisation were accessible and visible. Staff told us the senior leadership from above divisional lead level were present and supportive, and felt there was good communication and feedback mechanism to ward staff. Staff felt that they were performance-orientated but also understood the challenges staff faced, for example the length of stays due to complex social circumstances.

Divisional leads we spoke with felt they were focused on patient care and the patient experience. They attended regular meetings with senior executives and felt listened to with the challenges the medicine division faced.

Staff we spoke with told us how management had supported them to take on more senior roles and succession planning.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust's vision was 'to be the safest trust in England, outstanding in all that we do.' The service's vision was 'aspiring to be the BEST.' BEST was an acronym for building partnerships, efficient and effective, sustainable services, and transformational ambition.

Some staff we spoke with were able to describe the overarching vision and strategy for the trust. We observed the trust's quality priorities displayed on posters in areas we visited. Wards also displayed their own vision for the service. There was no strategy specifically for medicine however a new trust wide nursing, midwifery and allied healthcare professionals' strategy had been launched.

Medical care (including older people's care)

All staff we spoke with told us they felt there had been ‘’significant improvements’’ over the last 12 months. Staff told us whilst they recognised things were not perfect, there had been a lot of changes made recently and concerns had been listened to and they had felt well supported to make the required changes at ward level.

Staff we spoke with felt positive about the care provided and described it as safe with major improvements in the patient’s experience.

Culture

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

All staff we spoke with were proud of the organisation as a place to work and spoke highly of the culture. Staff told us they felt respected and valued.

Staff at all levels were actively encouraged to speak up and raise concerns. Staff we spoke with described an open culture where they could raise concerns with their line manager, divisional leads, or senior leadership team. They felt there was a flattened hierarchy and spoke positively about this.

There was a freedom to speak up policy to enable staff to speak up if they had concerns about colleagues’ professional behaviours. Most staff we spoke with were aware of this.

Patients we spoke with were positive about their experience and interactions with staff, they told us they felt confident and comfortable to raise concerns, though they had not needed to during their inpatient stay.

Governance

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

The divisional structure was a triumvirate of director, nurse, and general manager. They were supported by two emergency and acute medicine clinical director posts, the latter of which was vacant at the time of our inspection.

We reviewed clinical governance meeting minutes. The governance structure had recently changed. Leaders we spoke with felt positive about this. Staff we spoke with felt the structure was clear, and the local leadership team had plans in place to address risks to the service, with access to information, such as monthly performance reports to maintain quality.

Staff told us that ward meetings were not consistently held, however they with told us information about incidents and quality performance indicators were emailed or disseminated informally by the ward managers and deputy managers.

Staff we spoke with were aware that senior management colleagues attended monthly safety and quality meetings. Minutes we reviewed discussed incidents and the learning outcomes however staff we spoke with below matron level told us they did not receive copies of the minutes.

Medical care (including older people's care)

Management of risk, issues, and performance

Local leaders did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks to senior leaders. They did not always identify actions to reduce their impact. They had plans to cope with unexpected events.

Local leaders were not aware of all the risks and challenges we found on inspection. For example, we found equipment which had expired their safety check date and unsafe storage of controlled substances hazardous to health (COSHH) such as cleaning chemicals. Records were not always stored securely, and we found risks within medicines management. In addition, we found no action had been taken for increasing the compliance of mandatory training.

Although there were systems in place to allow staff to escalate risks to senior leaders, some risks we found on inspection had not been identified, escalated, or listed as a risk on the risk registers within the medicine division or trust risk register.

Records of governance meetings showed that known risks were considered and discussed at these meetings. The divisional leads attended a monthly Performance Overview and Support meeting which was chaired by the Chief Finance Officer. The division was held to account for performance, patient experience and quality of care.

The service had a risk register which identified 49 risks, this included 4 extreme risks, 14 high risks, 24 moderate and 6 low risks. All risks were RAG rated. We asked service leads about their main risks which aligned with the divisional risk register. They included workforce challenges and equipment. However, it was not clear what mitigating actions in place for all identified risks on the register.

There were also areas such as falls risks where data showed this to be a concern for the division. Quality metrics showed there were 18 falls reported in July 2023 which had reduced from 26 in June 2023. There were several actions being taken including post fall learning, relaunch of the falls and bone health group and staff knowledge of the falls policy.

The medicine division had 22 serious incident actions which were more than 1 month overdue and 31 SI actions overdue in August 2023. There were 264 open overdue incidents greater than 3 months in the incident reporting system. The trust was aware of the backlog for serious incidents and had put plans in place to improve this.

The trusts winter and escalation plan for 2023/24 was still in the planning phase and going through governance processes.

Information Management

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

The trust's main patient records management software worked well and included all relevant patient observations, assessments, and results. There were some paper records. Staff told us they had enough computers and handheld devices; however, the internet connection was prohibitive in accessing information quickly.

The service had built in IT safeguard improvements to this software, such as the red, amber, green (RAG) rated 'footsteps' system to support clinical prioritisation of patients.

Most data was stored securely however we did observe some omissions in this area in some of the wards we visited.

Staff told us there was a backup in the event the IT system failed and there was a procedure for medication administration during any downtime.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff told us the matron and divisional leads did walkarounds. Staff told us they felt leaders openly engaged with them and were receptive to feedback and suggestions. Staff told us that the divisional leadership team supported several quality improvement projects to help improve services, for example there is a current quality improvement project for falls reduction.

We heard staff routinely thanked each other through a private messenger group application.

Staff also told us there was a therapy husky dog to provide comfort and support to colleagues, as well as patients trust wide.

The trust had invested in staff wellbeing and staff could access reiki sessions, and physiotherapy as part of the wider wellbeing drive which was set up in response to the 2022 staff survey results.

The NHS Staff survey 2022 results showed the service had all slightly lower or similar scores than the average for the hospital and comparator average. There were no significant differences. Most of the scores were mid-range. For example, they scored 7.16/10 for being compassionate and inclusive and this was just below the hospital average of 7.32/10 and the same as the comparator average. There were some lower range scores for appraisals 4.63/10 which matched the inspection findings. They scored 4.40/10 for burnout, but this was following the COVID-19 pandemic.

Learning, continuous improvement and innovation

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

The service displayed ward information on a quality board. This gave information about the ward's performance, such as patient safety message of the month, improvement initiatives, IPC, risks and learning from incidents, to staff, patients, and visitors.

Staff received learning specific to their ward which captured learning after significant events and safety reminders.

Staff we spoke with told us how managers had supported them to develop their career. For example, they attended courses to extend skills such as male catheterisation and cannulation.

Healthcare assistants told us they were supported to commence registered nurse training.

The hospital supported student nurses from a local universities though structured placement. Student nurses we spoke with told us they got good levels of support and some of them had jobs on the wards they worked on.

Medical care (including older people's care)

Staff told us they were involved in improvement projects such as pressure ulcer reduction and felt that local level leaders were open to suggestions and ideas.

Surgery

Requires Improvement ↓

Is the service safe?

Requires Improvement ↓

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

Mandatory training

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

Nursing staff received and kept up to date with their mandatory training. The nursing staff achieved an overall completion rate of 90.6% across the surgical division, against the trust target of 90% compliance.

Medical staff were not up to date with their mandatory training. The medical staff compliance rate was 68.4% across the surgical division, against the trust target of 90%.

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

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. Nursing staff told us managers gave them warning through the trust's electronic training system that they needed to update a training module and that they were always given support to access the training.

Safeguarding

Most staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Not all staff had completed training on how to recognise and report abuse and compliance rates for training were below the trust target.

Nursing staff received training specific for their role on how to recognise and report abuse. The compliance figures for nursing staff were at 93.3% overall for Safeguarding Level 2 training for adults and 88% for children, across the surgical division, against the trust target of 90% completion.

Medical staff received training specific for their role on how to recognise and report abuse. The compliance rates for medical staff were at 71.4% overall for Safeguarding Levels 2 adults and 65.2% for children, across the surgical division, and this was below the trust target of 90% completion.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Theatre staff demonstrated a good knowledge of safeguarding and had completed the appropriate levels of safeguarding training. They understood how to support patients from abuse in their surgery department.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff discussed safeguarding risks during patient handovers and staff huddles.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were aware of safeguarding procedures, how to make referrals and access advice; there were safeguarding leads throughout wards and a head of safeguarding in place. Ward staff knew where safeguarding policies were for support. They used online forms to refer safeguarding notifications or queries to the local authority multi-agency safeguarding hub. Nursing staff said they would inform their nurse in charge or matron depending on the severity of their concern.

We reviewed the trust's safeguarding adults at risk of abuse and neglect policy which was in date (April 2022), version controlled and had a review date of February 2025.

Staff told us matrons produced safeguarding reports where any learning for staff was included.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Hand hygiene points were visible at the entrances of each unit. Empty bed spaces had checklists completed to indicate they were clean and ready for the next patient.

Across the surgical division the service performed well for cleanliness. Cleanliness audits scored between 81% and 99.2% across the surgical division, in the previous 6 months before inspection. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

The latest (2022) Patient-Led Assessments of the Care Environment (PLACE) score was 98.4% for cleanliness, across the surgical division.

However, in one store room we found boxes which were stored directly on the floor which prevented floor cleaning.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were seen to wash hands, use antibacterial gels and PPE. Masks were worn in line with trust policy. Some patients told us that staff always washed their hands and wore PPE. However, we did observe staff sitting on one patient's bed.

Staff worked effectively to prevent, identify, and treat surgical site infections.

Data on infection rates was also collected monthly for each ward. This included information on MRSA, clostridium difficile, pseudomonas, Escherichia coli (E. coli) and methicillin-susceptible Staphylococcus aureus (MSSA). In the period September 2022 to March 2023, data showed that the infection rates for all surgical wards across the trust were low.

We observed hand sinks in every room with a poster above every wash basin about hand washing hygiene. Handwashing and gel available at every entrance and all pedal bins were foot operated.

Surgery

Appropriate use of personal protective equipment (PPE) was adhered to during the inspection. However, not all staff were compliant with uniform requirements. We saw that staff did not always adhere to guidance in particular several staff were wearing rings with stones. We witnessed a doctor not being bare below the elbows during a patient follow-up visit.

All curtains were disposable and labelled with date fitted and date to be changed. The wards used 'I am clean' stickers. However, we found dirty linen in the linen cupboard and escalated this to the ward manager.

During the inspection we saw thermometer equipment being used for 4 patients without being cleaned between each usage.

Environment and equipment

The overall design, maintenance and use of facilities, and premises did not always keep people safe. Storage areas were not locked as required. The servicing and safety testing of some equipment had expired.

The design of the environment followed national guidance. However, it was noted that wards and units were difficult to find due to limited clear signage.

Staff carried out daily safety checks of specialist equipment. We checked resuscitation trolleys on wards and in the theatre suite. Daily checks were completed correctly on all wards. However, in multiple areas we found equipment which had expired their safety check date. For example, medical equipment such as 14 pressure care items, 9 beds and 3 therapy machines. This also included items which had never been safety tested such as fridges, freezers, toasters, and microwaves.

Patients could reach call bells and staff quickly responded most of the time when called.

The service had suitable facilities to meet the needs of patients' families.

Fire extinguishers were present on all inspected services and in date. We also saw that fire exits were checked and clear. The fire safety policy was available to all staff and staff were aware of hospital fire procedures.

The service had enough suitable equipment to help them to safely care for patients. Wards had access to specialist mattresses and chairs to reduce the risk of pressure ulcers for those patients who needed them.

Staff disposed of clinical waste safely.

There was no signage on any entrance or exit doors warning staff not to allow members of the public into unit before checking the appropriateness.

Across multiple areas within surgery, we observed cleaning cupboards, sluice rooms, storerooms, and utility rooms were left open. Most of these rooms had locks or keypad locks on the door, but they were not being used. This meant there was easy access to consumable products such as intravenous fluids, syringes, blunt fill needles and hand sanitisers. We also found a tin of gloss paint.

There was unsafe storage of controlled substances hazardous to health (COSHH) such as cleaning chemicals found inside unlocked rooms and on unmanned cleaning trolleys.

Domestic staff were not wearing protective gloves when using peracide disinfectants. The COSHH data sheet stated, “avoid excessive exposure to hands / skin – use suitable gloves if necessary.”

The COSHH folder was kept in the sluice room and on review of the folder we found that it was out of date and last reviewed 2018. The elective cleaning rota was also held in the sluice room, and it had last been updated in August 2021. We found sterile catheter equipment being kept in the sluice room, this raised an infection, prevention, and control concern.

Staff did not always record fridge temperatures. We found that over a 3-month period (June to August 2023) for one ward fridge there were 17 occasions when temperatures were not recorded. In addition, hygiene checks had only been completed 14 times. On another ward fridge there were only 2 occasions when temperatures were not recorded however the fridge temperatures was out of range on 20 occasions. Staff reset all fridge temperatures every day instead of only on the days it was out of range.

We were advised that bariatric equipment was not held on all wards but could be requested as required.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Records showed that staff had used the early warning scoring system that the trust used to correctly record, calculate, and review patients for signs of deterioration as required. The trust supplied data to demonstrate that an audit programme took place to ensure that staff followed the trust’s early warning and sepsis scoring protocols.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We looked at sets of records which were a combination of paper and digital records on the trust’s system. We noted that they were usually fully completed, accurate and legible. Those assessments that the trust required to be done on admission were always completed.

We observed the World Health Organisation checklist for safe surgery (WHO checklist) being used and noted good practice in that patients were checked in by both the surgeon and anaesthetist. We looked at five records for patients in theatre during our inspection and the WHO checklist was correctly followed and recorded in all cases. Compliance audits for the WHO checklist were 83.3% across the surgical division, at the time of the inspection.

Staff knew about and dealt with any specific risk issues. Where an indicator of sepsis was identified, the trust followed a national pathway (Sepsis 6) to provide testing and treatment to patients within one hour. We reviewed the trust sepsis assessment form and noted that the trust used an SBAR approach (situation, background, assessment, and situation) to review patients following an acute episode of deterioration.

Early warning scores were used to monitor patients and detect deteriorating patients, or patients who required escalation or additional care or treatment. The trust had a dedicated critical care outreach team, staff knew the process for escalating concerns for deteriorating patients with the team and could give examples of when this had happened. We saw in patient records that the team attended promptly.

The service had 24-hour access to mental health liaison and specialist mental health support via direct referral, if concerned about a patient’s mental health.

Surgery

Staff arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff we spoke with knew how to access the mental health support. There was access to specialist nurses and crisis teams.

The service did have a specific process for medical patients who were being cared for on surgical wards (outlying patients). The trust had agreed principles for caring for these patients and could identify them as part of their winter pressures position; this information included that there was appropriate medical consultant oversight from a medical speciality.

Staff shared key information to keep patients safe when handing over their care to others. The wards had daily safety briefings which highlighted potential risks to patients. The agenda included points such as 'patient specific risks,' capacity in the ward, staffing levels and a review of patients coming to the unit.

Shift changes and handovers included all necessary key information to keep patients safe. Handovers were supported using briefing documents to ensure consistent messages across shifts. We observed hand over sheets on all wards we inspected. The nursing handover document included key information regarding individual patients which included a plan of care, key risks, and discharge plans.

Nurse staffing

The service had enough staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. However, staffing had continued to be a challenge across the trust. Nursing staff turnover for the surgical services at the time of the inspection was 8.3% across the surgical division.

The percentage of shifts filled against the planned nurse staffing across the trust was 96% across the surgical division, at the time of the inspection. Overnight average fill rates for staffing were at least 100% for the three months before inspection.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The ward manager could adjust staffing levels daily according to the needs of patients.

The service sickness rates for nursing staff were 6.3% across the surgical division.

Managers made sure all bank and agency staff had a full induction and understood the service.

On inspection we observed staff working hard to complete tasks for patients; however, we were assured that staff had the time to always provide person centred care that met individual patient needs.

Medical staffing

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

Surgery

The service had enough medical staff to keep patients safe. Medical staff matched the planned numbers on rotas we reviewed for the three months prior to inspection.

The service had reducing vacancy rates for medical staff across the surgical division. There had been a 3% increase of medical staff in June 2023 compared to June 2022. Unfilled medical staff posts from June 2022 to June 2023 (WTE vacancies) were now General Surgery at 10%, Urology at 17%, Trauma and orthopaedics at 30% and zero Vascular vacancies, across the surgical division.

The service had turnover rates of 18% for medical staff across the surgical division.

Sickness rates for medical staff were 3.4% across the surgical division.

Managers could access locums when they needed additional medical staff. Locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Senior clinicians and consultants we spoke with said there was no shortage of junior doctors on the wards. We saw enough numbers of medical staff on the wards we visited to meet the needs of patients.

The service always had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. We reviewed 8 sets of patient records across 12 wards and theatres which were a combination of paper and digital records. We noted that they were fully completed, accurate and legible. Those assessments that the trust required to be done on admission were always completed.

The majority of food and fluid balance charts and Malnutrition Universal Screening Tool (MUST) scores were completed in line with guidance; weight was recorded on admission and then weekly thereafter, we saw recording of patient weights in line with this. However, there were occasions when MUST charts were out of date and nutrition charts were incomplete.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Patient records showed good documentation of patient's allergies including positive documentation of no known allergies.

Records assured us patients were receiving their medicines as prescribed.

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

We saw evidence of pharmacist clinical checks to review patients' medicines regularly whilst they were an inpatient and saw that actions raised by pharmacists were actioned by the medical team in a timely manner. However, audits were not always completed in a timely manner with most wards rated amber for the RAG rated completion figures.

Staff completed medicines records accurately and kept them up to date. Staff followed national practice to check patients had the correct medicines when they were admitted. Medicines recorded on both paper and digital systems for the 4 sets of records we looked at were fully completed, accurate and up to date.

Staff usually stored and managed all medicines and prescribing documents safely. In theatres, Controlled Drugs (CD) were kept securely, and staff checked them twice a day. Similarly, drugs that needed to be kept cool were kept in a locked fridge and were found to be in date. Controlled drug fridge temperatures were recorded daily, and no concerns were noted by the inspection team. Staff could explain the process of escalation if fridge temperatures were outside of the safe temperature ranges.

Staff stored and managed all medicines and prescribing documents safely. Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff completed medicines records accurately and kept them up to date.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

Staff did not always recognise and report incidents or near misses. Incidents that were recognised were managed well. Managers investigated incidents were reported, and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Some staff we spoke with did not recognise and report incidents or near misses. Senior staff knew what incidents to report and how to report them and were able to articulate doing this in line with trust policy. Incidents that were recognised were managed well.

Incident learning was shared with staff, and we saw a safety bulletin which was issued regularly to all staff. This included information on learning from incidents and improvements across the trust.

The surgical service had 1 never event between August 2022 and July 2023. Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Managers for the service had sight of all incidents and all incidents rated moderate and above were reviewed by the patient safety team. Incident forms were also reviewed by a designated consultant and any learning shared. Staff met to discuss the feedback and look at improvements to patient care.

Surgery

The electronic incident reporting system included a prompt on the duty of candour. This is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with demonstrated an awareness of the duty and the importance of being open and honest when delivering care.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers investigated incidents thoroughly. Patients and their families participated in these investigations.

Managers debriefed and supported staff after any serious incident. Case reviews took place as well as learning from care that had gone well to share good practice. Learning and any changes in protocols were shared via email.

Is the service effective?

Good ➔➔

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The trust had comprehensive policies, procedures and guidance which were aligned with that of national bodies such as the National Institute for Health and Care Excellence (NICE) and specialist bodies. Staff demonstrated awareness of the policies and knew how to access them.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers. Handover meetings showed individual needs of patients were discussed. Our patient records reviews showed that patients' psychological and emotional needs were recorded.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural, and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Nursing staff asked patients about any food intolerance or allergies as part of their pre-assessment. This also included specific dietary or cultural requirements, such as vegetarian or halal. This information was passed to the catering team so suitable food could be provided for the patient during their stay.

Specialist support from staff such as dietitians and nutrition assistants were available for patients who needed it. We saw that patients requiring this extra support were regularly reviewed. When modified diets were needed, assessments of patient's requirements were detailed above their beds.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Malnutrition Universal Screening Tool (MUST) scores were completed on admission and then again 24 hours post operatively. We saw that this was accurately completed on the patients we looked at during our inspection. Nurses on the ward could provide high calorie juices accordingly, in line with policy, and refer to dietitian if appropriate.

The trust had nutrition specialist nurses to support patients including those receiving artificial nutrition support, for example percutaneous endoscopic gastrostomy (PEG); A PEG feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall.

Patients waiting to have surgery were not left nil by mouth for long periods. We reviewed the Trusts standard operating procedure (SOP) for surgical patients who were nil by mouth.

The policy had information to support staff with a protocol for intravenous fluids and information for pre fasting guidance for patients before surgery.

The trust provided 24 hour medication to help patients with effective nausea and vomiting. They could top this up with additional IV fluids for maintenance. There was always cereal and toast available if patients had been unable to eat. Nurses had access to snacks and salt if a patient was low in sodium.

All wards had forms to identify special diets such as gluten free, allergy aware, renal, halal, kosher, finger food, energy dense, neutropenia diet, thickened fluid, red tray an adaptive cutlery required.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The trust used differing methods to assess patient pain levels which included FLACC assessment, Burford thermometer and Visual analogue scales (VAS) score.

FLACC is a behavioural pain assessment scale used for nonverbal or preverbal patients who are unable to self-report their level of pain. Pain is assessed through observation of 5 categories including face, legs, activity, cry, and consolability. The Burford thermometer assesses pain by asking patients to indicate the intensity or severity of their pain on a diagram of a thermometer. It is a version of a verbal descriptor scale that visually represents increasing degrees of pain along the thermometer. Visual analogue scales (VAS's) are used for subjective ratings of emotion or other sensations such as pain.

Patients usually received pain relief soon after requesting it. We spoke to patients who had received pain relief on time and when requested.

Staff prescribed, administered, and recorded pain relief accurately. We saw staff completing and updating the patient records.

All staff we asked knew about the trust's specialist pain management team. The latest pain team referral figures showed that 1274 patients, across the surgical division, had been referred to the pain management team between September 2022 and August 2023 inclusive.

Patient outcomes

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

The service participated in relevant national clinical audits and managers used these audits to improve patient outcomes, care, and treatment. Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time.

The 2021 National Joint registry audit showed the results were within expected range for 3 indicators and were much better than other trusts for one indicator relating to case ascertainment (hips, knees, ankles and elbows).

The Bowel cancer audit figures showed that the trust figures were deemed to be good by the National Bowel Cancer Audit Dataset 2022 and were similar or slightly better than other trusts in the region. The 2022 report includes results for patients in England and Wales diagnosed with bowel cancer 1 April 2020 – 31 March 2021, and patients diagnosed between 01 April 2019 and 31 March 2020 who underwent a major resection after 31 March 2020.

The National Oesophago-gastric Cancer Audit database shows that the trusts outcomes were better or similar to national audit outcomes for the management of high grade dysphasia patients and the management of oesophago-gastric cancer patients.

The Prostate Cancer Audit showed that the trust performed much better than other regional trusts for Prostate Specific Antigen (PSA) and TNM completion. (TNM - T describes the size of the tumour, N describes the involvement of lymph nodes and M describes if the cancer has spread to a different part of the body.)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

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

Managers gave all new staff a full induction tailored to their role before they started work. All staff working at the hospital had an induction programme relevant to their role and the department they worked in. New staff were required to complete e-learning and face-to-face training.

The clinical educators supported the learning and development needs of staff.

Managers supported staff to progress through regular development meetings and yearly constructive appraisals of their work. Staff had the opportunity to discuss training needs and were supported to develop their skills and knowledge. Medical staff appraisal rates across surgical services were 68.7% and nursing staff appraisal rates were 91.2% at the time of inspection.

Staff told us they found the appraisal process useful, and they were encouraged to identify any learning needs they had, and any training they wanted to undertake. Staff were supported by their managers to improve their practice where indicated.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. To ensure effective services were delivered to patients, we saw different teams and health professionals working with staff at the service as a multidisciplinary team (MDT).

When we visited the wards and observed a handover, we saw a variety of staff working together, such as nurses and support workers, to benefit patients. Nursing staff said they had good communication between theatre and ward staff. They felt the trust had an informal culture of cross-service collaboration, for example by borrowing equipment and asking advice.

We could see from the handover sheets and records we examined that there was detailed communication between staff of different grades and roles.

There was a discharge team who had links with local services, local authorities, and care providers.

We saw therapist input and contributions to patients' discharge. The patient input into care was included throughout and involvement of family member as the patients next of kin was also present.

There were many examples of multidisciplinary working including the daily safety briefing, ward rounds which included input from a consultant, doctors, pharmacist, physiotherapist and as well as nursing staff.

There was a dedicated physiotherapist team who worked collaboratively with the nursing and medical staff to ensure that patients received the support they required. The physiotherapy team worked seven days per week. Patients told us they were not rushed or restricted to time when receiving physiotherapy.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends.

Pharmacy staff were available Monday to Friday and there was an on-call service at weekends and out of hours.

Physiotherapists provided treatment seven days a week with an on-call service available overnight. There was no dedicated occupational therapist, but referrals could be made.

Speech and language therapy were offered Monday to Friday. There were a low number of speech and language therapists available within the trust which reflects a nationwide shortage of this staff group.

X-ray, computerised tomography (CT) scanning, interventional radiography and endoscopy was accessible 24 hours a day, seven days a week.

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

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units. We saw displays on wards we visited through our inspection on healthy lifestyles and health promotion. There were leaflets available for patients to take on a variety of topics including diabetes, weight loss, stop smoking and stress.

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

There were guidelines in place to support patients withdrawing from drugs or alcohol.

The multidisciplinary team provided health and self-care advice to patients to support them to manage their own conditions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They used agreed personalised measures that limit patients' liberty. Although decision making was not always recorded correctly on documentation we reviewed.

We reviewed additional sections of service user records relating to Mental Capacity Act (MCA) assessments and Deprivation of Liberty Safeguards (DoLS) applications. We saw capacity assessments, best interest decisions and consent to care and treatment was not always in line with legislation and guidelines and staff did not consistently recognise and respond to concerns in relation to mental capacity.

Staff did not always consistently assess capacity in a way that was decision-specific and time-specific. We found examples in service user records where staff had recorded that service users had 'no capacity'. Staff did not record the decision prompting the consideration of the service user's capacity or record the mental capacity assessment and decision made in the service user's best interest. However, the trust has been completing significant work across the area, and we have seen clear improvement in audits for record keeping since inspection.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with had attended mandatory training surrounding mental capacity act and deprivation of liberty safeguards training and understood capacity was decision and time specific. Staff did not always implement Deprivation of Liberty Safeguards in line with approved documentation.

Staff liaised with the psychiatric liaison team for all mental health patients.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. We saw DoLS audits on wards and the trust held MCA steering group meetings.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

Staff made sure patients consented to treatment based on all the information available.

Surgery

Staff clearly recorded consent in the patients' records.

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Good

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness. We reviewed the friends and family data results for surgical wards and the results were positive.

Staff followed policy to keep patient care and treatment confidential.

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

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Patients were treated with compassion, and we saw staff provided care in a respectful manner that maintained patient dignity.

We observed a medical student with a patient and noted that they asked the patient before any treatment was given. Everything was explained to the patient and reasons why, in a very caring manner.

We also observed 2 physiotherapists with a patient. They were very caring and asked good questions to the patient to get information. Asked about previous walking aids used for them to work out best treatment.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Surgery

Staff demonstrated empathy when having difficult conversations.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff were fully committed to working in partnership with patients and their relatives, involving them in decision making processes about care and treatment.

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

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced and informed decisions about their care.

Patients gave positive feedback about the service. We saw lots of thank you cards on the wards.

Is the service responsive?

Requires Improvement

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

Service delivery to meet the needs of local people.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

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

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. There had been no breaches on any surgical wards.

Facilities and premises were appropriate for the services being delivered.

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

Meeting people's individual needs

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

Surgery

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Support was available for patients with physical and learning disabilities. Staff said they treated every patient as an individual, which meant they made reasonable adjustments to meet the needs of patients with a learning disability or who were living with dementia and their family members.

Initiatives to enhance the care of those with a learning disability were in place. Health passports were in use. These detailed personal preferences, triggers, and any interventions which were helpful in supporting individuals during difficult periods.

Staff recognised the importance of involving relatives and carers for any patient with additional needs. The patient records that we reviewed reflected that individual needs were assessed, and care planning was informed by this. Patients with learning disability were given a RAG rated bracelet for staff to identify them as needing additional support as learning disability.

Staff supported patients and those close to them during referral, transfer between services and discharges. Staff always informed patients of possible changes to their care before it occurred. Before discharges staff informed the patient and their family of where they were to be discharged to and what expectations to have of the services being provided.

The service had information leaflets available in languages spoken by patients and the local community. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff knew how to access interpreting services for patients whose first language was not English. Translation could be provided face to face or over the telephone. Communication aids such as letter boards were also available.

Staff told us they had access to communication aids to help patients become partners in their care and treatment. There was a laminated book with different pictures for patients with learning disabilities. There was access to a whiteboard and pens as well as communication cards for expressions of emotions.

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

Access and flow

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

In terms of the trust's elective recovery in October 2023, the 18-week consultant led referral to treatment times for all patients was 61.5% against a goal of 92%. This had deteriorated over the last few months. The lowest performing speciality was Ear, Nose and Throat (ENT) with 44.7% and 2938 patients. This was significantly below the trust target of 92%.

The service's 18 week performance from August 2022 to July 2023 showed a mixed picture within specialisms. There was high compliance within breast surgery, general surgery, and upper gastrointestinal surgery. However lower compliance for trauma and orthopaedics which was 83%, ENT which was 49%, general surgery endoscopy which was 17.6% and vascular surgery which was 64%. This meant the service was not able to meet the demand, there would be longer waiting times and as patients may suffer adverse outcomes and harm as a result.

In July 2023 the mean number of days from decision to admit for some surgical specialisms were high for Trauma and Orthopaedics (209 days) and upper gastrointestinal surgery (277 days).

Surgery

In October 2023 there was a total of 8706 patients waiting treatment for Trauma and Orthopaedics and 6569 patients waiting treatment for ENT. These specialities were the ones with the largest waiting list times. There were at least 832 surgical patients waiting over 52 weeks for treatment, with 610 patients within Trauma and Orthopaedics and 322 patients within ENT. Some of these patients were waiting over 65 and 78 weeks to receive treatment. These wait times did not meet NHS targets.

Trust cancer waiting metrics, as of September 2023 included the following. The proportion of patients seen by a specialist within two weeks of GP referral was 83.6% against a target of 93%. The 62-day wait for patients referred with suspected cancer was 73.6% against a standard of 85% and 31-day treatment performance for patients was 93.6% against as standard of 96%.

Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards. Managers worked to minimise the number of surgical patients on non-surgical wards. Outlier figures for the surgical division were not provided.

Managers and staff started planning each patient's discharge as early as possible. The average length of stay for trauma and orthopaedics was 5.1 days for patients at the time of our inspection. For general surgery the average length of stay was 3.6 days and 2.9 days for colorectal surgery.

There were 64 out of hours surgical bed moves, in the 12 months prior to inspection. Reasons for increased bed moves included decant of wards for deep cleaning, ongoing infection prevention control, moving a patient to a side room for privacy and dignity.

Managers and staff started planning each patient's discharge as early as possible. The average length of stay for surgical specialities was 4.3 days for patients at the time of our inspection.

We observed that medical / trauma and elective surgery were in separate areas, the elective orthopaedic wards were not compliant with recommendations for ring-fenced orthopaedic beds.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Managers monitored the number of patients where discharge was delayed, knew which wards had the most delays, and took action to reduce them.

Staff supported patients when they were referred or transferred between services. Managers monitored patient transfers and followed national standards.

There were 705 operations cancelled across the trust, on the day of surgery or following admission, for non-clinical reasons (excluding non-elective), between August 2022 and July 2023. The highest number of cancelled operations related to ophthalmology followed closely by general surgery.

Learning from complaints and concerns

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

Surgery

Patients, relatives, and carers knew how to complain or raise concerns. Patients we spoke with had said they felt able to raise concerns and could see that the service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes. There were 185 complaints received by surgical and cancer services for the period 2022/2023. Local and national guidance required that all complaints were acknowledged within three working days, the trust set itself a 95% compliance target in this area. For the month of July 43% of complaints across the service were closed in the timescales agreed with the complainant.

We reviewed 11 complaints and responses randomly chosen and found them to be detailed, appropriate and candid. In July 2023 there were 27 outstanding complaints requiring a response.

Managers shared feedback from complaints with staff and learning was used to improve the service.

There were 316 compliments received by surgical and cancer services for the period 2022/2023.

Is the service well-led?

Requires Improvement ↓

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

Leadership

Leaders had the skills and abilities to run the service. However, they did not always manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Surgical services had managers with the right skills and abilities to ensure the service was providing high quality care. The divisional structure currently had 6 tiers.

At the time of the inspection there were 2 deputy divisional nurses overseeing the division reporting to the Chief Nurse. The divisional nurse role had been recruited to with a start date in September 2023.

Leaders were inspiring a shared purpose and were focussed on delivering and motivating staff to succeed. Managers were keen to retain staff and invested in education for staff to progress.

The leadership team understood the current challenges and pressures impacting upon service delivery and patient care. However, senior leaders were not aware of all the risks we found on inspection.

The clinical leadership team were visible and approachable. Staff said they had confidence in working together, and in leaders understanding issues and working better to improve them.

Surgery

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a vision for what leaders want to achieve in surgery and this was in line with the trust vision. The service promoted training, and staff were aware of the vision for surgery and were able to share this with us during inspection.

The trust planned expansion of elective and diagnostic capacity including the establishment of a Community Diagnostics Centre. In addition, development, and implementation of the Mexborough Elective Orthopaedic Centre (MEOC) and development and implementation of a sustainable trauma business case. There was a long term vision for the vascular service and the trust were exploring and developing the case for the trust to be the second robotic centre for the ICS (e.g., Urology, General Surgery, ENT).

Divisional service development priorities included improving the utilisation and throughput of elective recovery theatres and out-patient transformation. There were plans to address resources and pathways to manage and address backlogs as well as Day Case Arthroplasty service development. Priorities included creating the ophthalmology hub with data sharing and single point of access.

The trust had identified a number of divisional challenges and priorities, such as, achieving a full establishment of medical, nursing, and administrative workforce. This included ensuring that SAS doctors had career development pathways and that nursing staff had improved skill mix, training, that there was contingency planning and clear career development opportunities.

In addition, the trust aimed to increase nurse endoscopists and non-clinical / medical endoscopists through recruitment and training programs. This included robust inductions, preceptorship, and clinical development plans for new and developing staff.

The trust had plans for recruitment and retention programs- Breast, Dental, ENT, General Surgery, Ophthalmology, Trauma & Orthopaedics as well as administrative recruitment and retention support and strategies.

Staff told us they provided patients with person-centred care and that working well in a team was key to achieving their vision and strategy.

The management team shared they were dedicated to workforce retention and prioritising wellbeing and development across staff groups.

Culture

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

Staff were positive and caring towards patients and their relatives who used the service. In addition, we also noted caring and respectful interactions between staff of all grades and disciplines.

Surgery

The care and service delivered showed a strong team approach to work. Staff from all disciplines told us they felt valued in their roles and were very much part of the team. Staff we spoke with expressed pride and commitment in their work.

There was a clear focus of patient centred care and teamwork, support between colleagues was strongly evident throughout the different areas we visited for both nursing and medical staff.

The service promoted equality and diversity in daily work. We found that 85.3% of medical staff and 99.4% of nursing staff nursing staff across the service had completed Equality, Diversity, and Human Rights level 3 training.

The surgical and cancer division had a "speak up" partner who escalated concerns, where appropriate, to the Freedom to Speak Up Guardian.

Governance

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

Staff at all levels of the organisation understood what to escalate to a more senior person, and this happened for reporting low staffing levels. Ward managers told us that they had the option to report red flags when staffing levels were low. The number of red flags were reported monthly to the board.

We saw a performance board showing examples of audit results from January 2023 and showed when an action was required, progressing, or resolved. It also showed pictures of when things had not been compliant.

We saw many examples of 'you said / we did examples' such as when a patient raised a concern about long medication waits. The trust worked with doctors and pharmacy to highlight patients that were potential for discharge the day before, so that they could ensure medication was ordered and discharge letters completed.

Management of risk, issues, and performance

Leaders and teams did not always use effective systems and processes to manage performance and risk. The systems did not identify many of the risks found by the inspection team. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Senior leaders were not aware of all the risks and challenges we found on inspection. For example, ensuring premises and environment were safe and secure, compliance with IPC policy and completion of mandatory training. We also found equipment which had expired their safety check date some had never been tested and unsafe storage controlled substances hazardous to health (COSHH) cleaning chemicals. These were not listed on either the surgical or trust risk register.

However, managers took immediate action with regard to most of the risks we raised with them at the time of the inspection.

The service had a systematic process, involving staff of all roles and grades, in reviewing and improving the service. This included identifying risks and planning to reduce the level of risk. There was a rolling agenda of meetings to improve quality and patient safety.

Surgery

There was a risk management process related to risk with monthly risk meetings. The risks were escalated to the divisional meetings.

Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact giving a red, amber, green (RAG) rating. The Surgical and Cancer service risk register contained 24 extreme risks and 20 high risks. We reviewed divisional governance meeting minutes and saw that extreme and high risks were appropriately reviewed and updated on a monthly basis.

Some of the surgical risks impacted on patient waiting times and as a result patients may suffer adverse outcomes and harm due to delays in treatment. Delays were especially longer for patients waiting for treatment within trauma and orthopaedics and ear, nose, and throat (ENT).

Other risks related to increased demand and capacity within the service or funding shortages.

Two risks related to vacancies within the service and trust. For example, the service did not have a vascular MDT coordinator to assist with the lack of tracking of urgent vascular patients. The trust did not have enough radiographers.

We saw some of the surgical risks had also been moved to the corporate risk register. For example, the trust had identified they did not have effective information systems to support medical revalidations and appraisals for medical staff and this was listed as a moderate risk. Another risk listed as moderate was the ineffective process to manage and monitor the ambient temperature of rooms which store medication. This meant some medicines may be less effective and have to be disposed of which could lead to delays for patients to receive medications.

Senior leaders completed monthly analysis on referral to treatment and performance. They had identified specialisms such as trauma and orthopaedics and ENT where capacity did not meet the demand.

Senior leaders were making good progress against the risks associated with long waiting times. They had been exploring alternative patient pathways with virtual wards and clinics and same day emergency care provision (SDEC). They had also implemented an interim standard operating procedures to manage patient tracking and had commenced clinical validation exercises.

All serious incidents (SI), incidents and moderate harms were reported to the Surgery and Cancer Division Clinical Governance Meeting and progress reports discussed. There were 8 outstanding SI action plans for the division in July 2023. There had been several serious incidents resulting from patients being lost to follow-up or review.

Quality and performance dashboards highlighted that overall, the Surgery and Cancer division were performing well in all but 2 areas. The two weaker areas were lower than target appraisal rates and low Friends and Family Test (FFT) response rates. All other areas, which included number of complaints, falls with severe harm, falls with moderate harm, and MRSA rates were all low or zero. There were low number of pressure ulcers (category 2) and no pressure ulcers graded category 3 across the division for the last quarter.

There was effective oversight of performance regarding antimicrobial prescribing and stewardship. We saw monthly meeting minutes which evidenced ongoing audit of medicine management compliance and antibiotic prescribing data. Antibiotic prescribing varied across the surgical wards depending on speciality, as expected.

Surgery

Information Management

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

Staff had access to the IT equipment and systems needed to do their work. However, the trust was developing data to ensure divisions had the systems to understand performance make decisions and improvements.

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. Systems were in place to collect data from wards and teams.

Information governance systems were in place and ensured the confidentiality of patient records.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

We saw the staff engagement group met monthly and this covered a wide variety of agenda topics in recent minutes we reviewed. We saw that staff survey questions had been updated to align with the NHS People Promise and that the trust had asked additional questions regarding the awareness of trust values. The initial staff survey results showed an encouraging and improving picture in relation to feedback. Work was being undertaken in relation to communication of the results and engagement with local teams, to embed a cycle of year-round engagement.

The response rate for the staff survey was 65.2% and the comparator average for acute trusts using the same provider was 43%. The trust was a leading acute trust for the response rate amongst comparable trusts and achieved the highest ever response rate for the survey at the trust, which is a positive sign of engagement. However, the information received did not show statistic broken down for the Surgery and Cancer Services division.

There was a clear focus on engagement activities to develop a culture of inclusion. The trust held events for staff from ethnic minority groups.

The patient satisfaction survey results for the surgical outpatient department were positive with a response rate of 130 patients. Out of the 130 responses 113 patients had an excellent experience, 15 had a good experience and 2 people did not answer.

It was noted in the June 2023 Surgical and Cancer division governance minutes that the friends and family test (FFT) response rates were not at the level required. However, improvements had been noted and further spot checks were planned.

The endoscopy patient survey showed an overall positive response with 100% (n 20) patient happy with the care they received. All stated they received information relating to their procedure and all had the discussed their tests with the doctor or nurse. All patients felt they had opportunity to ask questions, and all felt they were treated with respect throughout the procedure.

Surgery

Learning, continuous improvement and innovation

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

Working in partnership with two additional trusts, Doncaster, and Bassetlaw Teaching Hospitals (DBTH) were leading the programme to implement a new, dedicated orthopaedic hub for the people of South Yorkshire. Surgical procedures would include hip and knee replacement inpatient procedures alongside foot and ankle, hand and wrist, and shoulder day case surgery. In the first year of operation the centre planned to undertake approximately 2,200 orthopaedic procedures on behalf of the three partner trusts, equating to about 40% of the current orthopaedic waiting list locally.

Known as the Montagu Elective Orthopaedic Centre (MEOC), the facility would feature two state-of-the-art theatre units, two anaesthetic rooms and a recovery suite, in addition to 12 inpatient beds in a dedicated orthopaedic facility. This development would be based at Montagu Hospital, co-located with rehabilitation services and with access to the planned Community Diagnostic Centre.

In the previous financial year as part of the elective recovery programme the 'My Planned Care' patient platform was launched with the purpose of enabling patients to be kept better informed about how long they may be waiting for procedures. The Patient Advice and Liaison Service (PALS) were the designated contact point, and a dedicated email inbox had been set up.

Doncaster Royal Infirmary

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Description of this hospital

Doncaster and Bassetlaw Teaching NHS Foundation Trust provides acute services for 420,000 across South Yorkshire, North Nottinghamshire, and the surrounding areas. The trust employs over 6000 staff.

Doncaster Royal Infirmary (DRI) is one of the acute hospitals forming part of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust. There are more than 500 beds. It provides a full range of acute clinical services to the local population including:

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Maternity and gynaecology
- Outpatients and diagnostic imaging
- Critical care
- End of life care
- Children and young people's services

Diagnostic imaging

Good ↑

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff but did not always make sure everyone completed it. Training for autism had not been received by staff at the time of the inspection.

Staff received but did not always keep up-to-date with their mandatory training, with compliance rates at an average of 87% against a trust target of 90%.

The mandatory training was comprehensive and met the needs of patients and staff. Staff were provided with training specific to their job role, this meant they received the required training relevant to their role.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, and dementia. The trust had appointed learning disabilities ambassadors into each area, these staff received enhanced levels of training and delivered learning sessions in their own teams. They attended overall trust meetings with ambassadors from other parts of the trust. The autism training for staff had not been held yet but was planned to be rolled out later in 2023 for all staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers told us they could view this on a dashboard to see overall compliance in training as well as individual results and due dates.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it, but this was not always kept up to date and was below the trust training target.

Staff received but did not always keep up to date with training specific for their role on how to recognise and report abuse. The compliance for training across the trust in diagnostic imaging was at 87.5% completion in safeguarding training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. The Trust had a specific safeguarding team that staff could contact at any time for concerns and referrals.

Staff could access safeguarding advice from the Trust's lead nurse for safeguarding.

Diagnostic imaging

Staff followed safe procedures for children visiting the department. There was a children's waiting area in one of the sub-waiting areas with an area children could wait in if they would prefer. There were a small number of children referred to diagnostic imaging for suspected physical abuse checks. If these patients did not attend (DNA) staff would send a DNA report back to the referrer.

Staff attended paediatric multidisciplinary meetings to discuss referrals, images and reports relating to children.

We reviewed the trust's safeguarding adults at risk of abuse and neglect policy which was in date (April 2022), version controlled and had a review date of February 2025.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Staff provided records to show cleanliness of equipment had been checked. All rooms and public areas were cleaned daily by hospital domestic staff, and cleaning checklists were available to staff.

Clinical area cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

The service generally performed well for cleanliness. Recent PLACE scores for the hospital showed higher than national average scores in most areas. The latest (2022) Patient-Led Assessments of the Care Environment (PLACE) score was 98.4% for cleanliness.

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

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff disposed of ultrasound gels in bottles at the end of every day. Sonographers cleaned and disinfected ultrasound probes before use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. Patients were not left alone, and there was a staff member always observing patients from other wards or areas of the hospital whilst they were waiting to ensure they were safe.

The design of the environment followed national guidance. There was clear signage throughout the departments where ionising radiation or magnetic resonance imaging (MRI) equipment was used and there were controls to restrict access to patients and staff. Equipment used in MRI environments were suitable for use and labelled as MR safe. There was appropriate PPE available including lead aprons and coverings.

We saw radiation protection supervisor reports showing reviews undertaken against IR(ME)R and learning shared with staff through team meetings and training.

Diagnostic imaging

Staff carried out daily safety checks of specialist equipment. Staff provided servicing and maintenance documents for all equipment. Staff were able to raise any immediate concerns to managers who took action to rectify faults quickly.

Staff completed quality assurance (QA) checks on all equipment. These were mandatory (must do) checks based on the Ionising Radiation Regulations 2017 and IR(ME)R 2017 regulations. These protect patients against unnecessary exposure to harmful radiation. All x-ray equipment had been measured by the regional medical physics advisor and had been found to be safe.

The service had suitable facilities to meet the needs of patients' families. There was an area for children within one of the waiting areas and a specific feeding room for breastfeeding. This had been created by the manager in response to feedback received from patients.

The service had enough suitable equipment to help them to safely care for patients.

There were temperature controls in areas where radiological contrast was stored. Inspectors found contrast stock was well managed and all packages of contrast were within date. MRI safety was monitored and managed by a medical physics expert based at a local NHS trust and a specialist radiologist within the trust.

There was guidance for quality assurance and diagnostic reference levels (DRL) for equipment. DRLs were present in main x-ray rooms. Each piece of equipment had separate and specific DRLs, and the manager informed us they would contact their medical physics expert for advice.

The adult and paediatric resuscitation trolleys were well stocked, locked, and tagged. Equipment including suction and oxygen lines were clean. There were anaphylaxis and cardiac arrest kits kept with the trolleys. The checklists for resuscitation trolleys had some missing entries for the 3 months prior to our inspection visit. Trolleys were due to be checked daily and we saw this was happening most of the time, but there were some gaps in daily checks.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff responded promptly to any sudden deterioration in a patient’s health. The trust had clear policies and guidance in place for managing medical emergencies. Staff received basic life support training as a minimum and there was an emergency crash team who could be called to assist.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used a standard document for all examinations consistently across all sites. This document was uploaded to the patient record and there was a standardised process to check patient identification, contrast safety and World Health Organisation (WHO) safer steps to surgery checks.

Staff knew about and dealt with any specific risk issues. Radiology equipment had been risk-assessed and portable equipment tested to ensure the safety of staff and patients. Specific testing and reporting on equipment included radiographic tubes, generators, and ultrasound machines.

Staff asked patients if they were or may be pregnant. There were signs in the department asking patients to let staff know if they may be pregnant. If patients could not be sure, staff ensured a pregnancy test was completed before carrying out any examination involving exposure to radiation. This met with the radiation protection requirements and identified risks to an unborn foetus. Staff followed different procedures for patients who were pregnant and those who were not. For example, patients who were pregnant underwent extra checks and staff completed checklists to record them.

Staff shared key information to keep patients safe when handing over their care to others. Images and reports were made immediately available to all referrers and clinicians. Previous images and reports were also available to help staff compare previous clinical findings.

Shift changes and handovers included all necessary key information to keep patients safe. Staff attended a "huddle" every morning before the main shift began to exchange information on equipment, expected patients, any identified risks, and to prepare for the day ahead.

Diagnostic imaging policies and procedures were written in line with the Ionising Radiation (Medical Exposure) 2000 regulations. The trust had named and certified radiation protection supervisors and liaised with the radiation protection advisor (RPA). Local rules are the way diagnostics and diagnostic imaging work to national guidance and vary depending on the setting. Staff had written and agreed policies and processes to identify and deal with risks. This met with IR(ME)R 2017.

Staffing

Allied health professional (AHP) staffing

The service had enough nursing and support staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The service had low vacancy rates with 1 WTE band 5 vacancy within radiology which was being recruited into during the inspection.

There was sufficient staff to cover out of hours. Monday to Sunday 8pm until 8 am, there were 2 radiographers and a radiography assistant (RDA) working on the general department, 1 CT radiographer and 1 radiographer twilight (until midnight) and an RDA (night). During weekends there were 4 radiographers, 2 RDAs and a senior radiographer co-ordinator.

The service was reviewing the job descriptions of the experienced band 5 staff nurses to recognise the skill set required as a band 6 staff nurse, as they recognised this as a national skills progression.

Managers made sure all bank and agency staff had a full induction and understood the service. We saw examples of the this during our inspection on site, with information provided to all staff to ensure they understood the service.

Diagnostic imaging

Medical staffing

The service had enough medical staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. Medical staff matched the planned numbers on rotas we reviewed for the three months prior to inspection.

The service had low vacancy rates for medical staff.

The service had low turnover rates for medical staff at 1.41%.

Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work.

The service always had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records. The record system was accessible and reliable, and images could be viewed and reported on remotely by all registered clinicians. We reviewed 10 patients records and these were completed appropriately and in line with service and national guidelines.

Records were stored securely. Staff accessed records using their own login and password.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. This matched the incident policy that the provider had in place.

The service had no never events.

Staff reported all incidents of repeated or excessive radiation dose to the RPA who advised if any reached a notifiable dose. All incidents reported at Doncaster Royal Infirmary over the previous 12 months were no or low harm outcomes.

Managers shared learning with their staff about never events that happened elsewhere. Staff attended meetings and discussed learning from incidents across the region.

Diagnostic imaging

Staff reported serious incidents clearly and in line with trust policy. We reviewed the incident log and saw appropriate action had been taken and correct reporting followed.

Staff understood the duty of candour. Staff we spoke with described the duty of candour during the inspection well and understood the importance of putting it into practice.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

Radiologists and reporting radiographers attended monthly discrepancy meetings where findings were discussed, actions agreed, and learning was shared. Reporting radiographers liaised with staff regarding poor image quality, identified trends, and led workshops on making improvements.

Managers investigated incidents thoroughly. We reviewed the radiology incident log which showed all reported incidents and action taken was clearly recorded.

Is the service effective?

Inspected but not rated

We do not rate effective in diagnostic imaging, however we found:

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. All policies and guidelines were stored on the trust intranet. As staff received new guidance and directives, the department managers ensured updates to clinical practice.

The departments were adhering to local policies and procedures. The local rules were not displayed in all rooms with latest version of the rules at the beginning of our inspection, but these were changed to the current version in all rooms during our time on site.

We saw reviews against IR(ME)R and learning shared to staff through team meetings and training. The trust had a radiation safety policy, which met with national guidance and legislation. The purpose of the policy was to set down the responsibilities and duties of designated committees and individuals. This was to ensure the work with Ionising Radiation undertaken in the Trust was safe as reasonably practicable.

Radiation protection supervisors (RPS) for each modality led on the development, implementation, monitoring, and review of the policy and procedures to comply with IR(ME)R.

Diagnostic imaging

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Staff made sure patients had enough to eat and drink. Including those with specialist nutrition and hydration needs. There were water machines for patients and their relatives to use when waiting to be seen.

Staff ensured patients requiring CT examination using contrast were sufficiently hydrated prior to their procedure.

Patient outcomes

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

The service participated in relevant national clinical audits. We saw an audit had been conducted in March 2023 on the amount of Antero-Posterior' (AP) chest x-rays and postero-anterior (PA) chest x-rays being performed at the trust. The quality of chest x-rays audit outlined by the Royal College of Radiologists (RCR) published in 2016 and reviewed in 2022 states "Every effort should be made to perform a PA erect chest x-ray". The targets set for this were 75% PA for inpatients and emergency department patients, and 95% AP for outpatients and general practice patients. It was found that radiology was operating below the expected standard suggested by RCR, with 47% of adult emergency department chest x-rays performed PA instead of the recommended target of 75%. We saw this information being shared with staff through the radiology newsletter in May 2023 and a request for staff to change the x-rays performed unless not possible, in which case this was expected to be recorded in patient records.

Managers and staff used the results to improve patients' outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Staff told us they participated in regular audits and that these were shared in team meetings with actions for improvements. An example of this is quality assurance (QA) annual audit reports completed for each location in the trust. We saw that the tests were carried out daily and the results from each test were held electronically on each scanner. These results also identified any results that were out of tolerance (quality noise and homogeneity).

We saw examples of audits within CT, DEXA, fluoroscopy, MRI, Ultrasound, X-Ray, and nuclear medicine. We also saw examples of the audit results being discussed at the radiation safety meeting.

Annual Medical Physics QA was undertaken by Sheffield Teaching Hospitals in March of every year. The reports we saw were February 2022 to February 2023 to coincide with the Radiation Protection Annual cycle. We reviewed the annual dosage audits which showed the values monitored and compared to the previous year's results.

Managers used information from the audits to improve care and treatment.

Managers shared and made sure staff understood information from the audits. Improvement was checked and monitored.

Competent staff

The service made sure staff were competent for their roles. Managers appraised some staff's work performance and held supervision meetings with them to provide support and development, but this was not always every year.

Diagnostic imaging

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. All new staff followed the trust competency framework where staff must perform several observed procedures to gain competency in that area. Designated supervisors approved and signed off the competency framework. Radiographers and sonographers told us the department supported them to complete competencies.

The service was committed to developing the skills, knowledge and competence of its students, staff, and managers. Students enjoyed their placements and took up permanent posts once trained. All staff were able to make use of opportunities to learn, develop, and share good practice.

Managers gave all new staff a full induction tailored to their role before they started work. We saw examples from the Head of Imaging of welcome emails sent to new staff. These included a full welcome PowerPoint, including details of the radiology senior management team and the local rules for them to read prior to commencement in their role.

Newly qualified staff told us the department had offered them a good level of competency training.

Managers supported staff to develop through yearly, constructive appraisals of their work, although compliance rates for appraisals were at 71.04% for the trust overall within diagnostic imaging.

Managers supported staff to develop through regular, constructive clinical supervision of their work.

The clinical educators supported the learning and development needs of staff.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. There were multiple opportunities to attend team meetings including through Teams. Notes were always available and shared following these meetings.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Mandatory training had to be up to date for staff before additional training could be undertaken.

Managers made sure staff received any specialist training for their role. Staff told us about continued professional development (CPD) opportunities they had requested and had approved. This was across the diagnostic imaging department. Staff were proud to have ensured they can continue in CPD training and that this was supported.

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

Multidisciplinary working

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

Medical staff could contact a duty Radiologist any time to discuss issues and to provide support to other doctors and staff throughout the trust.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Diagnostic imaging

Seven-day services

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

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests. There were radiographers and radiologists in the department staff team on a 24/7 rota. During weekends there were 4 radiographers, 2 radiographic assistants and a senior radiographer coordinator on call for emergency interventional procedures. This meant there were clear arrangements in place for urgent scans.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas. For example, we saw 'stop smoking' information, dementia awareness displays and information on being active.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

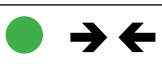
Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained verbal consent from patients for their care and treatment in line with legislation and guidance. Diagnostic imaging, and medical staff understood their roles and responsibilities and knew how to obtain consent from patients. They could describe to us the various ways they would do so. Staff told us they usually obtained verbal consent from patients for simple procedures such as plain x-rays. In some general cases this was inferred consent. Specialty medical staff obtained consent for any interventional procedures in writing before attending departments and for biopsy procedures.

Staff made sure patients consented to treatment based on all the information available.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Mental Capacity Act and Deprivation of Liberty Safeguards training was part of the Safeguarding Level 2 e-learning module for all staff. The Trust were in the process of changing this to become part of the mental health training being launched and this was in the process of being adopted.

Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Good 

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

Diagnostic imaging

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. All staff including reception staff, were observed to be compassionate and respectful to every patient who used the service. Patients told us that staff were friendly, and we observed this in action during the inspection. We observed that all staff introduced themselves when patients were called from the waiting area, for their appointment.

Patients said staff treated them well and with kindness. We spoke with four patients, and they all felt staff provided caring treatment towards them saying “staff were friendly, and I felt comfortable.”

Staff followed policy to keep patient care and treatment confidential. Patient records were kept safe and in line with policy. Conversations were held with patients in private consultation rooms with the door closed. This meant the information regarding the patient was confidential.

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

Staff collected patients from waiting areas and took them to private changing facilities.

Staff spent time with patients and those close to them to give explanations about their care and encouraged them to ask questions.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff giving reassurance to patients in a calm and relaxed manner.

Staff understood the emotional and social impact that a person’s care, treatment, or condition had on their wellbeing and on those close to them. We observed staff providing care before, during, and after procedures and showing consideration to patient’s emotions, allowing them time to ask questions or comply with requests. Staff were aware some positioning could be uncomfortable and allowed patients to be independent or made adjustments where possible.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families, and carers in a way they could understand, using communication aids where necessary. Staff shared with us examples of alternative communication methods such as drawing for ease of understanding in certain patients when needed.

Diagnostic imaging

We saw sign language finger spelling on the walls in staff x-ray area for use with deaf patients. Staff told us they are being supported to do sign language training to be able to communicate better with deaf patients.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Patients gave mainly positive feedback about the service. We saw the results of the most recent patient survey broken down by speciality. The completion rates for August 2023 were low in numbers from patients with 0 received in MRI, 1 in CT and 12 within radiology. Although results were mainly all either good or very good in the responses received. There was 1 response received in August 2023 with poor feedback in radiology.

Is the service responsive?

Good

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

Service delivery to meet the needs of local people.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. Staff told us about additional slots for appointments were being offered due to a demand for services for post-menopausal bleeds (PMB) in patients. There had been an increase in requirement for scans for this reason, and the service had adapted what it was offering to meet this for the local population.

There was a new role to the service of a 'cancer pathway navigator', this post had been created in January 2022. There had just been recruitment to expand this to include a second position for this role who was due to start imminently. The cancer pathway navigators looked for any cancellations on a daily basis and contacted any patients waiting to be seen at short notice to aim to ensure any cancellations were filled. The demand in the local area has increased over the last year, so the service has appointed a second person for this role due to demand.

Diagnostic imaging reporting was electronic, and the department used paperless methods to reduce time and administration.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion.

Facilities and premises were appropriate for the services being delivered.

The service had systems to help care for patients in need of additional support or specialist intervention. There were sufficient facilities to meet the needs of inpatients and rooms were large enough for wheelchairs and staff accompanied patients from wards.

Managers monitored and took action to minimise missed appointments. Managers ensured that families of children or vulnerable patients who did not attend appointments were contacted.

Diagnostic imaging

Staff respected inpatient mealtimes and, where possible, organised inpatient imaging to avoid them.

The service relieved pressure on other departments when they could treat patients in a day. Reporting radiographers checked suspected fractures straight away and provided results back to the minor injuries department to ensure efficient patient care or discharge.

There was a free bus service provided for patients between hospital locations where needed and this was pre-bookable.

Meeting people's individual needs

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

The main waiting area was large and airy. There was sufficient seating with various sub waiting areas and a small area with children's seating which were all clean and well maintained. Sub waiting areas provided adequate seating arrangements. Patients attending departments had access to drinks and snack facilities, a café, and a shop.

We saw a display on the wall in the patient area for learning disability awareness week, there was also information available on falls awareness, and leaflets for local services including community support.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. We saw examples of this during our inspection, and staff were able to tell us about this.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff told us they used 'big word' for interpretation support, and they were getting trained in sign language for communication with deaf patients.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. These were arranged in advance when the requirement was known prior to the appointment, but staff knew how to access this for any requirements on the day.

There was an x-ray booklet specifically for children available and also for adults with learning disabilities in the waiting areas.

Contact information is provided to patients when they are transferred to other services and all information is sent electronically between services for immediate sharing of information.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Referral to treatment (RTT) rates were measured against national targets for all patients on cancer pathways, two week waits, urgent and planned care, and routine images.

Diagnostic imaging

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. CT scan figures showed significant reductions in waiting times for patients over the last 12 months. August 2023 showed 91.2% of patients were seen for CT scans within 14 days. MRI scan data showed 80.5% of patients were seen for urgent referrals within 14 days.

Diagnostic waiting times in the service showed patients waiting longer than national targets set in these areas. For MRI services, there was a waiting list initiative in progress to aim to improve wait times and the service was currently performing at 62.57% and were aiming to perform at 95% by 31 March 2024. For CT scanning services, there was also a waiting list initiative in progress. The service was currently performing at 68.88% performance and aimed for 70% performance by 31 March 2024. Non-Obstetric Ultrasound (NOUS) was performing at 93.99% of its 95% target. DEXA scanning had showed steady improvement in performance, and this was expected to continue throughout 2023/2024. DEXA was currently performing at 48.18% of its 90% target. Nerve conduction tests were performing at 87.12% and additional sessions have been scheduled in the service with 95% performance expected from this by 31 March 2024.

Managers worked to keep the number of cancelled appointments to a minimum and there were plans in place to improve these performances.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Learning from complaints and concerns

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

Patients, relatives, and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. The hospital had a complaints policy, which staff accessed on the intranet.

Managers investigated complaints and identified themes. Learning was shared across the hospital in the daily morning huddle, monthly head of departments meeting, clinical governance meetings, quarterly medical advisory committee, and quarterly departmental team meetings.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. An example of this was a complaint received about a lack of a breastfeeding room or area in the department, the manager then created a space for this in the department because of the feedback received.

Is the service well-led?

Good ↑

Diagnostic imaging

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Staff described managers as being approachable and available. Staff knew how to contact managers at any point when they needed too and felt able to do this.

Managers provided clear leadership and were highly valued by staff we spoke with. Managers were keen to retain staff and invested in education for staff to progress. There was a radiology manager in post who staff felt supported by and who told us they were keen to support staff progression. An example of this was for the apprenticeships in place in the department, these have been expanded and staff on these programmes have had training opportunities for progression. These staff described to us that they felt confident in their roles and were keen to stay within the trust due to this.

The leadership team understood the current challenges and pressures impacting upon service delivery and patient care.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust vision was 'to be the safest trust in England, outstanding in all we do.' Four objectives originated from this vision, one of which included to provide outstanding care and improve patient experience. To deliver the four main objectives four breakthrough objectives were identified for 2022/23, for example, objective one was to maintain and improve CQC ratings by achieving improvements in quality and outcomes.

There was a vision for what leaders want to achieve and this was in line with the Trust vision. The service promoted training, and staff were aware of the vision for diagnostics and were able to share this with us during inspection. Staff told us about the focus on reduction in waiting times for patients, and a focus on improving the patient experience in the department.

Staff told us they provided patients with person-centred care and that working well in a team was key to achieving their vision and strategy.

The management team shared they were dedicated to workforce retention and prioritising wellbeing and development across staff groups.

Culture

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

Staff were proud to work at the trust and within their departments. Staff, from students to senior staff were loyal to the trust and chose to develop and progress within the service and across modalities.

All staff we spoke with said they felt able to raise any concerns to colleagues or managers and were aware of how to contact the Freedom to Speak up Guardian.

Managers described how they supported serious incident investigations with specialty colleagues and followed Duty of Candour where appropriate.

Equality and diversity was clearly promoted to patients, students, and staff throughout the service. There were no barriers to progression or development and staff received training in equality, diversity, and inclusion.

Staff were positive and caring towards patients and their relatives who used the service. In addition, we also noted caring and respectful interactions between staff of all grades and disciplines.

Governance

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

Minutes of meetings for the operational governance, clinical governance, and radiation safety committee group showed that these meetings were well attended by a wide range of staff. There was a variety of issues discussed such as radiation incidents, CT new building update and home reporting.

The radiation safety committee produced an annual report and met twice each year. They linked in with specific subgroups which made them able to work more effectively, these included the radiology clinical governance group who meet monthly and the optical radiation health and safety committee.

All modality areas had a quality assurance (QA) programme in place, and this had been brought in since the last inspection and was firmly embedded as business as usual. Each modality area created a full QA report, and we could see these reports were reviewed on a regular monthly basis.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Staff described good IT support and no recent breakdowns or failures in the picture archiving and communications system. Images were always available to all relevant professionals.

Service leads and managers worked together to provide information to the executive performance meeting. They monitored performance and provided information to the divisional leads, along with identified risks and issues for escalation. Service leads reported a good level of support in planning for the future including finance and workforce planning.

Managers monitored all targets and reported to the trust board through their overall performance reports.

The service had a systematic process, involving staff of all roles and grades, in reviewing and improving the service. This included identifying risks and planning to reduce the level of risk. There was a rolling agenda of meetings to improve quality and patient safety.

Diagnostic imaging

There was a governance process related to risk with monthly risk meetings. The risks were escalated through the governance meetings and the divisional meetings.

Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact giving a red, amber, green (RAG) rating.

Diagnostic wait times were monitored with initiatives in progress to improve performance for 2023/2024, we could see these wait times were improving and monitored.

There were systems to flag up urgent unexpected findings to GPs and medical staff. This met the Royal College of Radiologist guidelines.

Information Management

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

Staff could find all patient information such as diagnostic imaging records including previous images, and reports, medical records, and referral letters through patient records.

All staff had access to the trust intranet to gain information on policies, procedures, National Institute for Health and Care Excellence guidance, and e-learning. Some policies we reviewed for staff had not had their review date as recommended in the policy itself, examples of this included the guidance for staff in the use of chaperones and also the employers' procedures under IR(ME)R.

Information governance systems were in place and ensured the confidentiality of patient records.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

We saw the staff engagement group met monthly and this covered a wide variety of agenda topics in recent minutes we reviewed. We saw that staff survey questions had been updated to align with the NHS People Promise and that the trust had asked additional questions regarding the awareness of trust values. The initial staff survey results showed an encouraging and improving picture in relation to feedback. Work was being undertaken in relation to communication of the results and engagement with local teams, to embed a cycle of year-round engagement.

There was a clear focus on engagement activities to develop a culture of inclusion. The trust held events for staff from ethnic minority groups. Diagnostic imaging was included in this, and the manager shared this with us.

Learning, continuous improvement and innovation

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

Diagnostic imaging

Staff met regularly with all colleagues across the Trust sites to share learning and provide peer support. The service had continued professional development (CPD) lunch and learn sessions, online evening learning sessions and these were based on what was needed following audit results, staff learning, and from staff requests.

The trust logged all compliments and positive praise received in each area and for each location. This was shared with staff and the wider team for learning.

There was a monthly publication of 'General Radiology Newsletter' for staff. This featured 'image of the month' which showed a different x-ray image each month and focus on how to perform this well and potential challenges. This was to improve learning and continuous improvement in staff.

Staff we spoke with told us they felt supported to develop their career. There were apprenticeship training places available that were being expanded year on year for the number of places available on these.

Urgent and emergency services

Requires Improvement ↓

Is the service safe?

Requires Improvement →←

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

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff. However, training levels were below the trust target.

Nursing and medical staff received mandatory training. However, they did not always keep this up to date. We reviewed the latest compliance figures for UEC nursing and medical staff's mandatory training at DRI. The nursing staff's latest overall completion rate was 84.69% and medical staff was 52.96%. The ambulatory care unit nursing staff group achieved 76.23%. These did not meet the trust's 90% target.

However, the only UEC staff group to meet mandatory training compliance were paediatric nursing staff with 92.42%. Security staff had completed 100% of their mandatory training.

On our last inspection in February 2020, we told the trust they must ensure all staff; particularly medical staff complete mandatory and safeguarding training sessions as per trust policy and relevant to their role.

At this inspection the service had made some improvement, but compliance was still below trust target and this was a repeated breach of the regulation.

Medical staff told us that they did not have protected time which made it more difficult to complete mandatory training.

Managers monitored mandatory training. However, they did not always alert staff when they needed to update their training. Leaders told us that mandatory training was not a priority during the COVID-19 pandemic although they had since, recruited two band 7 staff and one band 6 post to support staff with training. Twice weekly sessions covered safeguarding and other focused topics. Leads had introduced lunchtime and breakfast teaching within the department.

In response to medical staff's lack of training compliance, the divisional director (DD) held a 'hot area of discussion' with regular reminders for colleagues. They targeted the staff groups with the lowest compliance, and highlighted figures at every management board meeting. The DD wrote to medical staff individually if necessary. The DD told us compliance had improved.

The mandatory training was comprehensive and met the needs of patients and staff. New doctors told us this training was easy to access.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia. Staff were asked to complete the Health Education England (HEE) Oliver McGowan training package which was being rolled out across the trust.

Urgent and emergency services

Safeguarding

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

Nursing and medical staff received training specific for their role on how to recognise and report abuse. At the time of our inspection divisional compliance across all staff groups was 100%.

However, safeguarding leads identified their training was no longer sufficient to meet the intercollegiate document recommendations. They had identified a more detailed safeguarding training package due to be adopted in early 2024 as part of the mental health training launch.

Work had been done around safeguarding training, to raise staff knowledge and awareness. Paediatric staff completed safeguarding adults and children training levels 1 and 2 online, and level 3 every two years was face to face. Additional sessions were available for staff to refresh their knowledge and skills.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. They worked with other agencies to protect them. Paediatric nursing staff documented and acted upon safeguarding concerns in patient notes, such as unexplained bruising for a looked after child.

Staff could access safeguarding adults and children's teams who visited the department daily to check and support staff. Staff had an out of hours number to call if they were concerned or could email for routine referrals. If a child absconded or left the department alone, staff would ring and leave messages, inform the nurse in charge, social worker and the police depending on the risk assessment criteria and severity.

Staff had access to a paediatric liaison service. We reviewed staff's documentation for patients receiving care and support from the child adolescent mental health service (CAMHS) and for patients eligible for referral to these services. Notes documented appropriate support and CAMHS input.

Paediatric consultants would follow the trust's non-accidental injury process to review safeguarding information, inform social services and advise parents if necessary. The children's observation unit (CHOU) decided if further investigations were needed.

There was safeguarding information, posters or staff guidance promoting awareness or understanding of safeguarding adults and children processes and procedures in the department.

Staff had access to a trust wide domestic violence team in-house for support. They used a safeguarding flowchart to help staff exercise professional curiosity if they suspected abuse. From July 2023 the domestic abuse liaison officers offered staff ten-minute discussions twice weekly in the department called '10 at 10'.

The service undertook an audit in November 2022 to establish the demographics and outcomes of patients attending the UEC who were victims of domestic abuse. The audit showed the trust was compliant at ensuring high risk alerts were in place for victims considered to be at a high risk of domestic abuse.

Areas for UEC improvement was highlighted around staff referring patients to relevant services, along with considering discharge to a place of safety for domestic abuse and assault victims. The audit recommended working alongside practitioners to raise awareness of domestic abuse and embed the importance of professional curiosity. The service planned to develop and action this over the next year, steered by the domestic abuse liaison officer's work.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we asked confirmed they had a safeguarding lead and knew how to contact them. All staff could explain how they followed safeguarding processes or guidance.

There was a safeguarding children ten step walkthrough for staff on how to complete referrals for patients under 18 years old.

Agency nursing staff said they had to inform the nurse in charge about any safeguarding concerns. They could access the trust intranet to report these themselves.

Staff followed safe procedures for children visiting the ward. The paediatric physical environment helped to keep children safe.

The children's assessment area pathway within the department meant they and their parents/carers had to navigate areas mixed with adults. However, all children in the children's area were always accompanied.

The trust had a children's safeguarding team based onsite.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not use equipment and control measures to protect patients, themselves, and others from infection. They did not keep equipment and the premises visibly clean.

During the inspection we identified clinical areas that were not clean. UEC reception areas had dirty walls. Resuscitation room floors were unclean on our initial visit but were subsequently cleaned once we had reported our concerns.

We observed some staff were non-compliant with bare arms below the elbow standards. Staff did not always adhere to best practice regarding regular hand washing. Some hand sanitiser dispensers were empty.

Staff did not always clean equipment after patient contact, or label equipment to show when it was last cleaned. For example, a bladder scanner transducer had blood on. Two resuscitation blood glucose meters were also not clean.

Cleaning records were not always up to date to demonstrate all areas were cleaned regularly.

Cubicles and all bed spaces were cleaned after each patient use. We spoke to domestic staff who confirmed there was a lack of overnight staff and only limited cleaning was done between 8pm and 7.30am. They had raised this with managers who explained this was due to funding. Staff cleaned any body fluids in the department then the morning staff finished bays and cubicles. We could not be assured there were effective decontamination processes overnight for patients awaiting cubicles as there was not always enough fogging equipment. This also potentially meant new patients could not be admitted into uncleaned cubicles and bays which further limited patient flow.

The service had limited provision to accommodate potentially infectious patients who needed isolating in side- rooms. However, there was a separate designated yellow bay for COVID-19 positive patients.

The trust took prompt action in response to our infection prevention and control (IPC) concerns post-inspection. This included increased hand hygiene and cleaning audits.

Urgent and emergency services

The national patient led assessments of the care environment (PLACE) inspections on 20 and 21 September 2022 showed the trust's average remained in line with the 2019 results. Issues which were identified were easily rectified with no immediate concerns.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not keep people safe. Staff did not always manage clinical waste well. However, staff were trained to use equipment.

Patients could not always reach call bells, and staff could not always respond quickly when called.

During the inspection we observed that one overnight patient in Majors waited 30 minutes after ringing their call bell for staff assistance. The service did not monitor call bell response times. This meant we could not ensure staff always responded quickly enough.

Patients waiting in the minor injuries unit (MIU) portacabin modular build had no call bells or emergency buzzers. Staff showed us an airhorn they would blow if patients deteriorated, and they needed the resuscitation team. We escalated this to the senior leaders who confirmed this was an interim measure and that a wireless call bell system had been installed on 23 August 2023 to replace the airhorn.

In MIU there was no resuscitation trolley or signage telling staff where the nearest trolley was located.

The MIU did not display a fire exit or evacuation procedure and staff only had one entrance or exit back into the UTC.

After our inspection leaders had carried out a review of MIU and confirmed all staff who worked on the unit including bank and agency had sufficient and safe access to resuscitation equipment and knew its location (so did not need signage). Fire safety was also checked. The trust had completed fire risk assessments and were compliant with regulations.

The design of the environment did not always follow national guidance. The department had a layout with some small, hidden areas unseen by staff. This caused a lack of oversight, including one corner of the main UEC waiting room. On the day of our inspection the supernumerary nurse in charge was sat behind the main reception desk. This meant no staff circulated this area to check patients' welfare and identify any potential warning signs.

The waiting areas quickly became overcrowded with people having to stand or wait by the entrance and doorways, as space was limited. Waiting areas were poorly ventilated which meant they became very hot when busy. Some patients and relatives waiting for long periods could not always access water. The service had secured funding to enhance patient waiting areas to reduce crowding and provide a safer environment.

The department had a designated mental health assessment room. The room complied with some of the royal college of psychiatrists (RCPs) latest psychiatric liaison accreditation network (PLAN) standards such as no ligature points within the room. The standards provide a clear and comprehensive description of best practice in liaison psychiatry services. However, the room's furniture was not weighted which meant it could be moved or lifted by people.

The psychiatric liaison room location had been on the divisional risk register for nearly six years. The room's location next to the paediatric area was a potential safeguarding issue and may cause undue distress for children and other patients. The service had put in controls to manage any risk however the safety risk assessment for the mental health assessment room was not signed or dated therefore it was not clear when staff had completed it.

Urgent and emergency services

Since our last inspection there had been improvements to large areas of the emergency department environment. Many areas were more open plan, so had improved observations of patients in the department. There were improvements to the children's waiting area with child appropriate layouts. The children's area had four cubicles with working suction oxygen and call bells.

The department had provision for relatives of end-of-life patients in a quiet calm side room to reflect and sit with their loved ones.

The service had enough suitable equipment to help them to safely care for patients.

However, staff did not always carry out daily safety checks of specialist equipment. We reviewed resuscitation trolley checklists for adults and children. The children's area resuscitation trolley had two missed check dates on 18 January and 20 May 2023. However, the trolley contained all required contents with equipment in-date and sealed. The trust completed a review of all resuscitation trolleys to ensure items were within their expiry date and had seals intact.

Some equipment had been awaiting repair for some time. For example, a broken echocardiogram (ECG) machine and a large monitor screen had been reported and awaiting repair since November 2022. We also saw broken drawers in consumables trolleys and the trolleys were held together with adhesive tape.

Equipment was not always correctly or safely stored. A pat slide between consumable racks was stored on the floor which should be hung up or elevated. UEC consumables in boxes with packets removed were also stored on the floor.

Sharps bins we checked were not above the fill line. However, they were not always clean, signed or dated. Two sharps waste bins containing clinical waste had no label completed.

The trust took prompt action to address our concerns. Following our inspection, the trust reviewed and removed any out-of-date equipment across the trust. They planned to complete a spring clean of broken or obsolete equipment before October 2023.

Post-inspection leads had also reviewed the roles and responsibilities across clinical areas for the management of stock and equipment (medical and non-medical). They instructed every clinical area to review their stock and equipment and take appropriate action for any expired or broken equipment.

Assessing and responding to patient risk

Staff completed risk assessments for each patient. However, they did not always remove or minimise risks and update their assessments when screening patients at risk of sepsis.

The department used the national early warning score (NEWS2) tool which staff managed well. There was effective identification and management of deteriorating patients throughout the department. Staff completed at least hourly NEWS2 rounds, but more often for patients with higher acuity.

Staff used screening tools for patients such as the sepsis six pathway, Manchester triage model and Malnutrition Universal Screening Tool (MUST).

The majors area had a large patient tracker dashboard visible to all clinical staff at the main station. However, at the time of our inspection this was still awaiting IT support to display NEWS2 scores. Staff were using a red, amber, green (RAG) clinical escalation system.

Urgent and emergency services

A senior medic maintained clinical oversight of ambulance arrivals at the emergency assessment unit (EAU) front door. Although no doctor stayed on the EAU permanently, the responsible doctor handed over any EAU patients remaining to the next doctor after each shift and updated the clinical patient management system. Consultants completed an EAU walk round twice daily.

Patients with chest pains were prompted to come to the front of the queue for a rapid assessment. Staff could access the rapid assessment therapy service (RATS) team who reviewed patients and completed mobility assessments led by allied health professionals (AHP).

Staff we spoke with felt patients were safe in the department when it was busy. Staff could track patients in the department's waiting areas as they were displayed on screens. Ambulance crews accompanied and managed patients into the EAU until handover to nursing staff.

The medical team saw patient referrals in EAU and admitted them to the acute medical unit (AMU) where necessary. UEC admitting teams discussed all patients. There was an AMU system which showed patients waiting to be seen with colour-coded NEWS scores; the UEC system fed into this.

Staff used paediatric advanced warning scores (PAWS) for the initial assessment of children and their clinical deterioration. This was a screening tool that evaluated the degree of illness and the likelihood of their transfer to an external paediatric intensive care unit (PICU). Staff recorded follow up actions for patients at risk, and when warning scores were high.

Receptionists could alert their nearest triage nurse or push an emergency alarm if patients became unwell in waiting areas.

The service used the sepsis six pathway and care bundle for the management of sepsis. However, staff did not always remove or minimise risks and update their assessments. We reviewed one patient's set of notes who had been in the department for over 23 hours. Nursing staff had not recorded hourly nursing assessments. Despite being a query sepsis patient, no nursing observations were recorded for over five hours between 22:33pm and 03:45am the next day. This did not comply with the trust's sepsis six pathway which required staff to complete observations according to the patient's level of risk.

At the time of our inspection, staff covered both sepsis recognition and NEWS2 within a training course with a deterioration element.

Related training included all resuscitation courses levels 2-4, trauma intermediate life support (TILS), recognition and management of the seriously ill (RAMSI), some division-specific ReST days and vital signs training, mainly for HCAs.

Staff completed a 25-point skin inspection for all patients on admission. The trust had a pressure ulcer system which considered if patients had diabetes, neuropathy, or ischemia for staff to refer to a foot ulcer pathway.

The service used falls kits for patients at high risk of falls which contained yellow socks and a blanket. Staff administered these and they worked well as a visual prompt. Signs asked staff to see yellow and think falls risk. Staff had access to a falls holistic care team and a therapy assistant practitioner.

However, nursing staff on EAU and on the corridor off the major clinical area told us there had been several inappropriate transfers to the unit of patients at high risk of falls. For example, one shift had 11 high falls risk patients to three nursing staff preventing them from completing any baseline observations or other tasks except monitoring and helping support patient's mobility.

The service had 24-hour access to mental health liaison and specialist mental health. The department could access psychiatric liaison any time of day. Staff had access to a crisis team and seven-day substance misuse or drug and alcohol provider. Both were based in the department so staff could refer patients for prompt and effective support.

The adult mental health triage form included background, observations and behaviour, nursing assessment, suicide risk screen, clinical assessment from a doctor or liaison staff member before admission. If the patient was considered high risk, staff undertook continuous observation. They commenced the missing persons policy and informed the mental health team if high risk patients absconded.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. At the time of our inspection the trust was rolling out a new mental health assessment (MHA) tool.

Nurse staffing

The service had enough support staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

However, the resuscitation and children's areas did not always have enough nursing staff with the right training. The number of nurses did not always match the planned numbers. The service did not always have low or reducing vacancy and turnover rates.

The service had enough nursing and support staff to keep patients safe. The adult department had 13 registered nurses per shift, supported by six healthcare assistants (HCAs) and four support staff. We were told the daily rota was the same across day and night shifts.

On our last inspection we told the trust they must ensure enough nursing staff in the minor injuries unit (MIU). On this inspection we found MIU nursing staff numbers had improved.

We reviewed the staffing establishments across all UEC areas including paediatric for the six months from February to July 2023. Numbers were filled on nearly all shifts.

However, not all adult UEC nurses had paediatric training. Their numbers on shift were inconsistent day to day. For example, UEC had to request a paediatric nurse from paediatric UEC or the children's ward to attend if a paediatric case arrived in resuscitation.

Nursing staff in resuscitation told us they ideally needed three registered staff when the area was busy but rarely achieved this to meet establishment. At the time of our inspection, they had two registered nurses (RNs) and a healthcare worker who could carry out procedures but not administer medicines for patients. This meant patients in resuscitation could have increased lengths of stay and delays awaiting transfer from this area onto wards or other areas.

Urgent and emergency services

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. The service had a staffing uplift shortly before our inspection. Leads completed the Shelford 2014 safer nursing care tool (SNCT) supported by NHS England/Improvement, and then applied professional judgement.

Nursing leads and managers told us their staffing had improved since our last inspection and workforce challenges did not impact upon safe patient care. The service had a workforce plan; however, this was in its infancy.

The service had recruitment programmes in place to include roles such as advanced nurse practitioners.

The service did not always have low and/or reducing vacancy rates. The top three nurse bands with the highest vacancy rate were band 2 with 20.7 whole time equivalent (WTE) by July 2023, band 3 with 11.7 WTE then band 6 with 10.58 WTE.

The band 7 nurse vacancy rate on the ambulatory care unit (ACU) was 7.36 WTE.

The turnover rate was 16.7%.

The sickness absence rate was 6.98% which was lower compared to the other large divisions.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Nursing leads told us these staff worked regularly so were well orientated to the department.

Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training, and experience. The medical staff did not match the planned number.

However, they kept patients safe from avoidable harm and provided the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service did not have enough medical staff. However, they kept patients safe. UEC was supported by 22 whole-time equivalent (WTE) consultants who provided cross-site services in both hospital UEC departments. However, they needed 34 consultants and two were retiring soon after our inspection.

At the time of our inspection the department had 6 tier 4 WTE senior registrars in post and needed 20. The service had 20 WTE tier 3 or 4 senior house officers (SHOs) level and registrars in post which had increased from 7. However, overall, the service needed 54. For tier 2 junior SHOs the service had met its target of 30 WTE.

Medical leads had revised their workforce management system for planning the staff rota. The system provided individual hours worked, allocated and contracted. The clinical director felt this had saved or generated 600 hours of extra time from their current medical staff with no contract changes. As a result, senior medics could complete junior doctor rotas six months in advance.

Medical leads felt the service had made significant progress around their medical workforce in the 12 months up to February 2023. They had addressed historic underinvestment and poor workforce planning from the previous five or six years which had led to medical staffing shortfalls. The trust's hybrid international emergency medicine (HIEM) programme recruited tier 2 and 3 international doctors on a four-year scheme with two years in the UK. Their first cohort had just completed the programme, of which three doctors had come back on a 3-year contract.

The service also had other recruitment programmes in place for medical staff to include new innovative roles such as clinical fellows, and a practice educator.

The service always had a consultant on call during evenings and weekends. As the skill mix and levels were not high enough consultants covered all shifts 24/7. UEC doctors told us before August 2023, their out of hours rotas could feel under covered. From 4-8am there were only four doctors for the whole department which felt stretched. However, new doctor recruitment at the time of our inspection was improving this trend.

Medical staff submitted exception reports to flag work which varied from their agreed schedules. The main themes were extra hours worked and unpredictable emergency care which required junior doctors to stay late to ensure patient safety.

The service did not have low and reducing vacancy rates for medical staff. 29% of junior medical staffing posts, within emergency medicine were unfilled in the four months from March to June 2023.

The service did not have low and/or reducing turnover rates for medical staff. We reviewed the division's latest labour turnover rate. This had the highest long-term rate (LTR) full-time equivalent (FTE) percentage of 28.4%, and LTR headcount percentage with 28%.

Sickness rates for medical staff were not low and/or reducing. We reviewed the division's latest absence rates. These had the most overall occurrences, with 202 but only the third highest FTE percentage of 2.67% of all divisions.

Managers made sure locums had a full induction to the service before they started work. The service used a locum card to help orientate and familiarise new medical staff.

Service leads had put detailed operational planning to ensure all UEC pathways were staffed as safely as possible, with the need for patient cancellations minimised during ongoing industrial action by junior doctors. The service provided full emergency cover during the consultant strikes, as a minimum provision equal to Christmas day. The service's emergency planning response was led by the Chief Operating Officer and the division.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear and up-to-date or stored securely. However, they were easily available to all staff providing care.

Patient notes were not always comprehensive. We looked at six adult patient records and found that in two records nursing staff had not recorded hourly assessments regarding pressure area care. In some records we found no intentional rounding checks recorded, despite staff saying this was done every hour. In one set of notes where the patient had been in for over 17 hours, the capacity assessment was not fully recorded, falls and skin integrity was also not recorded every hour.

Adult patient's care plans were limited and not always person-centred on the trust's clinical patient management system. This meant we could not ensure staff had patient-centred care plans in place.

We raised these omissions with the matron and practice educator who confirmed they would follow this up with the relevant staff.

The four paediatric records we looked at were clear and documented the time of assessment, triage pre-alerts and processes. These patient notes had appropriate and personalised care plans with parent involvement, clear evidence of escalation in response to a deteriorating Glasgow coma scale (GCS), timely requests for paediatric or anaesthetic input and timely risk assessment and sepsis tool completions.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff could use a paediatric transfer tool for children from UEC to children's services with eligibility criteria to speed up transfer.

Patient's medical records were kept locked in trolleys when not in use. However, we saw some patient identifiable data in a book on a resuscitation trolley and in other areas smart cards had been left in unattended computers with screens open.

Medicines

The service did not use systems and processes to safely prescribe, administer, record and store medicines.

On our last inspection we told the trust they must ensure staff follow the proper and safe management of medicines. On this inspection we still found concerns relating to this area. We followed up and escalated these concerns as this was a repeat breach.

The children's UEC medicines were stored in a multipurpose locked small room. Staff had devised their own expiry date monthly check list instead of the generic trust version. Liquid medicine bottles such as peptic liquid and painkillers had no open date label. This meant staff could potentially use these medicines after expiry when they were less effective.

The children's UEC had loose mixed medicines removed from their original packaging. This was also the case with injectables in the pharmacy storeroom. We raised this with staff who removed and disposed of them. We reviewed the service's latest injectable medicines policy. This stated under 4.1.1 The Environment; 'before preparation the operator shall check the integrity of the packaging of any components being used'. This meant staff were not following policy.

We saw liquid medicines bottles which staff used infrequently such as those for sedating children were not labelled with the dates they were opened.

Vaccines and insulin were stored in a fridge out of their desired range at under 1 degree Celsius consistently during August 2023. This meant we could not ensure vaccines were still effective.

The pharmacy storeroom fridge had exceeded the maximum temperature of 8 degrees on 7 dates in August 2023. The checklist stated it reached 15 degrees on 12 August. This fridge also fell below the minimum temperature 11 times in August with no actions taken other than a reset on 12 August 2023.

Paediatric staff we asked were unaware of safe and secure handling of medicines policy or how to apply it. In paediatrics a warm tiny storeroom was used for medicines storage. A room thermometer had only arrived the day before our inspection and was not monitored by staff or triggered if the temperature rose above acceptable levels. There was no pharmacy input into the children's area.

Staff did not always check if patients wore wristbands. Staff had not consistently documented the allergy status for two patients with allergies. This meant any staff unfamiliar with the patient may try to prescribe them harmful or inappropriate medication.

We escalated our concerns around UEC's safe storage of medicines. The trust responded promptly to our concerns. Several actions were taken during and after our inspection. This included removal of out-of-date medicines and weekly medicine management audits.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored. However, managers did not always share lessons learned with the whole team and the wider service. They did not always support and debrief staff.

Staff knew what incidents to report and how to report them. They reported serious incidents clearly and in line with trust policy. We reviewed 20 incidents reported by staff between March 2022 and May 2023.

The most common incidents were clinical assessment (including diagnosis, scans, tests, assessments) implementation of care and ongoing monitoring, failure to act on test results.

We reviewed a sample of serious incidents. The investigation reports identified the root causes and learning points and actions. There were examples of improvement which included development of a vulnerability screening tool for patients flagged at risk after leaving the department.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff had understanding, knowledge, training for the duty of candour process. All incident responses we reviewed had duty of candour completed by the relevant division or investigation lead.

However, staff did not always receive feedback from investigation of incidents, both internal and external to the service. Several staff we asked did not demonstrate an understanding of lessons learnt from incidents. These staff were aware of serious incidents which had occurred in the service but could not always identify actions taken to prevent reoccurrence or examples of key learning shared with them.

Paediatric staff said they received feedback by email when incidents were closed but were often not involved in the outcome. They told us managers did not share much learning from incidents with them.

Leads planned to start weekly safety seminars and monthly quality seminars from September 2023. This was a multi-disciplinary approach to learning and open to all staff. Seminar content would include key learning from incidents.

Managers did not always debrief and support staff after a serious incident. Paediatric staff said when they escalated incidents or issues to the nurse in charge, their level of senior support could vary depending on the staff member.

Urgent and emergency services

Is the service effective?

Requires Improvement

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

The trust had an emergency care intensive support team (ECIST) visit which gave 19 recommendations to provide a consistent UEC pathway.

In response to the report the service facilitated workshops held to focus on the key issues. These would be taken forward through the accident and emergency delivery board for Doncaster attended by all system partners. The actions would then proceed to the trust's delivery and transformation board. The ECIST provided additional operational support to the service during busy periods such as the Easter bank holiday weekend.

Staff protected the rights of patients subject to the Mental Health Act (MHA) and followed the Code of Practice. Security staff had completed training in minimising and managing violence and aggression (level 3 advanced physical intervention skills). This meant they were suitably trained to understand and appropriately respond in the event patients with mental health needs became aggressive or violent when in UEC. As a result, they could respond to all patients with mental health needs, including those detained under sections of the Mental Health Act.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers. The medical staff board round in majors we attended discussed these needs for patients with any updates.

Nutrition and hydration

Staff did not always give patients enough drink to meet their needs. Nursing staff routinely did not complete fluid and nutrition charts, or malnutrition tools. However, patients had food to improve their health. The service made adjustments for patients' religious, cultural, and other needs.

We could not evidence staff always ensured patients had enough to drink. Water jugs were available on trolleys in most waiting areas. However, no staff circulated or completed welfare checks of patients in these areas. This meant patients waiting for longer periods were at greater risk of dehydration and not always overseen by staff.

Staff did not frequently refill or maintain beverage stations for patients in waiting areas. Some stations were dirty.

Nursing staff did not always fully, and accurately complete patients' fluid and nutrition charts where needed. Patient's meals and food intake was not documented in four records we looked at.

UEC had band 3 nutritional assistant (NA) posts who took feeding and dietary initiatives from the nurses. They worked under the dietetics team managed by the dietetic lead. They completed nutritional and swallowing assessments, as well as community referrals. However, at the time of our inspection the department only had one NA in post who was leaving. Although other nursing staff could fulfil this role, they could be asked to support other tasks. This meant nutritional support provision to patients was limited.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition, however, staff were not routinely completing this tool as part of their patient bundles. We showed the matron who agreed with us this should be included in patient records.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They gave additional pain relief to ease pain.

Patients received pain relief soon after it was identified they needed it, or they requested it. Staff prescribed, administered, and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They achieved good outcomes for patients.

The service participated in relevant national clinical audits.

The service participated in the trauma audit and research network (TARN). Since July 2023 47 submissions were done and trauma leads had almost finished the March 2023 backlog at the time of our inspection. There was a total of 417 left with a new TARN format to be released.

Outcomes for patients were positive, consistent, and met expectations, such as national standards.

The service had a lower-than-expected risk of re-attendance than the England average. The trust's percentage of patients that reattended the UEC department within seven days of a previous attendance was generally similar to the England and regional averages from March 2021 to February 2023.

In February 2023 the trust proportion was 8.1% compared to the England average of 8.4% and Midlands regional average of 8.8%.

Managers and staff used the results to improve patients' outcomes. We reviewed emergency assessment unit (EAU) performance for the ten months from October 2022 when it was reinstated to July 2023. Patient numbers nearly doubled for the last three months during this period. The EAU admission and escalation average length of stays (LoS) both reduced after a peak in December 2022. We also reviewed the top ten EAU admissions by specialty and saw this was frailty with an average LoS for patients of 12.08 days.

Where expected standards for any outlined audits were not met, leads developed and implemented an improvement plan and monitored these through the relevant trust committee.

Managers and staff carried out a programme of repeated audits to check improvement over time. At the time of our inspection the trust had rolled out an audit and assurance system to strengthen actions and assurance. Managers planned to use information from the audits to improve care and treatment. They shared and ensured staff understood information from the audits.

Staff undertook tendable audits as part of a trust wide accreditation scheme. The lead nurse or ward manager completed observations weekly and the UEC matron or service manager monthly. They noted and shared outcomes and subsequent actions.

We reviewed the service's average audit system scores across UEC areas from 1 March to 31 August 2023. It showed UEC achieved over 90% for weekly assurance in the environmental audit. However, it fell below this target for four inspections and achieved 59.1%. This matched with our findings on inspection.

The latest actions from audit data showed the IPC team completed a hand hygiene inspection in UEC on 30 June 2023. They found staff missed opportunities to perform hand hygiene before patient contact but had recorded no guidance, actions, or measurable outcomes to improve compliance. This meant we could not ensure audit system data had led to staff's sustained improvement.

Noticeboards with audit system information had out of date findings and analysis from October 2022. The scores did not match what we found on inspection. For example, hand hygiene achieved 99% and IPC was 95% but we found compliance in these areas was low.

Competent staff

The service made sure staff were competent for their roles. Managers did not appraise medical staff's work performance or hold supervision meetings with them to provide support and development.

Managers gave all new nursing staff a full induction tailored to their role before they started work.

Nursing staff appraisal completion rate was 87.7%, 15 of 122 staff were still due an appraisal. This did not meet the trust target of 90%.

However, managers did not support medical staff to develop through yearly, constructive appraisals of their work. 40 of 53 medical staff's appraisal was due. This was a completion rate of 24.53%.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Nursing staff promoted recently before our inspection told us they were encouraged to apply for senior roles. They found managers supportive and were grateful for senior involvement in the department which had not previously happened.

Doctors enrolled on the HIEM programme were given four hours weekly online teaching in their home country, covering medical and cultural topics such as NICE guidelines, audit pathways and patient language. Teaching was delivered by trust NHS consultants and other acute hospitals. When these doctors arrived in the UK, they were initially supernumerary for 1 to 2 months. A tier 2 speciality doctor recruited from abroad had regular medical supervision as part of their supportive introduction to UK practice.

The clinical educators (CEs) supported the learning and development needs of staff. Staff were complimentary of the support they received.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Nursing staff told us they were given appropriate training for their role and were offered or highlighted any relevant training such as paediatric modules.

UEC doctors could access weekly relevant training and had protected time to complete this. They had a schedule with medical topics at the start and careers advice later in the year. However, this was inconsistent with junior medical staff's lack of protected time to complete mandatory training.

UEC doctors told us they felt well supported and had plenty of senior colleagues to ask any questions. They could attend weekly case-based drop-in discussions.

However, we spoke to one doctor as part of a therapy team who worked under no consultant, and thus had no direct oversight. Their contract was fixed term and they had not been informed what would happen after. This meant they were not receiving any managerial support such as structured appraisals, one-to-ones, or supervision.

Managers made sure staff received any specialist training for their role. A tier 2 speciality doctor told us they were supported to take study leave to attend courses such as advanced life support (ALS), ATLS and emergency practitioner advanced life support (EPALS).

UEC leads were responsive to their junior medical staff needs. For example, when places on the official ATLS course could not be found, they organised a trauma course in-house. Doctors told us it was well run and attended.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary (MDT) meetings to discuss patients and improve their care.

The daily bed meetings fed into the MDT huddles. We attended this meeting which covered latest or updated position around patient numbers, discharge to assess, waiting times including ambulances and any waits over 24 hours. The meeting was chaired by the head of patient flow or chief operating officer and the matron with trust wide cross-site senior staff dialling in. Meeting feedback and actions were shared by all divisions.

We also observed a medical staff board round in majors. This was attended by all doctors in this area and the flow manager. The morning consultant handed over to their afternoon equivalent.

Staff worked across health care disciplines and with other agencies when required to care for patients. Medical and UEC teams worked well together and had a shared understanding of mutual challenges. For example, around managing patient flow and access to specialities.

Seven-day services

Not all key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. The co-located urgent treatment centre within UEC was open 24 hours 7 days a week.

However, some support teams to UEC such as rapid assessment therapy (RATS) did not have seven-day cover.

Urgent and emergency services

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support in the UTC's minor injuries unit. For example, leaflets on smoking cessation were available.

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

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. Nursing and clinical staff completed their training in the mental capacity act (MCA) and deprivation of liberty safeguards (DoLS).

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patients we asked said staff sought their consent before any care and treatment.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. Patient records we checked included this.

Nursing and clinical staff received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). This was part of staff's adults safeguarding level 2 e-learning module.

We reviewed the service's latest de-escalation principles and guidance including restraint policy. This policy included a restraint flowchart to provide staff with supportive guidance on de-escalation techniques and understanding the use of restrictive interventions and restraint.

We were told band 7 team senior nurses reviewed all incidents of rapid tranquilisation in UEC. There were no incidents involving sedation patients in the 12 months before our inspection.

Information was displayed in the main waiting areas or throughout the department promoting staff's awareness and understanding of the MCA and its key principles.

Is the service caring?

Good

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

Compassionate care

Staff treated patients with compassion and kindness. They took account of their individual needs. However, staff could not always respect patient's privacy and dignity. They could not always follow policy to keep patient care and treatment confidential.

Urgent and emergency services

Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff were discreet and responsive when caring for patients.

Staff could not always maintain patient's privacy and dignity. One patient in Majors (cubicle 5) had dried vomit on their gown. The patient told us staff had not offered them a clean gown.

UEC could have two trolleys in the centre of majors at peak times with patients awaiting a cubicle. However, staff never carried out examinations or treatment in this area, so their dignity was never compromised. Domestic staff waited until glass door cubicles were empty to enter and clean.

Staff closed cubicle curtains when providing personal care to patients and did not provide care interventions and treatment to patients in communal public areas.

Patients said staff treated them well and with kindness. Patients we spoke to said they felt safe, and staff responded promptly if they were in any pain. Patients felt staff were caring and listened to any issues or problems they had with warmth, reassurance, and comforting humour.

The paediatric nursing team were welcoming, kind and caring to the children and respectful to patients.

However, staff could not always follow policy to keep patient care and treatment confidential. Patients nursed in the majors area were at risk of having intimate discussions and treatment overheard and seen by others. We also heard the patient and relative in majors bay six could overhear the medical staff board round which discussed all patient names and diagnoses.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. A female patient required an Electrocardiogram (ECG); the male nurse appropriately offered the patient the choice of a female nurse to carry out the procedure.

Emotional support

Staff provided emotional support to patients, families, and carers to minimise their distress.

Staff gave patients and those close to them help and could give emotional support and advice when they needed it. Nursing staff felt they could give patients enough emotional support.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed a reasonable and proportionate staff response to one very agitated patient admitted with confusion wandering around the majors area.

Patients told us staff always considered and maintained their privacy and dignity. For example, staff dressed one patient before escorting them to the toilet and waiting outside.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff had access to a quiet and calm room for patients approaching the end of life (EOL) and their relatives.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families, and carers to understand their condition and make decisions about their care and treatment. However, UEC survey results were significantly worse than other trusts.

Urgent and emergency services

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. UEC had 'your opinion counts' for patients and families where their views or suggestions about the service was dealt with in confidence. Comments could be anonymous, but if patients wanted a reply, they were guaranteed this within 14 days.

The service saw a decline in their number of friends and family test responses for May 2023 compared to April's awareness campaign amongst staff. Subsequently responsible staff were allocated a specific role to ensure awareness was maintained.

Staff supported patients to make advanced and informed decisions about their care. Patients told us staff respected their choices.

CQC's urgent and emergency care survey 2022 showed the trust scored significantly worse than other acute NHS trusts with type 3 services for two questions:

- Q20. If a family member, friend, or carer wanted to talk to a health professional, did they have enough opportunity to do so? 5.4.
- Q34: Did a member of staff tell you who to contact if you were worried about your condition or treatment after you left the Urgent Treatment Centre? 6.5.

All other responses from 99 people to questions across nine topics scored about the same as other trusts.

Is the service responsive?

Requires Improvement

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

Service delivery to meet the needs of local people.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Divisional leads had undertaken work around meeting the needs of local communities and demographics. The service had a 'high intensity users' group' (HIUG), where mental health and local authority advocates came to discuss patient needs with UEC staff.

A chapel and multi faith room was available which patients and visitors could use.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The children's UEC had mixed sex disabled toilet facilities with an anti- ligature call bell if patients or visitors needed help from staff.

Facilities and premises were not always appropriate for the services being delivered however improvements had been made to the department.

Urgent and emergency services

The service had systems to help care for patients in need of additional support or specialist intervention. Staff could access an emergency assessment unit (EAU) in-reach team led by an advanced care practitioner (ACP) including a registrar level long-term locum doctor employed for this purpose. The team came to see, assess, and treat patients with frailty issues. They could facilitate moves to the frailty unit, or other inpatient wards as well as therapy team review leading to discharge. They worked well and supported staff to provide care for this patient group.

However, the locum was only employed 9-5 on weekdays and had no cover when they were on leave. This potentially delayed patients with frailty issues from early comprehensive geriatric assessment outside these hours.

The service relieved pressure on other departments when they could treat patients in a day. From the service's project charter work, leads had increased the number of patients streamed into the same day emergency care (SDEC) from UEC. This stayed consistent at an average of 436.4 patients per month over the period from August 2022 to August 2023.

The service had received NHS England funding to extend the (SDEC) opening hours.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities (LD) and dementia, received the necessary care to meet their needs. UEC had LD ambassadors who provided support to patients with LD. They wore a yellow badge for easier recognition.

Information was displayed from a regional children and young people's alliance to encourage staff to improve their communication with neurodivergent patients called 'STEP IT UP'. Each of the eight-letter acronym was an instruction to aid healthcare professionals when caring for patients with autism and learning disabilities.

UEC areas were designed to meet the needs of patients living with dementia. There was provision in the department for patients with dementia. For example, in majors a large collapsible whiteboard reminded staff to be delirium aware and 'think SQID'. This was a 'simple question in delirium' with an explanation of delirium and which patients were at risk. Staff could access delirium practitioners for more information.

The trust was in support of John's campaign. This was a public declaration stating staff always welcomed carers to support patients living with dementia or experiencing delirium.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. 'This is me' forms were in the department for staff to complete information to help them support patients with dementia in hospital.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. One acute liaison nurse was also a Makaton tutor. Their contact details were displayed for staff to contact if they needed help communicating with patients who had learning disabilities.

The service had information leaflets available in languages spoken by the patients and local community. The children's UEC healthier together website and waiting room display had information in different languages.

Urgent and emergency services

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff could use 'the big word' telephone interpreting service for quick access. Staff we asked reported no delays or issues when they needed this service.

Some staff told us they would use patient relatives as translators if appropriate. They would ensure consent was gained and be vigilant for any potential signs of abuse.

Access and flow

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

The service did not ensure patients could access emergency services when needed or receive treatment within agreed timeframes and national targets. However, managers monitored waiting times.

Trust wide ambulance handovers within 15 minutes deteriorated from 65.2% in May 2023 to 59.8% in June 2023. This did not meet the national average for June 2023 of 64%.

Trust wide ambulance handovers within 30 minutes deteriorated from 90.2% in May 2023 to 85.6% in June 2023. This met the national average for June 2023 of 78.2%.

Trust wide ambulance handovers within 60 minutes deteriorated from 98.2% in May 2023 to 95% in June 2023. This met the national average for June 2023 of 91.8%.

Doncaster Royal Infirmary consistently reported a higher percentage of ambulance handovers taking over 60 minutes, compared to Yorkshire Ambulance Service overall, from May 2021 to January 2023. There was a considerable increase from 17.7% in July 2022, to 42.2% in December 2022. This was followed by a reduction to 4.7% in April 2023.

There were systems to ensure ambulance handovers were effective as possible. The local ambulance trust had screens by the entrance and majors showing their real time handover performance and pre-alerted arrivals. This remained green and under 15 minutes during the day shifts of our inspection.

The trust's percentage of patients waiting more than four hours from the decision to admit to admission was lower than the England and Northeast and Yorkshire regional averages. Trust wide four-hour performance was 69.65% in June 2023 (against a standard of 95%). This was a reduction in performance from 74.16% in May 2023. The trust's performance was second highest in the region and remained lower than the national average of 72.8% for June 2023.

In June 2023 there were 17,094 attendances to UECs, of which 5,188 were in the department over four hours before admission, discharge, or transfer.

Doncaster Royal Infirmary UEC had 9,783 attendances in June 2023, of which 4,179 were in the department over four hours. This meant their performance metric of 57.28% was worse than the trust's other UEC.

(Source: NHS England - A&E SitReps)

Time to initial assessment

Urgent and emergency services

The trust's median time from arrival to initial assessment was consistently longer than the England average from March 2021 to February 2023.

The trust median increased considerably from 19 minutes in July 2022 to 50 minutes in December. This was followed by a reduction to 16 minutes in February 2023.

(Source: NHS England - A&E SitReps)

Time to treatment

The trust's median time from arrival to treatment was generally like the England average from March 2021 to February 2023. The only exception was December 2022, when the trust median temporarily increased to one hour 58 minutes (England median one hour 30 minutes).

Total time in accident and emergency (UEC)

The trust's median total time in UEC was shorter (i.e., better) than the England average from February to November 2022. There was then a temporary increase, from two hours 57 minutes in November, to three hours 20 minutes in December. However, as of February 2023 the trust median had reduced to two hours 51 minutes. This was shorter than the England median of three hours four minutes.

Median total time in UEC per patient

The trust consistently reported a shorter 95th percentile total time in UEC compared to the England average from September 2021 to February 2023.

There was an increase from 10 hours 42 minutes in July 2022 to 16 hours 19 minutes in December 2022. This was followed by a reduction to six hours 37 minutes in February 2023.

The percentage of patients admitted, transferred, or discharged within four hours of arrival at the trust was generally similar to the England and regional averages from April 2021 to March 2023.

The percentage of patients waiting more than four hours from the decision to admit to admission at the trust was consistently higher (i.e., worse) than the England and North East and Yorkshire regional averages from April 2022 to March 2023 (though for March 2023 the England average was not available).

The trust's performance peaked at 54.0% in December 2022, before reducing to 39.9% in March 2023. The North East and Yorkshire regional average for that month was 34.8%.

Emergency access within 12 hours

Trust wide 12-hour performance was 2.64% in June 2023, a slight deterioration in performance from 2.59% in May 2023. The trust was in the highest quartile nationally with national performance of 10.3% for June 2023. In June 2023 there were 452 12-hour breaches to a trust UEC (2.64% of all attendances).

Doncaster saw 405 12-hour (black) breaches in June 2023 (4.14% of attendances).

Urgent and emergency services

The number of the trust's patients waiting more than 12 hours from the decision to admit to admission increased from 24 in March 2022, to 501 in December. There was then a reduction to 116 in March.

The service's aim was to increase utilisation of virtual ward capacity making full use of community resource to relieve system pressures ahead of winter, in line with targets set within the national recovery plan for urgent and emergency care.

Performance data showed the department was often under significant pressure. For example, children's UEC's total for all paediatric attendances was 21,208 over the year. This was considerably more than the trust's other main UEC site.

There were also challenges for mental health patients accessing beds which meant these patients were kept in UEC for several days awaiting an inpatient mental health bed outside the trust.

There was also length of stay challenges in areas such as resuscitation. There were five adult bays and one paediatric bay. During our inspection we observed one patient in a resuscitation bay had waited 14 hours and another nine hours for a ward bed. Operations staff told us patients in resuscitation were often left over six hours before they could be transferred. These patients were often not admitted due to obstruction from specialties.

Managers worked to make space and to improve flow when resuscitation was full, but this was hampered by bed availability.

Nursing staff told us about some patients who were cared for on a corridor off the major clinical area which was inappropriate and did not meet their standard operating procedures (SOP) eligibility criteria. This could extend their length of stay when majors patient cubicles were full. This concurred with the emergency care intensive support team's (ECIST) system review report that patients awaiting beds were being cared for in this area.

Leads took action to address the UEC patient delays for specialist review by junior or orthopaedic surgeons from theatres. They explained a business case was progressing to increase the surgical emergency team workforce in the surgical ambulatory care service (ESAC) and SDEC, but this required longer-term cultural change. They hoped this would help staff refer into ESAC easier.

The urgent and emergency care (UEC) survey 2022 identified long waiting times before seeing a doctor or getting a bed was a key theme.

The service had developed multiple pathways to try and improve patient's waiting times and experience; for example, SDEC and fit to sit.

In January 2023 the service had introduced an ambulance response coordinator (ARC) seven-day secondment role at the front door of the EAU which was shared between four staff from the local ambulance trust. This helped flow and reduced waiting and turnaround times.

However, patients could often not be admitted onto specialty wards although they had a plan in place with senior sign off. Staff, especially consultants felt they had to chase all specialties and were not always supported when they escalated patients. Assessment areas within UEC became blocked with stranded patients later in the day. Divisional leads were hoping to work towards direct referrals from UEC to specialities without discussion, as in other hospital trusts.

This concurred with the ECIST system review report noting the UEC team described having no admission rights into the hospital and having to respond to additional investigation requests from specialty teams before patients were formally accepted. They noted patients who did not neatly fall into one specialty needed considerable arbitration across teams, which the UEC generally had to lead.

The number of patients leaving the service before being seen for treatments was low. As of February 2023, the service's percentage of patients leaving UEC before being seen by staff for treatment was 4.5% compared to the England average of 4.8% and Midlands regional average of 5.3%. This figure rose to 5.3% in March 2023, but had reduced slightly from 6% in March 2022.

Staff completed harm reviews for patients who did not wait.

Managers and staff started planning each patient's discharge as early as possible. The matron explained leads were looking to reduce a multitude of touchpoints and avoid repetition. This test was hoping to make positive changes to stream patients to the correct pathways quicker. These trials were taking place in September. The service would also explore phasing out the Manchester triage model to find a different triage system.

Staff could not always plan patients' discharge carefully, particularly for those with complex mental health and social care needs. The emergency assessment unit (EAU) was intended to be for patients predicted to stay under 12 hours. However, EAU patients often experienced delays for diagnostic tests and results, or social care input.

Staff supported patients when they were referred or transferred between services. Staff could refer and transfer children to the hospital's children's observation unit (CHOU) open 24 hours. The unit saw children and young people aged between 0-16 years old from health professionals as well as UEC. The service supported direct referrals to their children's observation unit.

Managers monitored patient moves. However, they could not always ensure between services they were kept to a minimum. Staff had incorporated a patient tracker with several innovative solutions to facilitate patient movement through the department. The tracker collected performance data for audit and monitored patient pathways.

Learning from complaints and concerns

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

Patients, relatives, and carers knew how to complain or raise concerns and felt comfortable asking staff how to do this. The service clearly displayed information about how to raise a concern in patient areas.

Managers investigated complaints and identified themes. We reviewed the number of complaints received by the service. The total number of complaints for July 2023 was 13 opened and 14 closed. Complaint themes included waiting times, staff attitudes, patients being left in the waiting room and not happy with treatment being given.

At the time of our inspection the service had two MP complaints in progress. The service had no Parliamentary and Health Service Ombudsman (PHSO) complaints in progress.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Urgent and emergency services

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Requires Improvement

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

Leadership

Leaders had the skills and abilities to run the service. They supported staff to develop their skills and take on more senior roles. They understood the priorities and issues the service faced. However, they did not always manage them. Leads were not always visible and approachable in the service for staff.

The divisional structure was a triumvirate of divisional director, divisional nurse, and divisional general manager. They were supported by two emergency and acute medicine clinical director posts, the latter of which was vacant at the time of our inspection.

At the time of our inspection the service had appointed a new divisional nurse who would commence their role from early October 2023. The divisional director had covered both divisions until UEC formed a new seperate division.

Leaders had the skills, knowledge, experience, and integrity they needed. Leads knew what service improvements were needed, and which priorities were outstanding from their revised development plan.

Divisional leads felt they were sufficiently focused on patient care and experience. They attended accountability meetings with senior executives so felt they had a voice and the chance to have important and necessary conversations. Medical staff said their triumvirate were approachable and understanding of their challenges.

However, several staff from different groups told us they had a lack of senior support. At the time of our inspection, the divisional triumvirate was about to change again. Leads acknowledged the division had felt a lack of consistent leadership.

Staff felt senior leaders above divisional level were performance-orientated without understanding the challenges staff faced such as their surgical review delays or surgeons not accepting patients from the department. Some staff felt senior management did not do enough to improve surgical patient flow through their department, being a major cause of delay and lack of bed availability. For this reason, staff felt there was silo working, especially within specialties.

The service had clear priorities for ensuring sustainable, compassionate, inclusive, and effective leadership. There was a development programme, which included succession planning. For example, the service worked to address sustainability amongst the medical workforce through the trust's hybrid international emergency medicine programme.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. Service recovery and a consistent strategy were delayed due to a high turnover of senior staff.

Urgent and emergency services

The trust's vision was 'to be the safest trust in England, outstanding in all that we do'. The service's vision was 'aspiring to be the BEST'. BEST was an acronym.

Building partnerships

Efficient and effective

Sustainable services

Transformational ambition

The service had a trust wide improvement plan which reported to the Transformation Board. This included metrics and national standards. A service leads meeting on 1 March 2023 discussed the next 12-month programme which began in April 2023. The plan included five key areas.

- Data and information to consider a trust wide strategy approach to patient data
- Board and ward round processes and ensure delays were highlighted and escalation plans developed
- Whole system discharge planning to develop and improve the alignment to home first principles and best practice
- The people, to build trust among the clinical teams through organisational development processes

Patient flow measurements were highlighted within the report and were another area of focus over the 12 months. A senior responsible officer (SRO) was assigned to the individual elements of the improvement programme. Progress against the plan was monitored through the trust's internal governance structure and reported to the Transformation Board.

Managers told us the trust and division's COVID-19 recovery had been slowed by their high turnover of senior and executive leads.

The divisional strategic programme previously had two or three iterations. These were stopped, reviewed, and restarted too often with some work taken off the table due to funding issues. This had stopped transformation programmes and caused ongoing delays to reconfiguration works such as the urgent treatment centre extension.

However, divisional leads said with more stable leadership their strategic direction was now clearer and consistent.

Culture

The service had an open culture where patients, their families and staff could raise concerns without fear. Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. However, not all staff felt respected, supported, and valued.

The service had undertaken a freedom to speak up review in response to whistle blowing concerns to the CQC and an action plan was implemented. The service had also completed a cultural change programme supported by organisation development partners. This was to address one of the division's top risks around their workforce challenges impacting upon safe care.

During focus groups with staff, we found not all staff felt supported, respected, and valued. Some staff described a lack of respect, listening and 'compassionate leadership' from the trust. Medical staff told us they felt disenfranchised from

higher management and felt pressure from them to meet performance targets. One consultant kept their own daily record of their clinical activities and work tasks for each shift to scan and store as evidence in anticipation of challenge from senior management about their performance. Another colleague found themselves shouting at trainees as they felt so under pressure.

Staff did not always feel positive and proud to work in the organisation. There was not always a strong emphasis on the safety and well-being of staff. The latest NHS Staff Survey 2022 results showed the UEC's three lowest scores out of a possible ten were 'we are recognised and rewarded' with 4.6, 'morale' with 4.7 and 'we are safe and healthy' with 4.8. These three and their six other metrics all scored at least 0.5 below trust average.

Governance

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet. Leaders worked with partner organisations. However, leaders did not always operate effective governance processes throughout the service to address breaches from our last inspection.

There were effective structures to support the delivery of the strategy and good quality, sustainable services. These were regularly reviewed and improved. Service leads held divisional clinical governance meetings on the last Friday of every month. Any staff could join or dial in from home. Minutes and themes were written on staff room noticeboards.

However, on this inspection we found two repeat breaches from our last inspection. The service had only made limited improvement around staff's mandatory training compliance. We found no improvements relating to staff's proper and safe management of medicines. This meant we could not ensure governance processes and systems of accountability were effective.

We reviewed clinical governance meeting minutes from June, July, and August 2023. Agenda items included mental health triage and sepsis tool updates as well as paediatric transfer process and observation.

Senior sisters' meetings chaired by the lead nurse were held every other month as a communication forum to keep staff informed.

Arrangements with partners and third-party providers were governed and managed effectively to encourage appropriate interaction and promoted coordinated, person-centred care. Divisional leads worked closely with their external partners on models to improve patient streaming. For example, they had coordinated six sessions with their urgent treatment centre provider supported by ECIST to test and support pathways in the hope reducing delays. Leads had undertaken other specialties work in gynaecology and oncology with external partners to divert patients out of UEC.

Divisional leads maintained strong links with their local integrated care partnerships in Doncaster, system partners in South Yorkshire and regional and national organisations. For example, leads engaged in specific collaborative work on UEC recovery to deliver a winter plan to reduce the known and reasonably foreseeable associated risks. The division's winter plan reflected NHS England guidance issued in July 2023 to identify a national approach.

Staff we spoke to at all levels were clear about their roles and understood what they were accountable for, and to whom.

Management of risk, issues, and performance

Leaders and teams did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact. Service leads could not always provide sufficient assurance about risks they faced. However, staff contributed to decision-making.

Urgent and emergency services

There were not always effective systems for identifying, recording, and managing risks, issues and mitigating actions. During the inspection we found risks relating to infection control, environment, equipment, and management of medicines which had not been identified and actioned effectively. However, trust and divisional leads took prompt actions to address our concerns when we raised these on inspection.

The service had a risk register and there was alignment between the recorded risks and what staff said was 'on their worry list'. We reviewed the latest divisional risk register. The main risks were long waiting times to access care, workforce challenges and delays in patient assessment and treatment. There were mitigating actions in place, for example staff were completing clinical harm reviews for all patients waiting in UEC over 12 hours.

There was a programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. However, the audit programme was not systematic or fully embedded.

The trust had also rolled out a new trust wide audit and assurance system, to strengthen actions and assurance. However, the trust was still refining the system's data sets questions, and the reporting processes. Some internal audit areas had not yet commenced such as NEWS2 or deteriorating patient.

Potential risks were considered when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. However, staff said the service's winter and escalation plans for 2023/24 had not yet been released or shared with them.

We followed this up with divisional leads who said these plans were still in the planning phase and going through governance processes. They had held two workshops for staff to discuss issues. They felt plans were progressing well and being put in place much earlier this year.

There were processes to manage current and future performance. These were regularly reviewed and improved. The service had performance targets as part of their UEC improvement programme to see 76% of patients within four hours by March 2024. They planned to achieve this by targeting three areas for patient performance standards and working closely with a third partner provider.

Performance issues were escalated appropriately. The service had ongoing work to improve performance and patient flow through the UECs, and into and out of the trust hospitals. In 2023/24 they planned to reorganise their divisional structure to create a new division of UEC composed of emergency and acute medicine. At the time of our inspection this had been led by their divisional director since April 2023.

Divisional leads assessed and monitored the impact on quality and sustainability when considering developments to services or efficiency changes. At the time of our inspection divisional leads had been in post for between 18 months to two years. During that time, they explained from a state of flux they became able to drive required changes despite COVID-19 and other disruptions.

Information Management

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

Information technology systems were used effectively to monitor and improve the quality of care. The trust's main patient records management software worked well and included all relevant patient observations and results on one system. This kept patient records paper-light.

The service had built in IT safeguards, such as the red, amber, green (RAG) rated 'footsteps' system to support clinical prioritisation of patients.

The service planned to use consultant connect technology to unlock UEC capacity by connecting paramedics to specialist consultants in SDEC units for advice and guidance.

There were arrangements to ensure data or notifications were submitted to external bodies as required.

Divisional leads told us e-referrals had been piloted for four weeks, which had seen a positive impact on waiting times. They planned to roll this out imminently as part of a pre-winter piloting system.

During out inspection we did observe some staff access cards were left at unattended computers. This meant personal and sensitive patient data was potentially accessible to unauthorised persons.

Engagement

Leaders and staff actively engaged with patients, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

People's views and experiences were gathered and acted on to shape and improve the service. The trust performed within the expected range for all nine sections in the CQC Urgent and Emergency Care Survey 2022.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. The division was part of a South Yorkshire UEC alliance which focused on service developments, and system wide areas of focus to local populations.

Service leads had helped develop direct pathways from ambulance services to SDEC medical and surgical pathways.

The staff engagement score in the latest NHS staff survey was 6.1 out of 10. This was 0.7 lower than the trust overall's score.

The UEC matron and business manager carried out weekly breakfast walkarounds. They delivered staff food and used the opportunity to have wellbeing check-ins and share learning with staff.

Staff routinely thanked each other through a private messaging function. They gave reward and recognition to their colleagues. Staff could access a therapy dog to provide comfort and support to colleagues, as well as patients trust wide.

Learning, continuous improvement and innovation

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

There were standardised improvement tools and methods, and staff had the skills to use them.

The service had completed quality improvement projects including patient-led redesign of pathways. Another QI project had resulted in improved ambulance handover times during April to August 2023 which had resulted in positive outcomes. Data showed that 63-72% of patients were handed over in under 15 minutes, and 94% of patients handed over within an hour.

There were systems to support improvement and innovation work, including objectives for staff, data systems, and processes for sharing the results of improvement work.

There was a public health consultant for health inequalities based onsite undertaking work around training and awareness for staff. For example, one training provider had supported quality improvement work with a focus on health inequalities. At the time of our inspection leads were discussing how to link this internal work with their system partners.

The service participated effectively in and learnt from internal and external reviews, including those related to mortality. Learning was shared and used to make improvements. The division fed any relevant incident learning from patient deaths into the trust's mortality and morbidity group. They contributed to the learning disabilities mortality review (LeDeR) programme to learn from the deaths of people with a learning disability.

Leaders and staff strived for continuous learning, improvement, and innovation. This included participating in appropriate research projects and recognised accreditation schemes.

The trust had been recognised nationally for recruitment of specialist registrars to consultant posts under the certificate of eligibility for specialist registration (CESR) programme, having promoted one new consultant consistently for the last ten years through this route. As a result, the trust was used as a royal college of emergency medicine (RCEM) case study for good implementation.

Medical care (including older people's care)

Requires Improvement ↓

Is the service safe?

Requires Improvement ↓

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

Mandatory Training

The service provided mandatory training in key skills to all staff, however compliance was below the trust target.

Training compliance trust wide for medicine was 87% for nursing staff, which was below the trust target of 90%.Training compliance trust wide for medical staff was 57%, which was below the trust target of 90%. However, there was wide variation between wards with some compliance levels at 22% and others at 100%, this was division wide across all sites.

Staff had not all completed resuscitation training with a compliance rate of 66%, below the trust target of 90%.

However, mandatory training was comprehensive and met the needs of patients and staff. Managers monitored mandatory training on the electronic staff record system and prompted staff when they needed to update their training. Staff confirmed this, and we saw red/amber/green (RAG) rated training compliance sheets displayed in some ward manager offices as a visual prompt for nursing staff. Managers we spoke with were aware some staff were behind target and had a plan in place to make sure staff accessed mandatory training in the near future.

There was a clinical practice educator who delivered face to face practical training. For example, staff we spoke with described simulation training designed to develop skills in the management of deteriorating patients. Staff told us that training was a mixture of face to face and online. Staff told us they received protected time for training.

Staff reported there was training available to develop skills further, and they were supported to complete extended role training. For example, some nurses we spoke with completed extended training in male catheterisation.

Safeguarding

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

Staff received adult and children safeguarding training. They were compliant for level 1 training however not all staff groups were compliance for levels 2 safeguarding adults or children's training. This meant the service did not always meet the trust target.

Staff we spoke with knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

We saw patients at risk identified in clinical records with an alert icon, which could be expanded to read the full safeguarding referral.

Staff we spoke with knew how to make a safeguarding referral and who to inform if they had concerns. For example, the trust named safeguarding lead and local authority safeguarding teams. Out of hours, staff escalated safeguarding concerns to the duty manager.

Staff gave specific examples of safeguarding concerns they had raised. Ward staff knew where safeguarding policies were and how to access them. They used online forms to refer safeguarding notifications or queries to the local authority.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

The trust had a plan in place to improve mental health training.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

Wards had housekeepers to support staff in maintaining levels of infection control. Environmental cleaning schedules for domestic staff to follow were displayed in some areas, such as sluices.

We saw evidence of cleaning schedules in wards. Ward areas were mainly visibly clean and had suitable furnishings which were clean, wipeable, and well-maintained.

Some wards we visited displayed audits indicating high compliance with environmental cleanliness. Clinical staff cleaned clinical equipment. Not all cleaned equipment we saw such as stored commodes and toileting aids were labelled with the date when cleaned.

Side rooms were available on all wards. We saw notices displayed on doors where patients with infections were being cared for and doors were closed in line with policy for managing infectious patients.

We observed that staff adhered to ‘bare below the elbow’ guidance and adhered to infection control policy.

We saw posters displayed around the wards we visited about infection prevention and handwashing. Hand washing facilities were available and antibacterial gel dispensers were situated at the entrance of the wards and on corridors. We saw 5-moments of hand hygiene posters displayed.

Patients we spoke with confirmed staff washed their hands before and after treating them. We observed hand hygiene practice. On the wards we saw that staff mostly either washed their hands before and after each patient contact or used hand gel, as recommended in trust and national policy.

The infection prevention reports were discussed at the infection, prevention and control committee and reported to Board. As of from April to August 2023 the medical division trust wide had no cases of healthcare acquired MRSA bacteraemia; 6 cases of healthcare acquired E.coli bacteraemia; and 18 hospital acquired Clostridium difficile cases. The service had oversight of their numbers of hospital acquired Clostridium difficile cases and were working to reduce this trust wide.

Medical care (including older people's care)

The trust submitted data as part of the Commissioning for Quality and Innovation (CQUIN) scheme for quarter 4 (January to March 2023). However, there was poor compliance with the uptake of flu vaccinations for front line healthcare workers (47%).

Environment and equipment

The design, and use of facilities and premises kept people safe. Staff were trained to use the equipment. However, equipment was not always maintained, and safety checked in line with trust policy. Substances hazardous to health were not always stored in accordance with regulations.

Access to all wards was by a secure buzzer and camera entry system. All fire exits were free of obstructions. Fire appliances were signposted and tested. The fire alarm was tested weekly.

Patients could reach call bells and staff mostly responded quickly when called.

Equipment was subject to routine planned preventative maintenance as defined by the equipment manufacturer and we saw that portable electrical equipment was not always maintained and safety checked. The trust had systems in place for recording the service and maintenance of equipment, identified through compliance stickers. Most equipment we looked at had been serviced in accordance with trust policy, however some were out of date.

Staff carried out daily safety checks of specialist equipment. For example, records we reviewed for checks of the emergency resuscitation trolleys had no gaps. Staff told us that resuscitation trolleys were checked and stocked by theatre staff and delivered to the ward.

Staff we spoke with said they had enough suitable equipment to help them to safely care for patients. For example, staff told us they had access to the correct equipment for the care of and moving and handling of bariatric patients.

Substances hazardous to health were not always stored in accordance with Control of Substances Hazardous to Health (COSHH) Regulations (2002). For example, on one ward, in the dirty utility room, we saw cleaning solutions left around the ward on desks and in unlocked sluice rooms. This meant there was a risk vulnerable people could access potentially hazardous substances. We made staff aware at the time and it was rectified.

We found multiple examples across all wards of out-of-date equipment, this included cannulas, swabs, oropharyngeal airways, and blood sample vials. This was escalated on day one of our inspection, however we found more examples across the following days on all wards we visited.

Staff disposed of clinical waste safely. We saw all clinical waste sharps bins were used and stored in accordance with national guidance.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients (NEWS2). This helped staff to identify and escalate deterioration in a patient's condition. The NEWS2 alert system was embedded into practice with individual electronic ward boards providing oversight of the clinical area. In all records we reviewed, NEWS charts were completed correctly, and there was clear evidence of escalation with deteriorating patients.

Medical care (including older people's care)

The trust took part in the Commissioning for Quality and Innovation (CQUIN) scheme and the audit results for 2022-2023 showed an increase in compliance with recording of NEWS2 score, escalation time and response time for unplanned critical care admission from 50% in quarter 1 to 100% in quarters 2, 3 and 4.

Staff we spoke with told us they could easily access trust policies on the recognition and management of the acutely ill and deteriorating patient.

Staff we spoke with told us that doctors responded quickly when patients were escalated and there was a critical care outreach team out of hours to support the medical on-call team.

We requested evidence of compliance with VTE assessments and audits, the trust told us that an electronic assessment pilot was currently being undertaken on Ward 16. The pilot data showed an improvement in completion rates, with the latest data showing completion of VTE assessments was 86%. This was an improvement from the start of the audit in which the first week VTE assessment completion rate was 37%.

We saw multiple examples of how staff dealt with specific risk issues such as patients at risk of falls. We saw patient falls risk assessments were completed on admission and falls risk was managed by cohorting patients, with a staff member allocated to each area when staffing allowed. In addition, patients were provided with non-slip socks. The trusts most recent data showed in the last quarter there were two falls with severe harm and three falls with moderate harm within the division of medicine.

Shift changes and handovers included all necessary key information to keep patients safe. Staff received a printed handover sheet which included any specific patient risks, for example, falls risk, resuscitation status and identified patients that required assistance with diet and fluids.

We observed staff attending multidisciplinary safety huddles. These were attended by physiotherapists, speech and language therapists, occupational therapists, and a discharge coordinator, in addition to medical and nursing staff.

Nurse staffing

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

Staffing requirements were calculated by ward managers using a recognised safer care process. However, the service did not always have enough nursing and support staff to keep patients safe. For example, on the wards we visited we saw that planned and actual staffing did not always match.

Staff we spoke with told us this was a regular occurrence. There was a staffing escalation process in place. Staff we spoke with explained, when staffing was suboptimal, they reported to the manager on call for medicine. The on-call bleep holder redeployed staff from other wards, requested bank staff and unfilled shifts were offered to staff through a closed social media group. Agency staff were used and allocated where needed. Staff we spoke with told us they had sufficient rest and meal breaks and usually left duty on time.

The vacancy rate for nursing within the division of medicine was 177.51 whole time equivalent as of March 2023.

The absence rate for nursing within the division of medicine was 6.11% at the time of inspection.

The vacancy rate for support staff within the division of medicine was 101.60 whole time equivalent as of March 2023.

Managers we spoke with explained the trust was actively recruiting registered nurses and had an extensive preceptorship programme to support staff entering the organisation.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training, and experience. However, they kept patients safe from avoidable harm and provided the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service did not always have enough medical staff.

Managers could access locums when they needed additional medical staff. Rotas we reviewed had few gaps in medical cover. Managers made sure doctors had a full induction to the service before they started work. Staff we spoke with said they felt supported by senior medics and felt the support and training they received was appropriate to their roles and responsibilities.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings and weekends. Staff we spoke with said that on-call senior medics were contactable when required. Staff we spoke to had good understanding of the long-term workforce plans and improving staffing numbers, they told us that things had improved more recently with staffing levels.

Staff we spoke with told us they had sufficient rest and meal breaks but did not always leave duty on time.

The vacancy rate for medical staff within the division of medicine was 36 whole time equivalent as of March 2023.

The absence rate for medics within the division of medicine was 2.39% at the time of inspection.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care. However, records were not always stored securely.

Records were held in paper and electronic formats. We reviewed 20 sets of patient records across medical wards from all 3 sites and found these were clear and comprehensive. The trust had a system in place to identify and alert staff members as to when risk assessments were due.

The trust had implemented audits of patient records which were uploaded on to an electronic system which could be benchmarked across the division.

Electronic systems for record keeping were used on all wards we visited and these recorded key information about patient risks and treatment, including alert icons for patients living with dementia, learning disabilities, patient acuity and discharge plans. The dashboards ensured that staff had easy access to key information, such as reviews by other members of the multidisciplinary team and clinical observations.

Records were not always stored securely. We saw examples of paper notes left open and unsecure. We also saw examples of electronic systems being left unattended for long periods of time with patient information on display.

Medical care (including older people's care)

Medicines

The systems and processes to safely prescribe, administer, record and store medicines were not always effective.

Patients did not always have wrist bands in place, this was escalated at the time of inspection and resolved.

We found examples across multiple wards of medicine items which were out of date. This included IV paracetamol, insulin, and topical creams. This was escalated on day one of the inspection, however we found further examples of this across the three days.

We observed medication rounds in which staff checked patients name and date of birth. We observed the electronic prescribing system that had been introduced which prompted staff when medicines were due to be administered.

Records we looked at assured us most medicines were being given as prescribed and where medicines were omitted, we saw evidence of reasoning why. However, oxygen prescribing was not always completed consistently.

We saw evidence of prompt action by the medical team where changes were made to medicines via specialist teams. Medicine reconciliation was carried out by the pharmacy team.

Patients own controlled drugs were recorded in a separate register. Most were returned upon discharge. However, we found three instances on two wards where patient's own medicines were not returned on discharge and still stored on the ward.

There was not an effective process to manage and monitor the ambient temperature of rooms which stored medication. This meant some medicines may be less effective and have to be disposed of which could lead to delays for patients to receive medications.

Medicines required to take home out of hours was dispensed in labelled packaging from the wards. There were checking systems for discharge medication, we observed two nurses checking medicines, these were correct for a patient discharge.

Ward staff told us they were supported by pharmacists Monday to Friday. Out of hours, pharmacists were contactable.

Incidents

The service did not always manage patient safety incidents in a timely manner. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff accessed the incident reporting and investigation policy on the intranet. All staff we spoke with knew what incidents to report and how to report them. All managers we spoke with knew their ward's most recurring top three incidents and gave examples of how these were being addressed and monitored. Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff we spoke with were familiar with the electronic incident reporting system and provided clear examples of incidents and near miss incidents they had reported recently. Managers shared learning about never events with their staff and across the trust.

Medical care (including older people's care)

Staff told us managers explained learning from incidents and these were shared by email or informal discussion.

Staff told us that the division leadership team supported several quality improvement projects to help improve services, for example there was a quality improvement project for falls and pressure ulcer reduction. There were 47 falls during 2022/2023 with severe or moderate harm, whilst this did not meet the trust target, there was a reduction in the number of falls resulting in harm.

The medicine division had 22 serious incident actions which were more than 1 month overdue and 31 SI actions overdue in August 2023. There were 264 open overdue incidents greater than 3 months in the incident reporting system. The trust was aware of the backlog for serious incidents and had put plans in place to improve this.

All staff we spoke with understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

We saw recent patient safety alerts displayed and managers we spoke with explained how these were implemented and monitored. This signposted staff to further information and covered key topics each month, such as learning from falls, prevention of pressure ulcers and incident reporting. Managers also told us of some quality improvement projects their wards were involved in to improve themes of incidents.

Is the service effective?

Good

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Staff we spoke with had a good understanding of the Mental Health Act, they followed guidance and could access support if required. Managers we spoke with had oversight on care and treatment and told us they ensured that staff were following guidance. We were told there was extra support available for staff to ensure they were up to date with evidence-based practice in the form of a practice development team.

Staff we spoke with explained how they accessed the most current best practice guidance online and trust intranet, for example National Institute for Health and Care Excellence (NICE) guidance.

Compliance against policy was monitored throughout the year using an annual trust audit schedule. In July 2023 there was a 95% compliance response rate against NICE guidance.

Medical care (including older people's care)

The trust submitted data as part of the Commissioning for Quality and Innovation (CQUIN) scheme for quarter 4 (January to March 2023). The results showed high compliance for the recording of the NEWS2 score, escalation time and response time for unplanned critical care admissions. This compliance had increased from 50% in Quarter 1.

There was also improved compliance with cirrhosis and fibrosis tests for alcohol dependent patients and was now 98% from 6.6% in quarter 1.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural, and other needs. Staff did not always complete fluid balance documentation when needed.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. For example, staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Where modified diets were required, assessments of a patient's requirements were detailed above their beds and on a whiteboard at the nurse's station. The service provided a wide choice of meals that catered for patient preferences.

We observed staff ensuring patients were comfortable and ready to have their meals at a protected time. For patients in need of extra assistance, families and carers were encouraged to come in to help. We observed family members being welcomed at lunch time.

We observed mealtimes on various wards and noted that all staff were involved in serving meals to patients, including senior staff. Patients that needed support with eating their meals were given it.

We observed additional comfort rounds taking place with options for biscuits, juice, tea, and coffee. Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

Staff monitored patients' fluid intake throughout the day. However, fluid balance charts in the records we reviewed did not always accurately capture fluid input and output where this was required.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain assessment was recorded routinely as part of electronic physiological observation recording. The system ensured completion of the assessment was mandatory.

The trust audited pain scores following analgesia to monitor effectiveness. The trust also had plans to review and add to their pain audits to expand on their scope of oversight.

Patients we spoke with told us they received pain relief soon after requesting it. Staff prescribed, administered, and recorded pain relief accurately.

Medical care (including older people's care)

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment. They were not able to use these findings to make improvements and achieve good outcomes for patients.

The service participated in some relevant national clinical audits. They submitted data for the National Audit of Care at the End of Life.

The National Audit of Care at End of Life for 2020/ 2021 showed high compliance for key themes such as involvement in decision making and communication with families and others. All other scores showed medium compliance within expected range.

The service had not submitted data to the National Audit of Dementia audit since 2018/2019. The results at that time showed within expected range for two out of four metrics. They had not submitted data for one of metrics relating to carer's feedback and scored worse than the national average for the other metric which related to discharge discussions by a multidisciplinary team.

The service did not submit data to a number of national clinical audits such as the National Inpatient Diabetes Audit, National Early Inflammatory Arthritis Audit, and the National renal audits.

It was noted in the clinical governance meeting minutes from May 2023 that the trust was one of the worst performing trusts for the early inflammatory arthritis service. This was due to lack of medical staff, delays in waiting times and not able to follow up patients in a timely manner.

The service were hoping to start participating in a number of audits. This included the respiratory audit because they were undertaking pilots and hoped to start submitting data in 2024. They had just started collecting data for Falls and Frailty Fracture Audit. They did not have a patient data base to submit information to the Inflammatory bowel disease audit.

The trust had been commissioned to provide a hydrotherapy service to patients within several medical services such as rheumatology, orthopaedic and neurology. However, the service had not provided this for last three years because the pool was not fit for purpose. Staff had identified this as a clinical risk to patient's treatment outcomes. A new business case was submitted in May 2023 for a new pool.

We were told that all outcomes from national audit reports and the resulting action plans were monitored by the Audit and Effectiveness Committee and discussed at speciality governance meetings. Any issues identified were escalated to divisional governance meetings.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers told us that local scheduled audits of different sets of notes on each ward each month, were recorded on an electronic system and uploaded onto the trust computer system. These included medical records audits, hand hygiene observation, sepsis documentation, falls, pressure ulcers (category 3 and above) and venous thromboembolism (VTE) risk assessments.

100% of VTE assessments were completed within 24 hours of admission between May and July 2023.

The trust developed action plans to improve outcomes. For example, the falls action plan and quality improvement project was developed in response to the findings from the audit of inpatient falls. In addition, other audits undertaken such as medication and risk assessment audits were used to extract emerging themes alongside incident reports, patient feedback and complaints.

Managers told us the implementation of electronic prescribing with mandatory fields had improved compliance and the trust had seen an overall improvement in accurate prescribing and administering of medications.

The trust held mortality and morbidity meetings to discuss learning from deaths. In July 2023 100% of all deaths for patients over the age of 18 were scrutinised by the medical examiner team.

The services sentinel stroke national audit programme (SSNAP) score overall had stayed the same as a rating of B. In July 2023, the data showed that 60% of stroke patients had been scanned within 1 hour of arrival into the hospital and 100% of eligible patients received thrombolysis treatment which exceed both trust targets.

The trust was JAG accredited for endoscopy.

Competent staff

The service made sure staff were competent for their roles. There were systems for managers to appraise work performance, but appraisal rates were below the trust target. Managers held supervision meetings with staff to provide support and development.

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

Managers gave all new staff a full induction tailored to their role before they started work. Staff we spoke with who were new to post, told us they felt well supported by their managers and peers. For example, they were allocated a 'buddy' and shadowed colleagues on supernumerary shifts. We were told there was an extensive preceptorship programme and additional support if required from practice development nurses.

However, staff told us they did not always have one to one meetings. Staff we spoke with told us managers supported nursing staff to develop through regular, constructive clinical supervision of their work, though this was informal and not always recorded. Established staff also told us they did not regularly have one to one meetings with their managers.

Appraisal rates varied between hospital sites. The overall appraisal rate within the medical division for medics, nursing and support staff and allied healthcare professionals was 67% which was below the trust target of 90%. In July 2023, the service did not meet the trust target of 90% as 70% of consultants had their job plans signed off.

Managers told us that they were confident poor performance was identified promptly and there were mechanisms in place to support staff to improve.

The clinical educators supported the learning and development needs of staff.

Managers told us that team meetings did not happen regularly, however information on development and training was disseminated in other less formal ways.

Medical care (including older people's care)

Multidisciplinary working

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

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. For example, we observed MDT board rounds which included consultants, junior doctors, physiotherapists, and nurses. We saw good communication, and a methodical approach through physical, mental, and social needs of patients.

Patients had their care pathways reviewed by relevant consultants. For example, when patients that were on general medical wards required review or input from specialist consultants, they liaised with each other effectively.

Nursing and medical staff we spoke with told us there was good teamwork across all disciplines and managers were approachable. Staff said they felt empowered to challenge colleagues' practice if they were concerned.

Staff liaised with the multidisciplinary team directly. For example, they referred to diabetes specialist nurses, dietitians, learning disability staff, elderly care psychiatric team and therapies colleagues.

Seven-day services

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

Consultants led twice weekly ward rounds on all wards, and daily board rounds. There was consultant presence every day, including weekends.

Patients were reviewed by consultants depending on the care pathway. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Managers we spoke with told us they received support from clinical in-reach services, for example, speech and language therapy, however, this was not available 7 days a week.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards. For example, we saw leaflets containing information on chronic diseases such as diabetes in patient areas. There were posters displayed to raise awareness of mental health which signposted families and carers to sources of practical help.

The trust website patient and visitors section had links to health promotion information, including leaflets in easy-read format.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

People who used the service were supported to make decisions in line with relevant legislation and guidance.

Medical care (including older people's care)

Staff we spoke with told us they received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) incorporated within mandatory adults safeguarding training. However, the content was no longer sufficient to meet the recommendations within the intercollegiate guidance. The trust was taking action to address this.

We reviewed four records of patients subject to DoLs which showed staff had completed assessments and recorded best interest decisions. We found one DoLs application was made prior to the completion of a mental capacity assessment. This was escalated at the time and resolved.

There was a policy for enhanced observation of patients. Staff we spoke with described a multidisciplinary team approach to making best interests decisions. For example, they involved clinicians, safeguarding team, patients, and their family/carers.

Staff we spoke with knew how to access the policy and get accurate advice on MCA and DoLS.

Staff described a multidisciplinary team approach to making best interests decisions. For example, they involved clinicians, safeguarding team, patients, and their family/carers.

The safeguarding team were responsible for the auditing of MCA and DOLs records.

Is the service caring?

Good

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients we spoke with said staff treated them well and with kindness. Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. Staff we spoke with gave examples of adapting care to meet the needs of people with religious beliefs.

We observed patients sitting out of bed, and staff told us they encourage families and carers to bring in patients own clothes.

Emotional support

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

Medical care (including older people's care)

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

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

Wards had visiting times however were flexible with these for patients who required extra family support. Staff told us this improved patient's eating and drinking and their morale.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff talked with patients, families, and carers in a way they could understand.

Patients and their families gave positive feedback on the service and their treatment. Staff we spoke with told us they received positive feedback from patients and their carers.

The trust provided the most recent friends and family feedback for medicine. The collection response rate was low for medicine with some wards collecting zero feedback. Wards which had collected friends and family feedback were generally positive.

Staff we spoke with described how families and carers were encouraged to participate in care if they and the patient wished to. Staff utilised therapeutic care staff to sit and ensure patients nearing end of life or patients in need of additional supervision were not left alone if their carers were away.

Is the service responsive?

Good

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

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

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

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

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The service had no mixed sex accommodation breaches in the last 6 months.

Facilities and premises were a challenge for the services being delivered. Investment in the estate was ongoing, but senior leaders were aware of the estate challenges.

Medical care (including older people's care)

The service had systems to help care for patients in need of additional support or specialist intervention. The service relieved pressure on other departments when they could treat patients in a day.

The service had systems to help care for patients in need of additional support or specialist intervention. Due to staffing shortages, additional one to one care was not always fulfilled on the wards; however, staff took action to mitigate against potential risks by cohorting patients. We saw several examples of this system happening during our visit.

We saw that staff had access to additional specialist equipment such as bariatric hoists and chairs.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet their needs.

Staff told us they accessed advice from a learning disabilities and dementia specialist when required. Staff supported patients living with dementia.

Patients were identified on the electronic white board. Patients identified as requiring 1 to 1 supervision were allocated this when staffing allowed.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff accessed interpreters when required.

Staff had access to information leaflets available in languages spoken by the patients and local community.

Patients were given a choice of food and drink to meet their cultural and religious preferences. We observed a meal service during inspection and saw examples of different food options available.

Access and flow

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

Managers monitored patient transfers and followed national standards. Managers worked to minimise the number of medical patients on non-medical wards and made sure they had arrangements for medical staff to review any medical patients on non-medical wards. However, given the significant strain on capacity in services it was not always possible to do this.

There were differing pathway options available within the medicine speciality. The hospital had capacity and flow problems due to the high number of patients with no care package immediately available for discharge to be carried out safely. This was outside of the trust's control.

Medical care (including older people's care)

The service's performance in July 2023 showed that 71% of patients received medical treatment within 18 weeks. This meant they did not meet the trust target of 92% or national NHS targets. The lowest performing services (under 70%) included cardiology, dermatology, endocrinology, gastroenterology, and respiratory medicine. There were at least 57 medical patients waiting over 52 weeks for treatment. There was also increased waiting times of over 21 weeks for a first appointment within gastroenterology and managers were working on this as a priority.

Senior leaders were making good progress against the risks associated with these long waiting times. They had exceeded their target for delivering 28% of outpatient appointments virtually by video or telephone.

The trust submitted data as part of the Commissioning for Quality and Innovation (CQUIN) scheme for quarter 4 (January to March 2023). The results showed an improved compliance for timed diagnostic pathways for cancer services from 1.4% in quarter 1 to 71%. In July 2023 97% of patients waited less than 6 weeks from referral for a diagnostics test.

The trust at the time of our inspection had 100% compliance rate with treating lung, haematology, skin, and upper gastrointestinal cancers within the 31-day target. However skin and upper gastrointestinal cancer were below target for 2 week waits at 88%.

The service did not have a triage process for triaging dermatology referrals due to the volume of referrals and the time required to support this process. The integrated care board had provided funding for the triage of 4000 referrals, but this has since expired. This was outside of the trust's control. The service had listed this as high risk on the risk register as this could have significant consequences for patients.

The services risk register listed an extreme risk that the community diabetes teams were no longer able to see patients with Type 1 diabetes who had been referred to them from outpatients. This meant that patients did not receive additional support for example with their insulin pumps, changes to treatment or psychological support.

Managers and staff worked to make sure patients did not stay longer than they needed to. In July 2023, the service met the trust target for reducing the length of stay for all patients who had been in hospital for more than 21 days. Senior leaders were aware of the pressures within the service. Managers and clinical leaders participated in site meetings held regularly throughout the day, every day. We were told during these meetings managers discussed the number of patients waiting to be provided with beds within the service, the number of discharges planned for patients, and plans on how to manage shortfalls between the 2.

They also monitored the number of delayed discharges and reviewed how to manage these effectively.

For the period of May to June, the trust's general and acute bed occupancy data showed the service was performing worse than their target and above the regional and national averages. Of these June was the worst performing month, seeing the trust at the 30th highest of 123 trusts, however this was the only month of the last three where the trust was in the worst performing quartile.

Managers monitored and took action to minimise missed appointments. The service had created an action plan to see what work was needed to achieve the trust target of 8% for 'did not attend' (DNA) rate and were focussing on the clinics which had a high DNA rates. In July 2023, the overall DNA rate for a first appointment was 11% and geriatric medicine was 24% and diabetic medicine and endocrinology were 14%. The overall DNA rate for a follow up appointment was 9%. Senior leaders were also reviewing the text reminder service because this was not available for all clinics.

Medical care (including older people's care)

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. Complaints were not always resolved within target timeframe.

Patients, relatives, and carers knew how to complain or raise concerns. For example, they discussed with staff directly and contacted the trust patient advice and liaison service (PALs).

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

The division of medicine had the most complaints in the trust with 267 complaints in 2022-2023, making up 44% of the total complaints for Doncaster Royal Infirmary.

Data showed in the last 12 months complaint responses completed against the agreed trust target showed medicine had been consistently falling short of the target. For the month of June 2023, 33% of complaints had been closed in the timescale agreed by the complainant.

Work was ongoing to complete complaints. There were plans to prioritise completion of complaints unresolved over 3 months. The trust reported in July 2023 that there were no complaints open longer than 6 months.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Staff we spoke with understood the policy on patient and carer experience (complaints) and knew how to handle them. Managers and staff, we spoke with said most complaints were about poor communication between staff and family members and carers.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, we saw displays containing details of compliments and suggestions for improvement following thematic reviews of complaints.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Requires Improvement

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

Leadership

Leaders had the skills and abilities to run the service. However, they did not always manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Medical care (including older people's care)

The divisional structure was a triumvirate of divisional director, divisional nurse, and divisional general manager. They were supported by two emergency and acute medicine clinical director posts, the latter of which was vacant at the time of our inspection. The service had appointed a new divisional nurse, their role would start from early October 2023

Staff spoke positively about their leaders and felt respected. Staff we spoke with told us about the senior nurses within the organisation were accessible and visible. The senior leadership from above divisional lead level were present and supportive, and staff felt there was good communication and feedback mechanisms. Staff felt that senior leaders were performance-orientated, but also understood the challenges staff faced, for example the length of stays due to complex social circumstances delaying discharges.

Divisional leads we spoke with felt they were focused on patient care and the patient experience. They attended regular meetings with senior executives and felt listened to with the challenges the medicine division faced.

Staff we spoke with told us how management had supported them to take on more senior roles such as ward management and also stroke nurse practitioners.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust's vision was 'to be the safest trust in England, outstanding in all that we do.' The service's vision was 'aspiring to be the BEST.' BEST was an acronym for building partnerships, efficient and effective, sustainable services, and transformational ambition.

Some staff we spoke with were able to describe the overarching vision and strategy for the trust. We observed the trust's quality priorities displayed on posters in areas we visited. Wards also displayed their own vision for the service. There was no strategy specifically for medicine however a new trust wide nursing, midwifery and allied healthcare professionals' strategy had been launched.

All staff we spoke with told us they felt there had been ''significant improvements'' over the last 12 months. Staff told us whilst they recognised things were not perfect, there had been a lot of changes made recently and concerns had been listened to and they had felt well supported to make the required changes at ward level.

Staff we spoke with felt positive about the care provided and described it as safe with major improvements in the patient's experience.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

All staff we spoke with were proud of the organisation as a place to work and spoke highly of the culture. Staff told us they felt respected and valued.

Medical care (including older people's care)

Staff at all levels were actively encouraged to speak up and raise concerns. Staff we spoke with described an open culture where they could raise concerns with their line manager, divisional leads, or senior leadership team. They felt there was a flattened hierarchy and spoke positively about this.

There was a freedom to speak up policy to enable staff to speak up if they had concerns about colleagues' professional behaviours. Most staff we spoke with were aware of this.

Patients we spoke with were positive about their experience and interactions with staff, they told us they felt confident and comfortable to raise concerns, though they had not needed to during their inpatient stay.

Managers did not always give staff appraisals and career conversations with only 67% of staff having had appraisals in the designated timeframe, this was below the trust target of 90%.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities however did not have regular opportunities to meet, discuss and learn from the performance of the service.

We reviewed clinical governance meeting minutes. The governance structure had recently changed. Leaders we spoke with felt positive about this. Staff we spoke with felt the structure was clear. The local leadership team had plans in place to address risks to the service, with access to information, such as monthly performance reports to maintain quality.

Staff told us that ward meetings were not consistently held, however they told us information about incidents and quality performance indicators were emailed or disseminated informally by the ward managers and deputy managers.

Staff we spoke with were aware that senior management colleagues attended monthly safety and quality meetings. Minutes we reviewed discussed incidents and the learning outcomes however staff we spoke with below matron level told us they did not receive copies of the minutes.

Management of risk, issues, and performance

Local leaders did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks to senior leaders. They did not always identify actions to reduce their impact. They had plans to cope with unexpected events.

Local leaders were not aware of all the risks and challenges we found on inspection. For example, we found equipment which had expired their safety check date and unsafe storage of controlled substances hazardous to health (COSHH) such as cleaning chemicals. Records were not always stored securely, and we found risks within medicines management. In addition, we found no action had been taken for increasing the compliance of mandatory training.

Although there were systems in place to allow staff to escalate risks to senior leaders, some risks we found on inspection had not been identified, escalated, or listed as a risk on the risk registers within the medicine division or trust risk register.

There were systems to allow staff to escalate risks. Records of governance meetings showed that risks were considered and discussed at these meetings. The divisional leads attended a monthly Performance Overview and Support meeting which was chaired by the Chief Finance Officer. The division was held to account for performance, patient experience and quality of care.

The service had a risk register which identified 49 risks, this included 4 extreme risks, 14 high risks, 24 moderate and 6 low risks. All risks were RAG rated. We asked service leads about their main risks which aligned with the divisional risk register. They included workforce challenges and equipment. However, it was not clear what mitigating actions in place for all identified risks on the register.

There were also areas such as falls risks where data showed this to be a concern for the division. Quality metrics showed there were 18 falls reported in July 2023 which had reduced from 26 in June 2023. There were several actions being taken including post fall learning, relaunch of the falls and bone health group and staff knowledge of the falls policy.

The medicine division had 22 serious incident actions which were more than 1 month overdue and 31 SI actions overdue in August 2023. There were 264 open overdue incidents greater than 3 months in the incident reporting system. The trust was aware of the backlog for serious incidents and had put plans in place to improve this.

The trusts winter and escalation plan for 2023/24 was still in the planning phase and going through governance processes.

Information Management

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

The service had a digital strategy in place that covered cyber security and information governance and an information governance assurance framework which outlined what the responsibilities of all roles were.

The service used the Data Security and Protection Toolkit (DSPT) to assess compliance with information governance and security. We reviewed the latest report from June 2023 which had an overall risk rating of “substantial” which is the lowest risk rating obtainable.

The key areas of Information Governance were monitored through reporting to the IG Committee. Regular audits were undertaken across the trust in line with the relevant DSPT Assertions - with actions identified and agreed by the service lead.

Progress against these actions was then monitored through the IG Committee who report to the Trust Audit and Risk Assurance Committee (ARC), which reports directly to the Board.

The trust’s main patient records management software included all relevant patient observations, assessments, and results. There were some paper records. Staff told us they had enough computers and handheld devices; however, the internet connection was prohibitive in accessing information quickly.

The service had built in IT safeguard improvements to the patient records management software, such as the red, amber, green (RAG) rated ‘footsteps’ system to support clinical prioritisation of patients.

Most data was stored securely however we did observe some omissions in this area in some of the wards we visited.

Staff told us there was a backup in the event the IT system failed and there was a procedure for medication administration during any downtime.

Engagement

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

Staff across the medical care services told us they routinely engaged with patients to gain feedback from them. This was done informally and formally through participation in the NHS Friends and Family test. Feedback from the NHS Friends and family survey was mostly positive across the medical wards.

Staff told us the matron and divisional leads did walkarounds throughout the hospital to speak to staff and ensure visibility of senior leaders. Staff told us they felt leaders openly engaged with them and were receptive to feedback and suggestions.

We heard staff routinely thanked each other through a private messenger group application.

Staff also told us there was a therapy husky dog to provide comfort and support to colleagues, as well as patients trust wide.

The trust had invested in staff wellbeing and staff could access reiki sessions, and physiotherapy as part of the wider wellbeing drive which was set up in response to the 2022 staff survey results.

The NHS Staff survey 2022 results showed the service had all slightly lower or similar scores than the average for the hospital and comparator average. There were no significant differences. Most of the scores were mid-range. For example, they scored 7.16/10 for being compassionate and inclusive and this was just below the hospital average of 7.32/10 and the same as the comparator average. There were some lower range scores for appraisals 4.63/10 which matched the inspection findings. They scored 4.40/10 for burnout, but this was following the COVID-19 pandemic.

Learning, continuous improvement and innovation

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

The service displayed ward information on a quality board. This gave information about the ward's performance, such as patient safety message of the month, improvement initiatives, infection rates, risks and learning from incidents, to staff, patients, and visitors.

Staff told us that the divisional leadership team supported several quality improvement projects to help improve services, for example there was a quality improvement project for falls and pressure ulcer reduction. There were 47 falls during 2022/2023 with severe or moderate harm, whilst this did not meet the trust target, there was a reduction in the number of falls resulting in harm.

Staff received learning specific to their ward which captured learning after significant events and safety reminders.

Medical care (including older people's care)

Staff we spoke with told us how managers had supported them to develop their career. For example, they attended courses to extend skills such as male catheterisation and cannulation.

Healthcare assistants told us they were supported to commence registered nurse training.

The hospital supported student nurses from a local universities though structured placement. Student nurses we spoke with told us they got good levels of support and some of them had jobs on the wards they worked on.

They told us that they were involved in improvement projects such as pressure ulcer reduction and felt that local level leaders were open to suggestions and ideas.

Surgery

Requires Improvement ↓

Is the service safe?

Requires Improvement ↓

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

Mandatory training

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

Nursing staff received and kept up to date with their mandatory training. The nursing staff achieved an overall completion rate of 90% against the Trust target of 90% compliance.

Medical staff were not up to date with their mandatory training. The medical staff compliance rate was 68.4% against the trust target of 90%.

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

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. Nursing staff told us managers gave them warning through the trust's electronic training system that they needed to update a training module and that they were always given support to access the training.

Safeguarding

Most staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Not all staff had completed training on how to recognise and report abuse and compliance rates for training were below the trust target.

Nursing staff received training specific for their role on how to recognise and report abuse. The compliance figures for nursing staff were at 93.3% overall for Safeguarding Level 2 training for adults and 88% for children, against the trust target of 90% completion.

Medical staff received training specific for their role on how to recognise and report abuse. The compliance rates for medical staff were at 71.4% overall for Safeguarding Levels 2 adults and 65.2% for children, and this was below the trust target of 90% completion.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Theatre staff demonstrated a good knowledge of safeguarding and had completed the appropriate levels of safeguarding training. They understood how to support patients from abuse in their surgery department.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff discussed safeguarding risks during patient handovers and staff huddles.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were aware of safeguarding procedures, how to make referrals and access advice; there were safeguarding leads throughout wards and a head of safeguarding in place. Ward staff knew where safeguarding policies were for support. They used online forms to refer safeguarding notifications or queries to the local authority multi-agency safeguarding hub. Nursing staff said they would inform their nurse in charge or matron depending on the severity of their concern.

We reviewed the trust's safeguarding adults at risk of abuse and neglect policy which was in date (April 2022), version controlled and had a review date of February 2025.

Staff told us matrons produced safeguarding reports where any learning for staff was included.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Hand hygiene points were visible at the entrances of each unit. Empty bed spaces had checklists completed to indicate they were clean and ready for the next patient.

Across the surgical division the service generally performed well for cleanliness. Cleanliness audits scored between 81% and 99.2% in the previous 6 months before inspection. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

The latest (2022) Patient-Led Assessments of the Care Environment (PLACE) score was 98.4% for cleanliness.

However, in one store room we found boxes which were stored directly on the floor which prevented floor cleaning.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were seen to wash hands, use antibacterial gels and PPE. Masks were worn in line with trust policy. Some patients told us that staff always washed their hands and wore PPE.

Staff worked effectively to prevent, identify, and treat surgical site infections.

Data on infection rates was also collected monthly for each ward. This included information on MRSA, clostridium difficile, pseudomonas, Escherichia coli (E. coli) and methicillin-susceptible Staphylococcus aureus (MSSA). In the period September 2022 to March 2023, data showed that the infection rates for all surgical wards across the trust were low.

During inspection observations we saw that some wards did not have infection prevent and control (IPC) audit data displayed. However, other wards had cleaning white boards in the main corridor identifying additional cleaning requirements and when items were to be cleaned.

Surgery

We observed hand sinks in every room with a poster above every wash basin about hand washing hygiene. Handwashing and gel available at every entrance and all pedal bins were foot operated.

We observed appropriate use of personal protective equipment (PPE). However, not all staff were compliant with uniform requirements. We saw that staff did not always adhere to guidance in particular staff wearing face piercings and wearing rings.

All curtains were disposable and labelled with date fitted and date to be changed. The wards used 'I am clean' stickers.

Environment and equipment

The overall design, maintenance and use of facilities, and premises did not always keep people safe. Storage areas were not locked as required. The servicing and safety testing of some equipment had expired.

The design of the environment followed national guidance. However, it was noted that wards and units were difficult to find due to limited clear signage.

Staff carried out daily safety checks of specialist equipment. We checked resuscitation trolleys on wards and in the theatre suite. Daily checks were completed correctly on all wards.

However, in multiple areas we found equipment which had expired their safety check date. This also included items which had never been safety tested such as kettles, toasters, and microwaves.

Patients could reach call bells and staff quickly responded most of the time when called.

The service had suitable facilities to meet the needs of patients' families.

Fire extinguishers were present on all inspected services and in date. We also saw that fire exits were checked and clear. The fire safety policy was available to all staff and staff were aware of hospital fire procedures.

The service had enough suitable equipment to help them to safely care for patients. Wards had access to specialist mattresses and chairs to reduce the risk of pressure ulcers for those patients who needed them.

Staff disposed of clinical waste safely.

There was no signage on any entrance or exit doors warning staff not to allow members of the public into unit before checking the appropriateness.

Across multiple areas within surgery, we observed cleaning cupboards, sluice rooms, storerooms, and utility rooms were left open. Most of these rooms had locks or keypad locks on the door, but they were not being used. One room was propped open with a waste bin. This meant there was easy access to consumable products such as intravenous fluids, saline, blunt fill needles, hand sanitisers, disinfection tables and dispensing bottles.

There was unsafe storage controlled substances hazardous to health (COSHH) cleaning chemicals as found these inside unlocked rooms.

Surgery

Staff did not always record food fridge temperatures. We found that over a 3 month period (June to August 2023) for St Leger wards 7, 8 and 9 fridges there were 8 occasions when temperatures were not recorded. On another ward fridge there were 33 occasions when no action recorded when temperatures were recorded as out of range. Staff reset all fridge temperatures every day instead of only on the days it was out of range.

The medical gases door was left open on St leger ward 7 and we saw 2 oxygen cylinders which were not stored securely and were on the floor.

There were processes in place for the management of faulty equipment. On the elective / orthopaedic modular ward the housekeeper reported faults with equipment, wrote the issue in a book and reported it electronically. Outstanding jobs were followed up. However, we saw that the boiler handle for the hot water had been reported twice on this ward and was not fixed since May 2023.

We were advised that bariatric equipment was not held on all wards but could be requested as required.

Assessing and responding to patient risk

Staff completed and updated most risk assessments for each patient and removed or minimised risks. Staff did not always identify and quickly act upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Records showed that staff had used the early warning scoring system that the trust used to correctly record, calculate, and review patients for signs of deterioration as required. The trust supplied data to demonstrate that an audit programme took place to ensure that staff followed the trust's early warning and sepsis scoring protocols.

Staff completed most risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We looked at sets of records which were a combination of paper and digital records on the trust's system. We noted that most were fully completed, accurate and legible.

However, staff did not always complete malnutrition universal screening tool (MUST) risk assessments or record scores for elderly patients. They did not always fully, and accurately complete patient's fluid and nutrition charts where needed. This meant there was a risk that elderly patients were not being assessed or closely monitored for their fluid or food intake which could reduce their treatment outcomes. This risk was escalated with the ward manager, but they did not understand why this risk had been raised.

We observed the World Health Organisation checklist for safe surgery (WHO checklist) being used and noted good practice in that patients were checked in by both the surgeon and anaesthetist. We looked at five records for patients in theatre during our inspection and the WHO checklist was correctly followed and recorded in all cases. Compliance audits for the WHO checklist were 83.3% at the time of the inspection.

Staff knew about and dealt with most specific risk issues. Where an indicator of sepsis was identified, the trust followed a national pathway (Sepsis 6) to provide testing and treatment to patients within one hour. We reviewed the trust sepsis assessment form and noted that the trust used an SBAR approach (situation, background, assessment, and situation) to review patients following an acute episode of deterioration.

Surgery

Early warning scores were used to monitor patients and detect deteriorating patients, or patients who required escalation or additional care or treatment. The trust had a dedicated critical care outreach team, staff knew the process for escalating concerns for deteriorating patients with the team and could give examples of when this had happened. We saw in patient records that the team attended promptly.

The service had 24-hour access to mental health liaison and specialist mental health support via direct referral, if concerned about a patient's mental health.

Staff arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff we spoke with knew how to access the mental health support. There was access to specialist nurses and crisis teams.

The service had a specific process for medical patients who were being cared for on surgical wards (outlying patients). The trust had agreed principles for caring for these patients and could identify them as part of their winter pressures position; this information included that there was appropriate medical consultant oversight from a medical speciality.

Staff shared key information to keep patients safe when handing over their care to others. The wards had daily safety briefings which highlighted potential risks to patients. The agenda included points such as 'patient specific risks', capacity in the ward, staffing levels and a review of patients coming to the unit.

Shift changes and handovers included all necessary key information to keep patients safe. Handovers were supported using briefing documents to ensure consistent messages across shifts. We observed hand over sheets on all wards we inspected. The nursing handover document included key information regarding individual patients which included a plan of care, key risks, and discharge plans.

Nurse staffing

The service had enough staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. However, staffing had continued to be a challenge across the trust. Nursing staff turnover for the surgical services at the time of the inspection was 8.3%.

The percentage of shifts filled against the planned nurse staffing across the trust was 96% at the time of the inspection. Overnight average fill rates for staffing were at least 100% for the three months before inspection.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The ward manager could adjust staffing levels daily according to the needs of patients.

The service sickness rates for nursing staff were 6.3%.

Managers made sure all bank and agency staff had a full induction and understood the service.

On inspection we observed staff working hard to complete tasks for patients; however, we were assured that staff had the time to always provide person centred care that met individual patient needs.

Surgery

Medical staffing

The service had enough medical staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. Medical staff matched the planned numbers on rotas we reviewed for the three months prior to inspection.

The service had reducing vacancy rates for medical staff. There had been a 3% increase of medical staff in June 2023 compared to June 2022. Unfilled medical staff posts from June 2022 to June 2023 (WTE vacancies) were now Ear, Nose and Throat (ENT) at 30%, General Surgery at 10%, Urology at 17%, Trauma and orthopaedics at 30% and zero Vascular Surgery vacancies.

The service had turnover rates of 18% for medical staff.

Sickness rates for medical staff were 3.4%.

Managers could access locums when they needed additional medical staff. Locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Senior clinicians and consultants we spoke with said there was no shortage of junior doctors on the wards. We saw enough numbers of medical staff on the wards we visited to meet the needs of patients.

The service always had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. We reviewed 8 sets of patient records across 12 wards and theatres which were a combination of paper and digital records. We noted that they were fully completed, accurate and legible. Those assessments that the trust required to be done on admission were always completed.

The majority of food and fluid balance charts and Malnutrition Universal Screening Tool (MUST) scores were completed in line with guidance; weight was recorded on admission and then weekly thereafter, we saw recording of patient weights in line with this. However, there were occasions when MUST charts were out of date and nutrition charts were incomplete.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, we found some unsafe storage of medicines.

Surgery

Staff followed systems and processes to prescribe and administer medicines safely. Patient records showed good documentation of patient's allergies including positive documentation of no known allergies.

Records assured us patients were receiving their medicines as prescribed.

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

We saw evidence of pharmacist clinical checks to review patients' medicines regularly whilst they were an inpatient and saw that actions raised by pharmacists were actioned by the medical team in a timely manner. However, audits were not always completed in a timely manner with most wards rated amber for the RAG rated completion figures.

Staff completed medicines records accurately and kept them up to date. Staff followed national practice to check patients had the correct medicines when they were admitted. Medicines recorded on both paper and digital systems for the 8 sets of records we looked at were fully completed, accurate and up to date.

Staff usually stored and managed all medicines and prescribing documents safely. In theatres, Controlled Drugs (CD) were kept securely, and staff checked them twice a day. Similarly, drugs that needed to be kept cool were kept in a locked fridge and were found to be in date. Controlled Drugs fridge temperatures were recorded daily, and no concerns were noted by the inspection team.

Staff measured the ambient room temperatures for rooms where other medication was stored. For August 2023, the room temperature had exceeded 25 degrees on three occasions. This did not comply with the safe and secure handling of medicines guidance from the Royal Pharmaceutical Society (RPS).

Staff managed all medicines prescribing documents safely. Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff completed medicines records accurately and kept them up to date.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

Staff did not always recognise and report incidents or near misses. Incidents that were recognised were managed well. Managers investigated incidents were reported, and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Some staff we spoke with did not recognise and report incidents or near misses. Senior staff knew what incidents to report and how to report them and were able to articulate doing this in line with trust policy. Incidents that were recognised were managed well.

Incident learning was shared with staff, and we saw a safety bulletin which was issued regularly to all staff. This included information on learning from incidents and improvements across the trust.

Surgery

The surgical service had 1 never event between August 2022 and July 2023. Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Managers for the service had sight of all incidents and all incidents rated moderate and above were reviewed by the patient safety team. Incident forms were also reviewed by a designated consultant and any learning shared. Staff met to discuss the feedback and look at improvements to patient care.

The electronic incident reporting system included a prompt on the duty of candour. This is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with demonstrated an awareness of the duty and the importance of being open and honest when delivering care.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers investigated incidents thoroughly. Patients and their families participated in these investigations.

Managers debriefed and supported staff after any serious incident. Case reviews took place as well as learning from care that had gone well to share good practice. Learning and any changes in protocols were shared via email.

Is the service effective?

Good ➔➔

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The trust had comprehensive policies, procedures and guidance which were aligned with that of national bodies such as the National Institute for Health and Care Excellence (NICE) and specialist bodies. Staff demonstrated awareness of the policies and knew how to access them.

Data for July 2023 showed the surgical division was 97% compliant for NICE guidance response rates against a target of 100%.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers. Handover meetings showed individual needs of patients were discussed. Our patient records reviews showed that patients' psychological and emotional needs were recorded.

The percentage of patients having a VTE assessment was 86% in August 2023 against a target of 90%. Work was ongoing to address compliance and there were plans to secure a VTE lead.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural, and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Nursing staff asked patients about any food intolerance or allergies as part of their pre-assessment. This also included specific dietary or cultural requirements, such as vegetarian or halal. This information was passed to the catering team so suitable food could be provided for the patient during their stay.

Specialist support from staff such as dietitians and nutrition assistants were available for patients however, we noted it took 3 days for an assessment for one patient's referral. When modified diets were needed, assessments of patient's requirements were detailed above their beds.

The trust had nutrition specialist nurses to support patients including those receiving artificial nutrition support, for example percutaneous endoscopic gastrostomy (PEG); A PEG feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall.

Nurses on the ward could provide high calorie juices accordingly, in line with policy, and refer to dietitian if appropriate.

Patients waiting to have surgery were not left nil by mouth for long periods. We reviewed the trusts standard operating procedure (SOP) for surgical patients who were nil by mouth.

The policy had information to support staff with a protocol for intravenous fluids and information for pre fasting guidance for patients before surgery.

The trust provided 24 hour medication to help patients with effective nausea and vomiting. They could top this up with additional IV fluids for maintenance. There was always cereal and toast available if patients had been unable to eat. Nurses had access to snacks and salt if a patient was low in sodium.

On some wards there was a menu collector who visited every morning and used a tablet to ask patients what they would want to pre order for dinner and tea. Options were read to patients requiring additional support. Food was provided with instruction of bed and bay for each patient. Any specific diet foods were labelled appropriately and also in a sealed container to prevent cross contamination.

On other wards, such as St Leger 7, 8 and 9 wards, there was a folder with laminated sheets for each day's dinner and evening meal options. Patients could choose main meals, sides, afternoon snacks, and desserts. Each food was labelled whether it was easy to chew, healthier eating, high energy, vegetarian, or vegan.

All wards had forms to identify special diets such as gluten free, allergy aware, renal, halal, kosher, finger food, energy dense, neutropenia diet, thickened fluid, red tray, and adaptive cutlery required.

Surgery

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The trust used differing methods to assess patient pain levels which included FLACC assessment, Burford thermometer and Visual analogue scales (VAS) score.

FLACC is a behavioural pain assessment scale used for nonverbal or preverbal patients who are unable to self-report their level of pain. Pain is assessed through observation of 5 categories including face, legs, activity, cry, and consolability. The Burford thermometer assesses pain by asking patients to indicate the intensity or severity of their pain on a diagram of a thermometer. It is a version of a verbal descriptor scale that visually represents increasing degrees of pain along the thermometer. Visual analogue scales (VAS's) are used for subjective ratings of emotion or other sensations such as pain.

Patients usually received pain relief soon after requesting it. We spoke to patients who had received pain relief on time and when requested.

Staff prescribed, administered, and recorded pain relief accurately. We saw staff completing and updating the patient records.

All staff we asked knew about the trust's specialist pain management team. The latest pain team referral figures showed that 1274 patients had been referred to the pain management team between September 2022 and August 2023 inclusive.

Patient outcomes

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

The service participated in relevant national clinical audits and managers used these audits to improve patient outcomes, care, and treatment. Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time.

The National hip fracture database annualised values based on 572 cases averaged over 12 months to the end of September 2023 showed that 42% of patients received prompt surgery. Figures showed that 48.8% of patients were assessed by a specialist geriatrician within 72 hours of presentation / admission. This was much worse than the national average. Hip fracture surgical procedure consistent with the recommendations of NICE CG124 was 59.9% which was much worse than national standards. Survival at 30 days post procedure was 91.8%. This was slightly worse than the national average.

The Bowel cancer audit figures showed that the trust figures were deemed to be good by the National Bowel Cancer Audit Dataset 2022 and were similar or slightly better than other trusts in the region. The 2022 report includes results for patients in England and Wales diagnosed with bowel cancer 1 April 2020 – 31 March 2021, and patients diagnosed between 01 April 2019 and 31 March 2020 who underwent a major resection after 31 March 2020.

Surgery

The National Oesophago-gastric Cancer Audit database shows that the trusts outcomes were better or similar to national audit outcomes for the management of high grade dysphasia patients and the management of oesophago-gastric cancer patients.

The Emergency Laparotomy Audit (NELA) database showed that the trust was slightly better than the national outcomes at 82% against a national figure of 80% median performance. These figures were based on all cases taken to theatre between 01 May 2023 and 31 July 2023.

The Prostate Cancer Audit showed that the trust performed much better than other regional trusts for Prostate Specific Antigen (PSA) and TNM completion. (TNM - T describes the size of the tumour, N describes the involvement of lymph nodes and M describes if the cancer has spread to a different part of the body.)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

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

Managers gave all new staff a full induction tailored to their role before they started work. All staff working at the hospital had an induction programme relevant to their role and the department they worked in. New staff were required to complete e-learning and face-to-face training.

The clinical educators supported the learning and development needs of staff.

Managers supported staff to progress through regular development meetings and yearly constructive appraisals of their work. Staff had the opportunity to discuss training needs and were supported to develop their skills and knowledge. Medical staff appraisal rates across surgical services were 68.7% and nursing staff appraisal rates were 91.2% at the time of inspection.

Staff told us they found the appraisal process useful, and they were encouraged to identify any learning needs they had, and any training they wanted to undertake. Staff were supported by their managers to improve their practice where indicated.

We were advised that not all wards had regular team meetings. One ward had not had a team meeting since October 2022.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. To ensure effective services were delivered to patients, we saw different teams and health professionals working with staff at the service as a multidisciplinary team (MDT).

Surgery

When we visited the wards and observed a handover, we saw a variety of staff working together, such as nurses and support workers, to benefit patients. Nursing staff said they had good communication between theatre and ward staff. They felt the trust had an informal culture of cross-service collaboration, for example by borrowing equipment and asking advice.

We could see from the handover sheets and records we examined that there was detailed communication between staff of different grades and roles.

There was a discharge team who had links with local services, local authorities, and care providers.

We saw therapist input and contributions to patients' discharge. The patient input into care was included throughout and involvement of family member as the patients next of kin was also present.

There were many examples of multidisciplinary working including the daily safety briefing, ward rounds which included input from a consultant, doctors, pharmacist, physiotherapist and as well as nursing staff.

There was a dedicated physiotherapist team who worked collaboratively with the nursing and medical staff to ensure that patients received the support they required. The physiotherapy team worked seven days per week. Patients told us they were not rushed or restricted to time when receiving physiotherapy.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends.

Pharmacy staff were available Monday to Friday and there was an on-call service at weekends and out of hours.

Physiotherapists provided treatment seven days a week with an on-call service available overnight. There was no dedicated occupational therapist, but referrals could be made.

Speech and language therapy were offered Monday to Friday. There were a low number of speech and language therapists available within the trust which reflects a nationwide shortage of this staff group.

X-ray, computerised tomography (CT) scanning, interventional radiography and endoscopy was accessible 24 hours a day, seven days a week.

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

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units. We saw displays on wards we visited through our inspection on healthy lifestyles and health promotion. There were leaflets available for patients to take on a variety of topics including diabetes, weight loss, stop smoking and stress.

Surgery

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

There were guidelines in place to support patients withdrawing from drugs or alcohol.

The multidisciplinary team provided health and self-care advice to patients to support them to manage their own conditions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They used agreed personalised measures that limit patients' liberty. Although decision making was not always recorded correctly on documentation we reviewed.

We reviewed additional sections of service user records relating to Mental Capacity Act (MCA) assessments and Deprivation of Liberty Safeguards (DoLS) applications. We saw capacity assessments, best interest decisions and consent to care and treatment was not always in line with legislation and guidelines and staff did not consistently recognise and respond to concerns in relation to mental capacity.

Staff did not always consistently assess capacity in a way that was decision-specific and time-specific. We found examples in service user records where staff had recorded that service users had 'no capacity'. Staff did not record the decision prompting the consideration of the service user's capacity or record the mental capacity assessment and decision made in the service user's best interest. However, the trust was completing significant work across the area, and we had seen clear improvement in audits for record keeping since the inspection.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with had attended mandatory training surrounding mental capacity act and deprivation of liberty safeguards training and understood capacity was decision and time specific. Staff did not always implement Deprivation of Liberty Safeguards in line with approved documentation.

Staff liaised with the psychiatric liaison team for all mental health patients.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. We saw DoLS audits on wards and the trust held MCA steering group meetings.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Good

Surgery

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness. We reviewed the friends and family data results for surgical wards and the results were positive.

Staff followed policy to keep patient care and treatment confidential.

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

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Patients were treated with compassion, and we saw staff provided care in a respectful manner that maintained patient dignity. For example, staff drew bay curtains to have private conversations or examine the patient.

Elective / orthopaedic modular ward staff gave an example a patient who did not want to receive bloods for religious reason who were given alternative treatments to support their recovery.

We observed a medical student with a patient and noted that they asked the patient before any treatment was given. Everything was explained to the patient and reasons why, in a very caring manner.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person’s care, treatment, or condition had on their wellbeing and on those close to them.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff demonstrated empathy when having difficult conversations.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff were fully committed to working in partnership with patients and their relatives, involving them in decision making processes about care and treatment.

Surgery

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

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced and informed decisions about their care.

Patients gave positive feedback about the service. We saw lots of thank you cards on the wards.

Is the service responsive?

Requires Improvement

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

Service delivery to meet the needs of local people.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

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

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. There had been no breaches on any surgical wards.

Facilities and premises were appropriate for the services being delivered.

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

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Support was available for patients with physical and learning disabilities. Staff said they treated every patient as an individual, which meant they made reasonable adjustments to meet the needs of patients with a learning disability or who were living with dementia and their family members.

Initiatives to enhance the care of those with a learning disability were in place. Health passports were in use. These detailed personal preferences, triggers, and any interventions which were helpful in supporting individuals during difficult periods.

Staff recognised the importance of involving relatives and carers for any patient with additional needs. The patient records that we reviewed reflected that individual needs were assessed, and care planning was informed by this. Patients with learning disability were given a RAG rated bracelet for staff to identify them as needing additional support as learning disability.

Surgery

Staff supported patients and those close to them during referral, transfer between services and discharges. Staff always informed patients of possible changes to their care before it occurred. Before discharges staff informed the patient and their family of where they were to be discharged to and what expectations to have of the services being provided.

We saw that wards stored personal care items such as toothbrush, toothpaste, shampoo, razors, non-slip socks. The service had information leaflets available in languages spoken by patients and the local community. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff knew how to access interpreting services for patients whose first language was not English. Translation could be provided face to face or over the telephone. Communication aids such as letter boards were also available.

Staff told us they had access to communication aids to help patients become partners in their care and treatment. There was a laminated book with different pictures for patients with learning disabilities. There was access to a whiteboard and pens as well as communication cards for expressions of emotions.

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

On ward 7 there was a board to show staff the information relating to each patient. Magnetic tiles were used against the patient's name about their level of enhanced care or supervision required and whether safety sides were indicated or not indicated against lying and standing blood pressure.

Access and flow

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

In terms of the trust's elective recovery in October 2023, the 18-week consultant led referral to treatment times for all patients was 61.5% against a goal of 92%. This had deteriorated over the last few months. The lowest performing speciality was Ear, Nose and Throat (ENT) with 44.7% and 2938 patients. This was significantly below the trust target of 92%.

The service's 18 week performance from August 2022 to July 2023 showed a mixed picture within specialisms. There was high compliance within breast surgery, general surgery, and upper gastrointestinal surgery. However lower compliance for trauma and orthopaedics which was 83%, ENT which was 49%, general surgery endoscopy which was 17.6% and vascular surgery which was 64%. This meant the service was not able to meet the demand, there would be longer waiting times and as patients may suffer adverse outcomes and harm as a result.

In July 2023 the mean number of days from decision to admit for some surgical specialisms were high for Trauma and Orthopaedics (209 days) and upper gastrointestinal surgery (277 days).

In October 2023 there was a total of 8706 patients waiting treatment for Trauma and Orthopaedics and 6569 patients waiting treatment for ENT. These specialities were the ones with the largest waiting list times. There were at least 832 surgical patients waiting over 52 weeks for treatment, with 610 patients within Trauma and Orthopaedics and 322 patients within ENT. Some of these patients were waiting over 65 and 78 weeks to receive treatment. These wait times did not meet NHS targets.

Surgery

Trust cancer waiting metrics, as of September 2023 included the following. The proportion of patients seen by a specialist within two weeks of GP referral was 83.6% against a target of 93%. The 62-day wait for patients referred with suspected cancer was 73.6% against a standard of 85% and 31-day treatment performance for patients was 93.6% against as standard of 96%.

Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards. Managers worked to minimise the number of surgical patients on non-surgical wards. Outlier figures for the surgical division were not provided.

There were 372 out of hours surgical bed moves, in the 12 months prior to inspection. Reasons for increased bed moves included decant of wards for deep cleaning, ongoing infection prevention control, moving a patient to a side room for privacy and dignity.

Managers and staff started planning each patient's discharge as early as possible. The average length of stay for trauma and orthopaedics was 5.1 days for patients at the time of our inspection. For general surgery the average length of stay was 3.6 days and 2.9 days for colorectal surgery.

There had been no breaches of ring-fenced beds since the modular ward opened on 1st November 2022. There had been no reported incidents where ring-fenced orthopaedic beds did not occur.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Managers monitored the number of patients where discharge was delayed, knew which wards had the most delays, and took action to reduce them.

Staff supported patients when they were referred or transferred between services. Managers monitored patient transfers and followed national standards.

There were 705 operations cancelled across the trust, on the day of surgery or following admission, for non-clinical reasons (excluding non-elective), between August 2022 and July 2023. The highest number of cancelled operations related to ophthalmology followed closely by general surgery.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. Not all complaints were responded to within the trust target.

Patients, relatives, and carers knew how to complain or raise concerns. Patients we spoke with had said they felt able to raise concerns and could see that the service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes. There were 185 complaints received by surgical and cancer services for the period 2022/2023. Local and national guidance required that all complaints were acknowledged within three working days, the trust set itself a 95% compliance target in this area. For the month of July 43% of complaints across the service were closed in the timescales agreed with the complainant.

Surgery

We reviewed 11 complaints and responses randomly chosen and found them to be detailed, appropriate and candid. In July 2023 there were 27 outstanding complaints requiring a response.

Managers shared feedback from complaints with staff and learning was used to improve the service.

There were 316 compliments received by surgical and cancer services for the period 2022/2023.

Is the service well-led?

Requires Improvement

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. However, they did not always manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Surgical services had managers with the right skills and abilities to ensure the service was providing high quality care. The divisional structure currently had 6 tiers.

At the time of the inspection there were 2 deputy divisional nurses overseeing the division reporting to the Chief Nurse. The divisional nurse role had been recruited to with a start date in September 2023.

Leaders were inspiring a shared purpose and were focussed on delivering and motivating staff to succeed. Managers were keen to retain staff and invested in education for staff to progress.

The leadership team understood the current challenges and pressures impacting upon service delivery and patient care. However, senior leaders were not aware of all the risks we found on inspection.

The clinical leadership team were visible and approachable. Staff said they had confidence in working together, and in leaders understanding issues and working better to improve them.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a vision for what leaders want to achieve in surgery and this was in line with the trust vision. The service promoted training, and staff were aware of the vision for surgery and were able to share this with us during inspection.

Surgery

The trust planned expansion of elective and diagnostic capacity including the establishment of a Community Diagnostics Centre. In addition, development, and implementation of the Mexborough Elective Orthopaedic Centre (MEOC) and development and implementation of a sustainable trauma business case. There was a long term vision for the vascular service and the trust were exploring and developing the case for the trust to be the second robotic centre for the ICS (e.g., Urology, General Surgery, ENT).

Divisional service development priorities included improving the utilisation and throughput of elective recovery theatres and out-patient transformation. There were plans to address resources and pathways to manage and address backlogs as well as Day Case Arthroplasty service development. Priorities included creating the ophthalmology hub with data sharing and single point of access.

The trust had identified a number of divisional challenges and priorities, such as, achieving a full establishment of medical, nursing, and administrative workforce. This included ensuring that specialty and specialist (SAS) doctors had career development pathways and that nursing staff had improved skill mix, training, that there was contingency planning and clear career development opportunities.

In addition, the trust aimed to increase nurse endoscopists and non-clinical / medical endoscopists through recruitment and training programs. This included robust inductions, preceptorship, and clinical development plans for new and developing staff.

The trust had plans for recruitment and retention programs- Breast, Dental, ENT, General Surgery, Ophthalmology, Trauma & Orthopaedics as well as administrative recruitment and retention support and strategies.

Staff told us they provided patients with person-centred care and that working well in a team was key to achieving their vision and strategy.

The management team shared they were dedicated to workforce retention and prioritising wellbeing and development across staff groups.

Culture

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

Staff were positive and caring towards patients and their relatives who used the service. In addition, we also noted caring and respectful interactions between staff of all grades and disciplines.

The care and service delivered showed a strong team approach to work. Staff from all disciplines told us they felt valued in their roles and were very much part of the team. Staff we spoke with expressed pride and commitment in their work.

There was a clear focus of patient centred care and teamwork, support between colleagues was strongly evident throughout the different areas we visited for both nursing and medical staff.

The service promoted equality and diversity in daily work. We found that 85.3% of medical staff and 99.4% of nursing staff nursing staff across the service had completed Equality, Diversity, and Human Rights level 3 training.

Surgery

The surgical and cancer division had a “speak up” partner who escalated concerns, where appropriate, to the Freedom to Speak Up Guardian.

Governance

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

Staff at all levels of the organisation understood what to escalate to a more senior person, and this happened for reporting low staffing levels. Ward managers told us that they had the option to report red flags when staffing levels were low. The number of red flags were reported monthly to the board.

We saw a performance board showing examples of audit results from January 2023 and showed when an action was required, progressing, or resolved. It also showed pictures of when things had not been compliant.

We saw many examples of ‘you said / we did examples’ such as when a patient raised a concern about long medication waits. The trust worked with doctors and pharmacy to highlight patients that were potential for discharge the day before, so that they could ensure medication was ordered and discharge letters completed.

Management of risk, issues, and performance

Leaders and teams did not always use effective systems and processes to manage performance and risk. The systems did not identify many of the risks found by the inspection team. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Senior leaders were not aware of all the risks and challenges we found on inspection. For example, ensuring premises and environment were safe and secure, compliance with IPC policy, completion of mandatory training and Malnutrition Universal Screening Tool (MUST) risk assessments. We also found equipment which had expired their safety check date some had never been tested and unsafe storage controlled substances hazardous to health (COSHH) cleaning chemicals. These were not listed on either the surgical or trust risk register.

However, managers took immediate action with regard to most of the risks we raised with them at the time of the inspection.

There was a risk management process related to risk with monthly risk meetings. The risks were escalated to the divisional meetings.

Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact giving a red, amber, green (RAG) rating. The Surgical and Cancer service risk register contained 24 extreme risks and 20 high risks. We reviewed divisional governance meeting minutes and saw that extreme and high risks were appropriately reviewed and updated on a monthly basis.

Some of the surgical risks impacted on patient waiting times and as a result patients may suffer adverse outcomes and harm due to delays in treatment. Delays were especially longer for patients waiting for treatment within trauma and orthopaedics and ear, nose, and throat (ENT).

Other risks related to increased demand and capacity within the service or funding shortages.

Two risks related to vacancies within the service and trust. For example, the service did not have a vascular MDT coordinator to assist with the lack of tracking of urgent vascular patients. The trust did not have enough radiographers.

We saw some of the surgical risks had also been moved to the corporate risk register. For example, the trust had identified they did not have effective information systems to support medical revalidations and appraisals for medical staff and this was listed as a moderate risk. Another risk listed as moderate was the ineffective process to manage and monitor the ambient temperature of rooms which store medication. This meant some medicines may be less effective and have to be disposed of which could lead to delays for patients to receive medications.

Senior leaders completed monthly analysis on referral to treatment and performance. They had identified specialisms such as trauma and orthopaedics and ENT when capacity did not meet the demand.

Senior leaders were making good progress against the risks associated with long waiting times. They had been exploring alternative patient pathways with virtual wards and clinics and same day emergency care provision (SDEC). They had also implemented an interim standard operating procedures to manage patient tracking and had commenced clinical validation exercises.

All serious incidents (SI), incidents and moderate harms were reported to the Surgery and Cancer Division Clinical Governance Meeting and progress reports discussed. There were 8 outstanding SI action plans for the division in July 2023. There had been several serious incidents resulting from patients being lost to follow-up or review.

There was a rolling agenda of meetings to improve quality and patient safety.

Quality and performance dashboards highlighted that overall, the Surgery and Cancer division were performing well in all but 2 areas. The two weaker areas were lower than target appraisal rates and low Friends and Family Test (FFT) response rates. All other areas, which included number of complaints, falls with severe harm, falls with moderate harm, and MRSA rates were all low or zero. There were low number of pressure ulcers (category level 2) and no pressure ulcers graded category 3 across the division for the last quarter.

There was effective oversight of performance regarding antimicrobial prescribing and stewardship. We saw monthly meeting minutes which evidenced ongoing audit of medicine management compliance and antibiotic prescribing data. Antibiotic prescribing varied across the surgical wards depending on speciality, as expected.

Information Management

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

Staff had access to the IT equipment and systems needed to do their work. However, the trust was developing data to ensure divisions had the systems to understand performance make decisions and improvements.

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. Systems were in place to collect data from wards and teams.

Information governance systems were in place and ensured the confidentiality of patient records.

Surgery

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

We saw the staff engagement group met monthly and this covered a wide variety of agenda topics in recent minutes we reviewed. We saw that staff survey questions had been updated to align with the NHS People Promise and that the trust had asked additional questions regarding the awareness of trust values. The initial staff survey results showed an encouraging and improving picture in relation to feedback. Work was being undertaken in relation to communication of the results and engagement with local teams, to embed a cycle of year-round engagement.

The response rate for the staff survey was 65.2% and the comparator average for acute trusts using the same provider was 43%. The trust was a leading acute trust for the response rate amongst comparable trusts and achieved the highest ever response rate for the survey at the trust, which is a positive sign of engagement. However, the information received did not show statistic broken down for the Surgery and Cancer Services division.

There was a clear focus on engagement activities to develop a culture of inclusion. The trust held events for staff from ethnic minority groups.

The patient satisfaction survey results for the surgical outpatient department were positive with a response rate of 130 patients. Out of the 130 responses 113 patients had an excellent experience, 15 had a good experience and 2 people did not answer.

It was noted in the June 2023 Surgical and Cancer division governance minutes that the friends and family test (FFT) response rates were not at the level required. However, improvements had been noted and further spot checks were planned.

Learning, continuous improvement and innovation

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

Working in partnership with two additional trusts, Doncaster, and Bassetlaw Teaching Hospitals (DBTH) were leading the programme to implement a new, dedicated orthopaedic hub for the people of South Yorkshire. Surgical procedures would include hip and knee replacement inpatient procedures alongside foot and ankle, hand and wrist, and shoulder day case surgery. In the first year of operation the centre planned to undertake approximately 2,200 orthopaedic procedures on behalf of the three partner trusts, equating to about 40% of the current orthopaedic waiting list locally.

Known as the Montagu Elective Orthopaedic Centre (MEOC), the facility would feature two state-of-the-art theatre units, two anaesthetic rooms and a recovery suite, in addition to 12 inpatient beds in a dedicated orthopaedic facility. This development would be based at Montagu Hospital, co-located with rehabilitation services and with access to the planned Community Diagnostic Centre.

Healthcare professionals at DBTH had introduced Magseed and Magtrace to help improve the accuracy and timeliness of breast tumour surgery.

Surgery

In collaboration with Macmillan Services and Aurora Wellbeing Services, DBTH announced the launch of a new mobile application specifically designed to empower and support cancer patients throughout their treatment journey.

The HealthZone Doncaster and Bassetlaw Cancer Care app was a free to use resource that had been designed with local people in mind. It offered people diagnosed with cancer access to information and support they needed whilst being treated for their condition.

Specialist Orthopaedic Surgeon working at DBTH had been awarded national recognition as an Associate Principal Investigator for contributions to Musculo–skeletal research by the National Institute for Health and Care Research (NIHR).

In the previous financial year as part of the elective recovery programme the 'My Planned Care' patient platform was launched with the purpose of enabling patients to be kept better informed about how long they may be waiting for procedures. The Patient Advice and Liaison Service (PALS) were the designated contact point, and a dedicated email inbox had been set up.

Maternity

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

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

Mandatory training

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

The 2019 inspection identified that the service provided mandatory training in key skills to all staff; however, not all staff had completed it. Safeguarding training shortfalls were observed as rates were below the trust target of 90%.

At this inspection the 2022/23 mandatory training logs provided by the trust for midwifery and medical staff identified continued shortfalls in mandatory training compliance. The trust target of 90% for completion of mandatory training was not achieved in some areas. Trust information provided following the inspection confirmed the following overall levels of compliance:

Midwifery and Nursing Staff – Compliance of above 95% was observed for the maternity pastoral team. Mostly compliance ratings were identified amber and red where compliance fell between 66.67% to 88.89%. We observed similar compliance shortfalls for wards M1 and M2 which were 88.88% and 88.89% respectively. Community midwives' compliance at Doncaster was 79.74%.

Medical staff compliance was 65.94% (Obstetrics and Gynaecology) which meant 91 of 138 medical staff had completed all their mandatory training.

Training dates were released to all managers in plenty of time to allow for allocation within the roster. Staff who required a yearly update received three email reminders and if the training was not completed following the third reminder, the names of those staff would be shared with the clinical director.

Staff said mandatory training was completed face to face and as electronic learning. Staff were alerted when they needed to update their training. All staff attended practical obstetric multi-professional training (PROMPT) training and cardiotocography (CTG) monitoring in work time (15 hours) and all mandatory trust training. Once 100% compliant with all training elements staff received a further 7.5 hours to pay back the e learning element of the CTG training (K2 package).

Mandatory training compliance and attendance was monitored by the practice educator and updates were shared with managers. Staff training records stored on their electronic staff record also identified training expiry dates. Non-compliance was escalated to line managers and additional management support ensured all staff were released to attend training. Some staff we spoke with said staff had been allocated mandatory training time, however, this was at times removed if there were midwifery staff shortfalls. Medical staff said their training time was protected which ensured completion of allocated training subjects and said they were encouraged by senior staff to attend the mandatory training sessions.

Maternity

Whilst on site we reviewed some consultants, doctors, and midwives training records in key areas such as practical obstetric multi-professional training (PROMPT) training, cardiotocography (CTG) and level 2 resuscitation training and noted that all training sessions for these staff groups fell below the Trust target of 90%. Training compliance for consultant staff and midwives ranged from 73% (consultants CTG and foetal monitoring) to 84.2% (midwives resuscitation level 2 adult and neonates).

Following the inspection, we received staff training compliance records. The consultant and midwife's compliance levels both confirmed ongoing non-compliance for PROMPT, fetal monitoring and cardiotocography training sessions. Training compliance was below the 90% trust target for both staff groups and ranged from 76.92% to 84.62% compliance across these training sessions for both staff groups. The master compliance spreadsheet confirmed additional training sessions were booked for some non-compliant staff. Later, additional training information statistics now confirmed that 100% of consultants had completed cardiotocography training sessions.

New doctors had started in post three-weeks previously; mandatory training compliance ranged from 37.84% attendance at the foetal monitoring day to PROMPT at 59.4%. Staff said they planned to ensure that all doctors had completed their training by December 2023.

The trust said that sepsis recognition and the national early warning score (NEWS) were covered within any course which had a deterioration element but not currently as stand-alone training. Staff said sepsis training was included in the Practical Obstetric multi-professional training (PROMPT) training package.

National Health Service Professionals and agency staff were supported by the Trust to complete PROMPT and foetal monitoring training sessions.

The highlight report for neonatal life support (NLS) midwives dated July 2023 identified the status and overview, including risks for NLS training. The risks were red, amber, and green rated; the milestone deadline, compliance level and expected dates of completion were identified. The latest completion date was March 2024.

Neonatal life support training (NLS) compliance at the end of July 2023 confirmed 198 midwives out of 227; 87.2% of midwives had completed this training against a training target of 90%. Separate training figures confirmed 100% (28) bank and agency midwifery staff and 85.4% (170) of midwives had completed this training. Systems were in place to capture future midwives whose training was due and for those 29 non-compliant midwives of which 24 had NLS dates booked.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, although, training records were not available to confirm staff safeguarding training compliance levels.

Nursing, medical and midwifery staff received training specific for their role on how to recognise and report abuse. The trust safeguarding training target was 90%. The trust confirmed that Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) training was part of the adults safeguarding level 2 e-learning module.

The trust said this was no longer sufficient content to meet the recommendations within the intercollegiate document. The relaunch of the mental health training included a more detailed package. The MCA/DoLs training was combined with L2 adult safeguarding training which meant the trust was unable to report on this separately.

Maternity

Adults and children's safeguarding training statistics at levels 1-3 were submitted by the Trust. At Doncaster Royal Infirmary we observed compliance generally fell below the Trusts training target of 90% for both medical and midwifery staff groups. Compliance ranged from 50% to 100% for midwives. Medical staff compliance was identified as 60%.

The safeguarding lead midwife told us that they delivered a mandatory study day every four to six weeks for staff, recent topics included substance misuse, bereavement, safeguarding, screening, and diabetes.

The safeguarding and vulnerabilities midwives had planned an infant crying awareness week to raise awareness about shaking injuries to babies. They had secured funding for cakes and stalls and had developed easy read booklets to share across the team. We were told that discussions around ICON take place at discharge for all patients.

Overall accountability for safeguarding lay with the Chief Executive Officer at the trust.

The Chief Nurse was responsible as the strategic and professional lead for safeguarding adults' practice.

The trust strategic safeguarding people committee was chaired by the deputy chief nurse and was attended by safeguarding professionals from both clinical commissioning groups. The trusts safeguarding team worked across all hospital sites and networked with other local authorities and hospitals.

The 2022/23 trust safeguarding report confirmed 100% attendance and report writing to child protection case conferences. These conferences ensured a plan was in place to keep children safe and eliminate the risk of harm.

The maternity service safeguarding leads worked across both sites. Staff we spoke with across the service expressed an excellent working relationship with the specialist midwives.

Staff were able to identify adults and children at risk of, or suffering, significant harm; knew how to make a safeguarding referral and who to inform if they had concerns. Safeguarding changes and updates were cascaded to staff through operations meetings.

The safeguarding team joined the daily staffing huddle to share information.

Policies and guidance which related to safeguarding, baby abduction and associated issues was in place. Safeguarding team information was displayed in areas we visited.

The trusts electronic system had flags on patient records that indicate domestic abuse, social services involvement, and other areas of concern. We were shown multiple records where the flags were in place. Women's records showed safeguarding assessments and background checks were completed. We reviewed six women's records all of which confirmed the safeguarding safety log was completed to record child protection information sharing checks and SystmOne checks with primary care records.

A baby abduction drill had taken place across both maternity units three-months prior to the inspection with an outcome to improve security measures. Staff said a security system timeline had been developed to assist with the improvement of security measures. We did not see a copy of this security guideline.

Safeguarding supervision sessions were introduced in the last four months. Safeguarding lead midwives had implemented virtual safeguarding supervisions and staff were given protected time to attend them. Community midwives said they were allocated safeguarding supervision sessions which they completed when able. The safeguarding supervision training report confirmed compliance from 11.53% (Central Delivery Suite) to 100% (M2) attendance by staff.

There was a shortfall in supervision compliance in the other maternity areas across maternity services so overall compliance was 25.5% for the entire maternity service. Further dates were to be offered from October 2023 and additional funding was secured for a further four supervisors so that a cascade model of supervision could be implemented.

The safeguarding and vulnerabilities midwives worked closely with external stakeholders and spoke of a new initiative which was a multi-agency meeting between the local authority, police, health visitors, drug, and alcohol service to ensure support was provided to women that needed it.

The safeguarding team gave examples of how they liaised and managed to reach out to hard-to-reach communities in their area. The service was currently working with an external organisation to support black ethnicity and asylum seekers as this population group had increased in numbers. A female genital mutilation service was in place as guidance for staff for women who had female genital mutilation performed.

If a woman was assessed as risk of suicide or self-harm the mental health crisis team was contacted. The service had policies, risk assessments and record notifications which were utilised when women showed signs or had a history of previous mental health concerns. This meant that all staff were kept informed of the woman's mental health status which was recorded electronically.

Staff confirmed that mental health drop-in sessions were provided for staff; another mental health update was planned for September 2023.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect women, themselves, and others from infection. They kept equipment and the premises visibly clean.

Infection prevention control (IPC) link midwife roles were present within the service. Clinical areas infection prevention control link midwives accessed additional training.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. The current pool cleaning guidance reflected current practice.

Flushing of taps helped control legionella in hot and cold-water systems. Trust records confirmed. legionella testing dates from 23 February to the 4 August 2023. The presence of legionella in testing on the 8 March 2023 was identified for the antenatal clinic, however, the service did not confirm what actions were taken in response to the legionella finding.

Staff followed infection control principles including the use of personal protective equipment (PPE). Hand rub was located throughout the unit. National Patient Safety Agency five moments to hand hygiene and hand cleaning techniques were displayed throughout the maternity unit.

The trust target for hand hygiene compliance was over 95%. Monthly hand hygiene audits and yearly hand hygiene competency assessments took place. The monthly tendable hand hygiene audits from May to July 2023 confirmed compliance ranged from 95% to 100% across the service. However, the M2 ward environmental audit dated 21 August 2023 identified hand hygiene compliance as 81.8% due to alcohol hand rub not at point of care and posters should be displayed above handwash sinks.

The trust confirmed five cases of puerperal sepsis and other puerperal infections within 42days of delivery and readmission rates for infections in mothers and babies in 2022/23. Postnatal readmissions were reviewed within 72 hours via the twice-weekly multidisciplinary incident review meeting. The only thematic trend identified from these reviews was that of raised body mass index over 35 and post-delivery wound infections and sepsis.

The trust confirmed these reviews identified good practice of treatment within the golden hour once sepsis was suspected, multidisciplinary involvement of interventional radiology and the skin integrity team. None of these incidents met the criteria for moderate harm investigation or serious incident investigation. One action to disseminate information / education to staff was created and monitored in governance meetings by the governance team and closed within date.

The service performed well for cleanliness. Tendable weekly and monthly ward accreditation audits identified shortfalls for each clinical area. Across the service the monthly tendable audits ranged from 86% (ward M2) TO 100% (Antenatal Clinic).

Cleaning records did not always confirm all tasks were completed. Cleaning checklist audits for wards M1/M2 were provided as evidence following the inspection. We were unable to see whether all checks were completed as signatures were missing on some checklists. Some checklists had no ward name identified and checks were completed from Monday to Friday only.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The 2019 maternity inspection identified the following breaches of regulation:

At the 2019 inspection we found that staff did not have local guidance for staff to follow when monitoring and responding to changes in temperature outside of accepted limits for the freezer and fridges used to store medicines and milk. At the August 2023 inspection this requirement was achieved.

At the 2019 inspection we found that staff did not complete daily checks of resuscitation equipment and document them as per trust policy. At the August 2023 inspection this requirement was achieved. We checked baby and adult resuscitation trollies on all wards we visited. Daily checks and items on them were all up to date and accurate. Daily checks on defibrillators were up to date and accurate on all wards we visited.

Resuscitation equipment check lists were also provided as evidence; however, the check lists did not identify the location name or what equipment had been checked.

At the 2019 inspection we found that the diagnostic ultrasound scanning unit in the early pregnancy assessment unit at DRI was calibrated and maintenance undertaken. At the August 2023 inspection this requirement was achieved.

Maternity

At the 2019 inspection we found that Entonox gases were not removed from birthing rooms and no atmospheric checks were in place to monitor levels of Entonox gases. At the August 2023 inspection this requirement was achieved. Labour ward rooms had scavenging systems in place to remove Entonox (nitrous oxide) gases. The Doncaster Royal Infirmary service report dated 31 March 2023 identified no concerns regarding levels of Entonox gases in birthing rooms.

At the 2019 inspection not all staff had received training in the use of hoists and written guidance was not available for staff on use of the hoist. The service provided YouTube type guidance for the evacuation of women from a birthing pool in an emergency. This guidance was practical in its nature and demonstrated how the midwifery team would move a woman from the birthing pool in an emergency.

At inspection staff did not confirm they had received training in the use of hoists, and there was no written guidance on hoist use seen in clinical areas. Following the inspection, the Trust confirmed that hoists were not used in clinical areas and all staff were required to have manual handling training.

There were no specific pool room evacuation guidelines, the trust provided photo guidance to support staff training. The service said initial training was undertaken by all coordinators and core central delivery suite (CDS) staff. The birthing pool at the Doncaster Royal Infirmary (DRI) site was out of commission for two years whilst building work was undertaken but was now operational.

The service planned to roll out training following the relaunch of midwife led pathways for all staff on the CDS and would form part of the induction for CDS. Staff would then have an annual refresh with the video guidance for the evacuation of women from a birthing pool in an emergency.

The design of the environment had suitable facilities which generally met the needs of women's families; two areas the central delivery suite and triage were redeveloped in 2023. Ward M1, the antenatal ward environment was being redeveloped.

The antenatal ward was currently incorporated on ward M2 which meant the overall antenatal and postnatal bed capacity was 26 beds. The ward had a further two beds that could be used in an emergency. There was limited space in the two-bedded high dependency area. Staff said no commissioning drills were run before the service moved into the newly upgraded maternity facilities.

The local clinical environment was well maintained. Women could reach call bells and staff responded quickly when called.

The entrance to the antenatal and postnatal ward displayed a personal welcome board which included a display names and weights of babies that had been born that month. Entry to the unit was via a bell operated entry system and close circuit television was in place.

Theatre 1 (Obstetric theatres) ventilation systems verification report dated the 20 March 2023 verification certificates confirmed the equipment had passed the checks.

Air conditioning servicing records dated December 2022 confirmed servicing of the antenatal unit and level three maternity ward air conditioning units. However, where maintenance was indicated for the antenatal waiting area, we did not see evidence which confirmed this was completed.

The service had enough suitable equipment to help them to safely care for women and babies. All portable appliance equipment had up to date testing. However, there was no evidence of daily checks on general equipment such as suction and blood pressure monitoring machines as the most up to date equipment checklist was from January 2022.

Following the inspection, the trust submitted the equipment maintenance calendar logs for 2022/23 which confirmed equipment service completion dates for maternity services at Doncaster Royal Infirmary. Service spreadsheets confirmed servicing of equipment across the service had taken place in 2022/23. However, we observed that two services in June (foetal monitor) and July (Volumatic pump) 2023 had not taken place. In addition, seven services were planned for August 2023 which were not confirmed as having been completed.

In labour ward the blood gas analyser was stored in the clean utility room.

Faulty or broken community midwifery equipment was sent to the community midwifery manager who arranged repair or replacement. Community team leaders monitored equipment that needed updating or calibrating via a spreadsheet.

The service confirmed community midwives carried a delivery pack plus bag and mask.

Placement of home birth equipment in the woman's home took place in advance of the home birth. Home birth drugs were supplied in a locked container for storage in the patient's fridge from 37 weeks' gestation. The home birth drugs, and home birth equipment were checked and signed for on a weekly basis to ensure they are complete and in date.

The trust loan worker policy provided clear guidance to ensure the safety of midwifery staff in the community.

Staff disposed of clinical waste safely and clinical and domestic waste containers were clearly labelled.

Arrangements for the control of substances hazardous to health (COSSH) were in place. On ward M2 on the antenatal unit we observed COSSH products were not always stored in locked cupboards. This was immediately escalated to a senior midwife. We went back to ward M2 later and found that the door to the COSSH room was open.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration.

The 2023 'Yorkshire and the Humber in-Utero Transfer Guideline (v5)' was produced in consultation with a transport service, local NHS Hospitals Trust, the operational neonatal network, and regional maternity colleagues. The document covered all aspects and escalation pathways associated with transfer to another provider. This document / agreement was next due for review in April 2024.

The triage pathway ensured all high-risk women went to Doncaster Royal Infirmary. Women who were high risk were seen in the triage area located within the central delivery suite where they were triaged.

Critical care was available 24/7 and the critical care outreach team was available 12 hours for 7 days a week. Maternal critical care leads liaised and planned with the obstetric unit for expected cases.

Community midwives completed PROMPT training for general emergencies. They had not received specific emergency training for home births and told us they would ring 999 in an emergency in line with trust guidance.

Staff completed sepsis training which was part of the practical obstetric multi-professional training (PROMPT) training package. Please see the sepsis training compliance levels within the mandatory training key line of enquiry.

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

Postnatal women who experienced a post-partum haemorrhage were cared for in the intensive care unit or on the labour ward dependent on acuity and dependency.

Staff handovers

Staff shared key information to keep women safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep women and babies safe. Safety huddles took place as part of the handover, with medics and sometimes an anaesthetist present.

Risk assessments

Staff completed risk assessments and psychosocial assessments were reviewed regularly for each woman on admission and on arrival. The psychological assessments were carried out on those women thought to be at risk of self-harm or suicide. The service monitored the antenatal risk assessments such as 'When mental health issues had been identified, had a plan been made, and if potential problems in postnatal period had been acknowledged'. Compliance in 2022 was 73.33% (Quarter 1) to 100% (Quarter 2).

The booking appointment was the first in a series of risk assessments undertaken at every antenatal appointment, to ensure the appropriate health professional provided the care. Risk assessments included social and medical assessment of the woman's mental health. Ongoing reviews of women's risk status took place at each appointment. Concerns resulted in consultant obstetrician referrals. We reviewed 14 women's electronic records which confirmed risk assessments took place.

During the first booking appointment the community midwife discussed and offered a range of screening tests, including blood tests and ultrasound scans designed to check the mother's health and baby's health and wellbeing.

Risk assessment of venous thromboembolism (VTE) and bleeding risk took place on admission to the service. We reviewed six women's records and saw in total eight VTE assessments documented across the six women's records. Two records had two VTE assessments documented; two other records had one VTE assessment documented. We were told that the night midwives would review these VTE assessments and escalate to senior staff if needed. The service audited women's antenatal VTE assessments; 100% compliance in completion of assessments was identified in quarters one to three in 2022.

Women's records and audit data showed carbon monoxide monitoring for all women were completed initially at booking. A pilot audit of carbon monoxide monitoring took place in October 2023; the maternity service audit confirmed 38% of 150 women, 12% of which were smokers had carbon monoxide levels monitored of these 5.8% (1) were referred. Six records showed some mothers did not have had risk assessments completed at every contact and monitoring ranged from one assessment to six assessments per women.

Deterioration tools in use

Deteriorating patient guidance, tools and specific condition guidance was in place.

Electronic tools identified women at risk of deterioration. This tool identified an electronic maternity early obstetric warning score (MEOWS). MEOWS is a system designed to allow early recognition of physical deterioration. At the 2019 inspection monitoring of women's maternity early obstetric warning scores were in place however, we were unable to ascertain whether scores were being escalated appropriately and whether patient outcomes had improved through this monitoring process. At this inspection we were told that escalation would take place to the obstetric senior house officer or paediatrician and five women's records confirmed MEOWS was scored and escalated when required.

The working copy of the documentation audit (v1) for 2022 confirmed scoring against individual criteria over four quarters in the areas of antenatal care, intrapartum, continuous electronic fetal monitoring, and post-natal care. The two postnatal MEOWS audit annual scores were 98% and 100%.

The service used the neonatal early warning score (NEWS) to aid the clinical assessment of infants. Two babies' records confirmed they had NEWS completed, scored, and evaluated. Of this one required escalation and we saw that escalation had taken place.

Safety Audits:

The trust confirmed the service had developed the 'Maternity Local Safety Standard for Invasive Procedures (LocSSIP) Outside of Obstetric Operating Theatres' guidance.

Use of surgical safety checklists for all cases in the maternity theatres took place. We were unable to observe the use of surgical safety checklist checks for caesarean sections as no women had these procedures during the inspection. Surgical safety checklists audit monitoring data from week commencing the 23 March 2023 to week commencing 21 August 2023 had taken place. The data confirmed a high level of compliance was achieved for the sign in, time out and sign out checks. Where there were shortfalls, these were identified, for example, two missed sign outs. Tendable surgical safety checklists audit outcomes from 1 September 2022 to 1 September 2023 confirmed 100% compliance for pre-anaesthetic time out and pre-incision STOP whilst, all personnel participate in sign out in full was score 95% for Obstetric and Gynae theatres.

Three women's records confirmed swab counts took place post vaginal birth, caesarean section, and suturing.

Monthly fresh eyes monitoring of intrapartum foetal monitoring reduced poor outcomes for babies. Cardiotocography (CTG) readings were interpreted through monthly fresh eyes audits. The April and July 2023 monthly fresh eyes audits reviewed 35 (April 2023 audit); 41 and 42 sets of notes (July 2023 audit). The audit data for both mostly showed an improving picture of fresh eyes reviews within 15 minutes. The April 2023 audit scores ranged from 73% (March 2023) to 74.9%. July 2023 audit scores ranged from 78.6% (May 2023) to 77.8% (July 2023).

There was some fluctuation in compliance against the number of fresh eyes reviews completed after 15 minutes and for those fresh eyes review not completed. Themes included failure to undertake fresh eyes review in the second stage of labour.

Reminders were given that fresh eyes reviews of the CTG be performed during the latent stage of labour, during induction and during the second stage of labour. Both audits identified action plans with timescales of August and up to September 2023.

Maternity

Midwifery staffing

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

The 2019 maternity inspection identified staffing shortfalls; this remained an area of concern at this inspection.

Hospital Midwives

The maternity service had an agreed funded establishment for midwives and support staff to provide minimum staffing levels to ensure safe delivery of care to the women and babies.

Daily, the supernumerary band 7 manager of the day monitored staffing levels across the service sites using the birth rate plus app, redeploying staff where necessary. The maternity escalation plans advised staff on managing situations where staffing fell below an acceptable minimum, or the workload exceeded safe working. At night the night matron who was based at home, unless required performed in an advisory role and received a handover from the day staff. Staff said this matron had to live no further that 30 minutes from the hospital.

No consultant midwives worked within the service.

The induction of labour (IOL) midwife role was currently overseen by the matron for inpatient services. Concerns remained about the lack of support to make changes identified through IOL findings. Currently, there was no cover for the IOL midwife role when absent from work.

A pay incentive was introduced to encourage midwives to work additional bank shifts to cover the shortfalls in midwives. The incentive was double time. This rate was reviewed to change the incentive offer to the harder to fill shifts, such as the nights and weekends. The community midwifery team also retained the full pay incentive rate as they remained short staffed.

The maternity service created several senior midwifery posts which provided additional support to the service. Some of these posts were: The maternal medicine post, which was shared with another local maternity service trust, vulnerabilities midwife, audit guideline midwife, project lead for Ockenden and the equity and equality lead midwife.

Staffing Levels and Acuity

Birthrate Plus is the recommended decision support tool for assessing and determining midwifery staffing levels and is used in conjunction with professional judgement to calculate the workforce required to deliver safe maternity services. A full assessment using the tool was undertaken on the case mix from September to December 2021.

The trust received the final assessment report in August 2022; presented at the trusts board of directors meeting on the 28 March 2023. The recommendation was to approve a regional approach in relation to the required numbers of registered midwives over and above the existing establishment.

The ‘Agency and Incentives in Maternity Paper – March 2023 confirmed the current funded position was 189.45 whole time equivalent (WTE) staff of which 169.04 wte were contracted; 154.18 wte midwives were at work and 14.86 wte midwives were on maternity leave which left a deficit of 35.27wte midwives. Staff confirmed maternity leave absence would improve throughout 2023 if midwives returned to work their usual hours.

Maternity

The recent birthrate plus 2022 reassessment of staffing data showed an uplift in midwifery staffing funded positions at 218.04wte, which left a deficit of 63.86 midwives. Staff sickness was not included and was approximately 8%.

The service was significantly challenged with the current vacancy and maternity leave position and by providing maternity services on two sites. The service placed all vacant shifts out for NHSP cover and achieved between 40-75% cover. The amount of agency midwives had decreased since summer 2022, and shift fill from NHSP was variable.

We asked qualified staff whether staffing levels were safe and were told they were at band 7 level. Labour ward and the central delivery suite had supernumerary band 7 senior midwives on day and night shifts and Doncaster's aim was to employ two band 7 midwives per shift.

Staffing levels were reviewed daily and at the staffing huddle on Mondays for the week ahead and Fridays prior to the weekend. Gaps in staffing were filled by the trusts own staff and bank staff; agency staff were employed if shifts were not filled by the first two staffing options.

Should the service require closure escalation to the executive team and local maternity services group took place. Senior midwives supported the acute and community services out of hours. The senior midwife on-call rotas were shared with all staff groups. The community team contacted senior managers to confirm any concerns or staffing shortfalls.

We reviewed the May and August 2023 midwifery staffing rotas for the central delivery suite and ward M2 the antenatal and postnatal ward with a staff member to ascertain what band 7 and band 6 midwife cover was present on day and night shifts. We reviewed the first and last week rotas in May 2023 and three weeks for August 2023. The staffing figures confirmed the following:

Central Delivery Suite:

- All day and night shifts were covered by band 6 and 7 midwives.
- There were 28 band 7 bank shifts identified in May 2023 which we saw were covered by the trusts own midwives.
- There were 105 band 6 bank / agency shifts on the central delivery suite in May 2023 which we saw were mainly covered by the trusts own staff.
- In August on the central delivery suite there were 118 band 6 bank shifts identified which included day and night shifts.

M2 ward:

- There were 186 bank and / or agency shifts identified on the staff rota. Staff said they worked safely, however, staffing on the ward was not safe and staff were beginning to burn out. Staff had raised their concerns recently and listening events had taken place with the senior midwifery team to listen to staff concerns.
- The band 7 midwife on M2 completed 40% clinical shifts and 60% management shifts.
- Band 6 midwife cover was confirmed on the ward in May and August 2023 for both day and night duty.

In August, staff said bank and agency usage had increased; to mitigate this risk in the last two weeks specialist midwives were rostered on the clinical areas for a day each week.

Staff shared a future staffing rota dated 2 October to the 29 October 2023 which had been partially approved for both hospital maternity sites. We saw 159 registered midwife and 112 maternity support worker shifts remained outstanding. The central delivery suite had 42 band 7 shifts outstanding on the staffing rota dated 2 October to the 29 October 2023. Staff told us that the October rotas were delayed due to a review of band 6 cover for each area which could result in some core band 6 midwives being redeployed to ensure equality of skill mix in each area.

Midwife recruitment

Recruitment of new band 5 midwives from the local maternity services regional network recently took place. This recruitment originally stood at 52 whole time equivalent (wte) midwives, however, some of these midwives had chosen to work in other hospitals so now the hospital expected 35 wte midwives to start in October or November 2023.

Staff said four band 7 midwives adverts were out at Doncaster for the central delivery suite.

Staff said there had been some international recruitment; three midwives were working in the service and four international midwives had just started work in the service and were currently being supervised as part of their induction process.

Midwife to birth ratio

To provide a safe maternity service, the Royal College of Midwives (RCM) advised there should be an average midwife to birth ratio of one midwife for every 28 births. The maternity service had not met their target of 95% for women receiving one to one care in labour at the 2019 inspection when the ratio was 1:32. At this inspection midwife to birth ratio compliance was 100% from April 2023.

Community Midwives

Maternity Community Caseload 2022/23

The maternity service paused the continuity of carer workforce model since July 2021. The Birthrate Plus Assessment report presented to the Trust Board of Directors on the 28 March 2023 said when continuity was recommenced a reassessment using the continuity of carer workforce model toolkit would take place. This was because this model of providing care had a different workforce requirement that was likely to increase. Currently, community staff told us that they employed hybrid working where staff worked two months on the maternity wards and one month in community.

The 2019 maternity inspection identified current community midwifery caseloads did not reflect the current ratio of 98 cases per wte. midwife. (National Institute for Health and Care Excellence guidance) The caseload information for midwives who worked 37.5 hours weekly ranged from 66 to 166 women per caseload. At this inspection, staff confirmed that caseloads for community midwives varied with one midwife having 106 patients on their portfolio due to staff picking up extra workloads due to vacancies within the service.

The community caseload information provided by the service confirmed community midwives' caseloads ranged from 21 (south team) to 118 (north team). However, not all community midwives worked full-time, and we observed some part-time midwives with higher caseloads, for example a midwife employed at 0.60wte in the east team had 79 woman

on their caseload as of the 7 August 2023. Overall, it appeared that all but three midwives' community caseloads were within the NICE guidance for community midwifery caseloads of 98 cases per wte midwife in the north, south, east, and central community teams. Caseloads for the three midwives which fell outside of this ranged from 99 to 118 cases per wte midwife.

The community midwives told us that they were well supported by the specialist lead midwives when this was needed. Staff described close working relationships with the community midwives.

Community midwives had an on-call escalation between 5pm and 10pm where they could be called in to support staff on the maternity wards. They gave examples of staff being called in to work outside of these hours and they would be expected to do their normal hours the following day. Staff said they were on call for home births and had no day of rest factored in following a birth even if late at night.

Women's and Children's Division Statistics:

Nursing and midwifery absence rates from 2022 to 2023 were 7.12% which equated to 807 absence occurrences.

Nursing and midwifery labour turnover rates from 2022 to 2023 were 51 staff which equated to 39.92 full time equivalent leavers. There were 54 starters which equated to 46.27 full time equivalent starters.

Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

The service had gaps in medical staff cover. Medical staff had the right qualifications, skills, training, and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

Staff confirmed that separate staffing establishments existed for both maternity units.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

We requested evidence to confirm the actual and planned numbers of consultant staff and other medical staff who worked within the maternity service and this information was not provided which meant we were unable to report on whether the medical staffing levels followed the relevant Royal College guidance.

All consultants and their teams saw women on the antenatal and postnatal wards every morning. During these ward rounds those women suitable for discharge and / or transfer were discharged or transferred. In addition, women whose care was midwife led or they had an uncomplicated vaginal delivery and intrapartum and postnatal period were reviewed if requested. Medical staff confirmed consultants were approachable and were well supported by them. Staff at different levels confirmed the workloads were quite heavy due to there being one registrar and senior house officer working overnight; although staff felt this was usually manageable.

Cross-site rotas confirmed senior paediatrician cover 24/7 to support the maternity service.

Second opinions by other consultants could be accessed easily to aid clinical decision making.

Medical staff were allocated to a 1:8 rota and said all rota slots were complete. Staff described medical rotas as manageable with on-call arrangements identified. Staff spoke of the internal use of locum medical staff when required. We reviewed the 2023 Doncaster Royal Infirmary Maternity doctor rotas which identified gaps in cover over the weekend periods. The service said all labour ward and central delivery suite shifts were prioritised which meant they were all covered with no gaps in the rotas.

Where deficits existed, locum shifts were advertised and when unable to cover the on calls rotas were prioritised. Consultants were on call during evenings and weekends.

Designated anaesthetic cover was in place for labour ward until 5pm, after this an on-call resident anaesthetist took over. They had a theatre recovery team available out of hours if needed.

Managers made sure locums had a full induction to the service before they started work.

Women's and Children's Division Statistics:

Medical and dental absence rates from 2022 to 2023 were 2.12% which equated to 96 absence occurrences.

Medical and dental turner over rates from 2022 to 2023 were 16 full time equivalent leavers. There were 24 starters which equated to 23.58 full time equivalent starters.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Women's notes were mainly comprehensive, and all staff could access them easily. We reviewed 14 women's' records and saw a variety of risk assessments were completed for each mother which included baseline risk assessments of ethnicity, comorbidities, body mass index, and those women aged 35 years and over. All blood screening test results were documented for 11 women in records we reviewed.

Mental health assessments were completed for the 11 women however, the frequency of each assessment ranged from five to 16 per for five women. Four women were asked the domestic abuse question, and the response was documented.

Five of six women had foetal movements recorded at each antenatal visit from 25 weeks.

When women transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medical team handovers took place twice daily. The handover book in the labour ward was poorly filled in and initially had no sheet identified for the 22 August 2023. Later we looked at the handover book again and saw that a handover sheet for the 22 August 2023 was present although limited information present. Some medical staff had not always completed this document at the start of the shift.

Mental health team referrals for mothers were through the electronic K2 system to the mental health nurse and midwife.

Midwife led referrals took place, for example, for babies with a tongue tie condition would be referred to the infant feeding team who in turn would refer the baby onto an NHS Trust to treat this condition.

When the mother and baby were discharged home their details were added to the ward discharge book. Daily checks of discharges ensured discharge information was shared with the mothers GP, community midwife and health visitors. In addition, should the mother come from out of area their midwife was contacted.

Each baby's red book was completed and given to the mother. The babies blood screening results were entered into the red book and electronically on the K2 system. Staff said the screening midwives also checked that relevant blood screening had taken place prior to the baby's discharge home.

When advanced care planning was required, the bereavement midwives supported the mother and family.

Medicines

We observed shortfalls in some of the service systems and processes to safely prescribe, administer, record and store medicines.

Staff had not always stored medicines including substances hazardous to health securely. On day one of the inspection doors although lockable were left open which meant people could access medicines. We escalated this practice immediately to the senior midwife who escalated this to the wider team during the safety huddle.

We continued to find shortfalls in medicines management systems on the Doncaster Royal Infirmary site some of which included:

Locks and keypads to doors were seen to be broken or were not working.

Entry into the M2 clean utility room could be accessed from the walk-in stock cupboard which posed a potential risk of medicines being accessed by non-staff members. The walk-in stock cupboard doors opened onto a public corridor.

Unsecured medicines trolley, oxygen, and Entonox cylinders. On day three of our visit, we revisited the modular build utility room and saw the medicines trolley was secure but medicines bottles within the trolley were not dated when opened. Medicines undated included paracetamol suspension, lactulose and peptic. Medicines used for the treatment of post-partum haemorrhage, Misoprostol foils were not in their original packaging, and we could not read the expiry date on the foils.

Some oral medicines in the central delivery suite had no date of opening identified. Drug strips were loose from their original packaging which included metformin, buscopan and peppermint tablets.

Staff said oxygen when used was rarely prescribed. It is important that where oxygen is used that it is prescribed by a specialist practitioner after a clinical review and documented on the mother's prescription chart.

Poor key management practice, the controlled drug keys were not separate from the main medicines' keys on the central delivery suite and keys were seen hanging from an open cupboard door which stored antibiotics and other drugs in the clean utility room, which was open next to the antenatal ward. The antenatal ward incident was escalated to the midwife who removed the keys and shut both doors.

Tamperproof seals were not present on emergency boxes and not all emergency boxes were checked daily. Ward M2 had emergency boxes for hypoglycaemia, cord prolapse, sepsis and pre-eclampsia. There was no record of daily checks being undertaken on the boxes. The cord prolapse box, pre-eclampsia box and the sepsis box stated that an emergency medicine was missing from each box on 19 July, these had still not been replaced at the time of the inspection.

Ambient room temperatures were not monitored in rooms where medicines were stored despite the room feeling warm. On the 24 August 2023 the stick-on thermometer read 26 degrees. Guidance states that ideally all medicines storage areas would be controlled between 15 degrees centigrade and 25 degrees centigrade. This is because some medicines may be affected, and it is important the maternity service contact their pharmacist for advice.

Fentanyl solution infusion bags were being decanted by staff into syringes. This practice was escalated with the maternity team as this was not usual practice and staff were advised these syringes should have been destroyed.

Staff said the pharmacy had advised them to draw the fentanyl up into 10ml syringes for epidural use from the intravenous fentanyl bags. We were told the reason for the bolus dose was because the anaesthetic team did not use patient-controlled analgesia pumps or intravenous infusion equipment and an investment would be required to purchase this.

Staff said they did not agree with this practice. A standard operating procedure (SoP) from pharmacy to support this procedure was not in place; staff said the SoP was being developed. We were told the trust had taken immediate action when this issue was raised. Following the inspection, the trust said there was an SoP in place at the time of inspection, but on review of the SoP when the issue was identified they amended it immediately. Following the inspection, the trust told us they had purchased new infusion pumps for this purpose.

Aromatherapy oils and carrier oils which should be stored separately were stored in the same medicines cupboards as traditional medicines.

There were discrepancies in the date of the oromorph solution. The date of opening on the bottle was 9 September 2023, but when we looked at the CD book the date of the new bottle opening was the 9 July 2023. The oromorph bottle contained 86.3ml which would match the date of the 9 July 2023. This suggested that the date recorded on the bottle was inaccurate and added after the bottle was opened.

It is important that the correct opening date is identified on the oromorph bottle as it should be used within 90 days of opening and any that is left after this returned to the pharmacy for disposal. We reviewed the oromorph controlled drug records and noted that there was one missing date of administration and three missing times of administration from the 9 July 2023 to the 22 August 2023.

Intravenous fluids were stored in boxes on the floor in the larger clean utility room and the emergency drugs box was on the floor behind the door and was noted to be very dusty. The risk was that this drugs box could have been removed by an unauthorised person due to open access to the box. We escalated this to staff who then placed the emergency drugs box on the dressing trolley which had emergency equipment on it.

Women's discharge medicines were stored in an unlocked cupboard. Some discharge medicines had dispensed dates prior to the visit so could not be assured that these women were given the discharge medicines to continue at home. The types of discharge medicines included antibiotics, deltapararin which is a prophylactic medicine used for VTE prevention and di-hydrocodeine which is a pain killer. We saw that the medicines to take home were over labelled with the mother's details identified, for example name, dose, and frequency of medicines daily.

Eclampsia drugs were in a taped box which did not have a tamper proof seal and were in ward M2 unlocked clean utility room. The pre-eclampsia algorithm identified magnesium sulphate and labetalol which is a beta blocker and identified it should be prepared in a bag; no pre-prepared labetalol bags were in the eclampsia box. If this is not local practice the algorithm may need to be reviewed so that it matches local practice.

The M2 ward controlled drugs (CD) cupboard of a double cabinet in construction. We saw methadone dispensed on the 20 June 2023 had no open date written on the label. We were aware methadone should be discarded 28 days after opening as it may no longer be safe. This was escalated to the midwife who then dated the methadone the 20 July 2023 which meant it should have been discarded as we found this on the 24 August 2023. The central delivery suite CD cupboard external door was locked; however, we observed the cabinet was not bolted to the wall.

All fridge checks were completed daily.

Staff completed medicines records but had not always kept them up to date as we found that reasons for dose omissions were not always recorded on three patient drug charts. We reviewed another seven medicines charts and noted that all the necessary sections were completed. We found that allergies were recorded were appropriate on all drug cards.

Peer medicines management audits were undertaken by pharmacy technicians who also completed a quarterly controlled drugs (CD) audit; the last CD audit on M1 was 28 July 2023 which confirmed 78.6% compliance. A new issue was identified, 'the 'Received by' section of the Requisition book is always signed.'

The last monthly medicines management audit took place on the 13 July 2023 on M1 which confirmed 93.8% compliance. The shortfall related to Are the recorded temperatures between 2oC-8oC? This was because temperatures outside the range had been recorded.

For both above audits we did not see any action plans in place.

At the 2019 inspection the patient group direction (PGD) paperwork did not clarify which midwives had completed competencies in this area and who were currently approved to carry out this task. At this inspection we saw midwives training documentation which was signed and dated by them and their assessor to confirm they were competent to give PGDs. Patient Group Directions (PGDs) were in use within the maternity service and had been signed and dated by midwives. The overall responsibility for the organisation, monitoring, and reporting of the trusts safe and secure handling of medicines lay with the chief pharmacist. However, responsibility for compliance against policy requirements rested with the management team of the division.

All PGDs were reviewed by the PGD review group, which was a sub-group of the drugs and therapeutics committee, following approval of the drugs and therapeutics committee, its chair requested approval from the trust lead clinician for clinical governance.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Maternity

Managers investigated incidents thoroughly and women and their families were involved in these investigations. Managers debriefed and supported staff after any serious incident. Staff said feedback was shared locally and at team meetings.

Daily reviews of all incidents highlighted which incidents met the 72-hour review criteria. The local maternity network service proforma was completed for case review and presented at the incident review meeting (IRM) on Mondays and Thursdays. If escalation was required, an email was sent to the trust patient safety incident investigation team to arrange a date for review and invite the consultant who has assisted with the IRM review. At this meeting a decision was made as to whether the incident was moderate or serious incident status.

Staff said monitoring of incidents took place through weekly incident and notes audits.

Senior managers and executive team members had completed training in serious incidents; most had attended a five-day course.

Oversight of SIs was through the governance and risk midwife. The governance team had oversight of incidents, actions and end dates and contacted the relevant handler to see if they required support. The serious incident panel met weekly to discuss SIs. All SIs were flagged at the divisional governance meeting and when closed agreed through divisional governance meetings.

Staff reported serious incidents (SIs) in line with trust policy. Trust wide evidence confirmed that nine serious incidents were identified within the children and family's division for 2022/23 and 2023/24. These incidents were closed in January 2023. Two incidents were referred to the Healthcare Safety Investigation Branch (HSIB). The outcome of the HSIB investigations identified that no root cause was identified, and the incidents were closed. Learning and recommendations were identified for each of the incidents, however, it was not evident of the progress made against each recommendation.

Six SIs were reported in 2023, two of which in June and August 2023 were identified as a HSIB investigation. The August 2023 incident identified that the HSIB investigation was declined, and a potential internal investigation would take place. The June 2023 HSIB referral investigation was identified as ongoing. We observed that both incidents had a duty of candour letter sent within 10-days of the initial discussion.

Escalation of incidents was discussed at the divisional governance board. Those incidents which required escalation were presented to the trust board and children's and families board for further discussion/review.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation when things went wrong. Staff we spoke with were aware of their responsibilities in relation to the duty of candour and incident reporting. Staff said incidents were reported through the incident reporting system, for example in the antenatal clinic the largest number of incidents related to antenatal screening.

Multi-agency involvement ensured women and their babies safeguarding needs/incidents were identified and these needs were met. Safeguarding concerns flagged up on the woman's electronic record to alert members of the multidisciplinary team.

Staff met to discuss the feedback and look at improvements to patient care; feedback was shared locally and at team meetings and incidents discussed at the clinical governance meetings.

Maternity

The bereavement midwife documented the loss of a baby through the incident reporting system. The labour ward lead, governance lead and governance midwife completed the MBRRACE – Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK form which was shared at the trust peri-natal mortality meeting. Baby deaths were tracked through the weekly peri-natal mortality meetings with a video link facility took place between Doncaster and Bassetlaw hospitals.

Trust 'National Perinatal Mortality Review Tool (PMRT) audits dated 20 April 2023 and 10 May 2023 confirmed eight perinatal deaths at Doncaster Royal Infirmary (DRI). The maternity monthly dashboard confirmed two perinatal deaths in April 2023 and one perinatal death in July 2023 at the DRI site.

Is the service effective?

Good ➔➔

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

Evidence-based care and treatment

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

Staff followed policies to plan and deliver high quality care according to evidence-based practice and national guidance. The service audit guidelines midwife worked with the multi-disciplinary team to ensure guidelines were kept up to date. Policies were standardised across the service.

The maternity clinical guidelines group met monthly and was chaired by the consultant lead for guidelines and the clinical governance midwife as deputy. The clinical governance administration and clinical governance lead consultant co-ordinated the review and posting of all operational policies and clinical/non-clinical guidelines. Three clinical guidelines were out of date. This guidance included: prevention of early onset of group b streptococcus infection, (January 2022), neonatal hypoglycaemia (September 2023) and newborn infant physical examination (July 2023). The DBTH Short Risk Register identified out of date maternity guidance and policies as an extreme risk.

Staff confirmed guidance was in place for women who wanted to receive care outside of current guidance.

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

An example of monitoring of women's care was confirmed after the review of women's notes which confirmed 'Fresh Eyes' of cardiotocography was performed for three of the six women who required this process during their birthing session.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural, and other needs.

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. The Making Mealtimes Matter' initiative meant all non-essential ward activity stopped during the meal service and all activities shifted to support patients to eat.

Staff fully and accurately completed women's fluid and nutrition charts where needed.

Staff completed nutritional assessments on all women on their admission to the service. Women's records showed that initial advice on diet, folic acid was given when they booked into the service.

Specialist support from staff such as dietitians was available for women who needed it.

Women confirmed they were happy with the variety and choice of food on offer at the hospital.

Water jugs and disposable cups were available for women's use in clinics and by beds.

Facilities were available for breast and formula feeding mothers.

Infant feeding advice was available for parents which advised on breast feeding. Peer support groups provided additional support.

Pain relief

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

Staff were able to access guidance to assist them when caring for women in labour which included guidance on pain management, for example, Guidelines for the Care of Women in Labour and Guidelines for Epidural Analgesia in Labour (v3).

Anaesthetists provided a 24-hour epidural service which staff confirmed provided quick responses to staff requests for pain relief for women.

Staff prescribed, administered, and recorded pain relief accurately.

Staff used the maternity early warning score (MEOWS) to assess women's pain and gave pain relief in line with individual needs and best practice. We saw MEOWS pain scores recorded in four women's records. The 2022 MOEWS audit confirmed 100% of women's pain was documented and escalated if required in labour.

Staff used pictorial communication tools for woman and families who had difficulty communicating.

Staff discussed all pain options and women received their preferred choice of pain relief.

Women said they had received their preferred method of pain relief pain relief quickly after requesting it and were aware of the types of pain relief available which included epidural, nitrous oxide (Entonox) and intramuscular pain relief. Women confirmed assessment and management of their pain and pain medicines received was well managed by staff.

Maternity

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women. The service was working towards accreditation under relevant clinical accreditation schemes.

To improve patient outcomes the service developed a better birth maternity improvement plan which identified core competencies midwifery and medical staff were expected to achieve over a three-year period; year one was 2023/24. Twelve competency modules were identified with the expected targets, monitoring systems and action plans were to be identified. The competency modules included the saving babies lives care bundle, smoking in pregnancy, neonatal basic life support and fetal growth restriction. As this is a new initiative it is too early to confirm whether patient outcomes have improved.

The July 2023 service action tracker monitored progress against ten safety actions identified by the clinical negligence scheme for trusts (CNST) a maternity incentive scheme to support the delivery of safer maternity care. Each safety action had a designated operational lead, monthly compliance levels identified, actions required and supporting evidence. The tracker was red, amber, green rated. Progress against safety action eight which related to training plans, inhouse and one day multi-professional training was mostly rated red as most areas were identified as non-compliant, and most training compliance levels fell below 90%.

The service had full accreditation for Baby Friendly Status awarded in July 2017 by the United Nations International Children's Emergency Fund (UNICEF). The UNICEF UK Baby Friendly Initiative supports breastfeeding and parent infant relationships by working with public services to improve standards of care.

The trust was reassessed on the on 24-25 May 2023 and 27-28 June 2023 for UNICEF UK Baby friendly initiative accreditation. The outcome of this assessment identified the service fell short of some standards for re-accreditation. A follow up assessment or further evidence was needed and that plans should be made for this by March 2024.

Managers shared and made sure staff understood information from the audits and ensured that improvement was checked and monitored. One example was monthly ‘fresh eyes’ audits and the outcomes have been reported in the reports assessing and responding to patient risk section.

The service participated in relevant national clinical audits and a comprehensive programme of repeated audits to check improvement over time. We saw a copy of the ‘Obstetric & Maternity Audit Plan 2023/24’ which was split between following audit drivers: National, Ockenden, Saving Babies Lives, National Institute of Clinical Excellence (NICE) and Local.

The audit programme was also informed by the outcomes of the Healthcare Safety Investigation Branch report findings, outcome of labour audits and audits on the management of 3rd or 4th degree tears.

The outcome from the 3rd or 4th degree tear audit carried out from May to October 2022 conclusion said improvements were needed; there was inadequate documentation for reason of delay of repair within one hour and limited documentation of type and duration of antibiotics and laxatives. Recommendations and an action plan were created with a plan to reaudit for 1 December 2023.

The induction of labour (IOL) midwife undertook monthly audits of IOL outcomes which were shared with staff. We were told there was no obstetric oversight of this process. When necessary, staff contacted the consultant / on-call consultant for advice. Monthly audit results confirmed when IOL clinical guidelines were not followed reasons were captured and confirmation of consultant involvement identified.

Competent staff

The service made sure staff were competent for their roles. Appraisal processes were in place, however not all staff had been appraised. Professional Midwifery Advocates held supervision meetings with midwifery staff at their request to provide support and development.

The 2019 inspection of the maternity service identified shortfalls in staff appraisal completion against the trust target of 90%. At this inspection staff appraisal completion statistics for all staff groups confirmed that the trust target was not achieved. The 2022/23 appraisal statistics for nursing and midwifery staff were 81.83% (46 were due, 201 staff appraisals were completed) whilst 25.64% of medical staff (10 appraisals were completed, whilst 29 appraisals were due.)

Managers gave all new staff a full induction tailored to their role before they started work which was confirmed by the midwives we spoke with. Staff said new starters completed a waterbirth study day. Medical staff spoke of local inductions and a six-week shadowing time introduced the doctor to the service. One doctor said they had not had a separate trust induction.

Staff had an identified mentor and preceptor and were supernumerary for two to four weeks dependent on their personal needs and role. Newly qualified midwives followed a three-week preceptorship programme. New doctors also completed an induction prior to working in the unit.

A core competency framework was agreed yearly with the local maternity and neonatal system which identified the module, target, training details and monitoring for a three-year period. The service provided a blank copy of this document, so we were unable to ascertain what progress was made against the core competencies identified for the maternity service.

Managers identified the training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff discussed their training needs with their line manager and were supported to develop their skills and knowledge.

Professional midwifery advocates supported midwives and could also provide supervision if requested by the midwife.

- Midwives and medical staff completed revalidation processes to remain on their professional registers.

The service was supported by a band 7 education lead midwife and two part-time clinical band 6 (1.2 whole time equivalent) midwives. Two midwifery clinical educators covered both hospitals. The clinical educator reported monthly reports on medical staff / staff training compliance and circulated this information to key people throughout the service.

The education team's responsibilities included the midwifery preceptorship programme, organisation of multi-professional training and the updating of staff who worked within maternity. Training was based upon requirements from national guidance and because of incidents, complaints, and claims. We saw staff training captured on a database that logged the individual's engagement and progress with professional development and skill maintenance.

The education priority was to deliver face to face training over the midwives first year. The clinical skills included, venepuncture, cannulation, intravenous additives, speculum use, epidural top-ups, catheterisation, and perineal repair competences.

The service supported students on placement and maintained close links with the Universities.

Staff maintained their expertise pertinent to their role, for example, specialist midwives and community midwives worked within the acute service should there be staffing shortfalls or to maintain and develop their expertise further in specialist areas, for example, diabetes, bereavement.

Simulation training across the maternity service included shoulder dystocia leading to neonatal resuscitation, cord prolapse in theatre leading to preterm neonatal resuscitation, maternity pool evacuation and baby abduction scenarios. We saw the training attendance records for all the simulation training exercises undertaken.

Junior medical staff gained skills through completion of rotational posts, accessed mandatory training/teaching sessions, such as K2 training and the practical obstetric multi-professional training (PROMPT) training package. Educational supervisors supported the doctors and some doctors said they had sufficient supervision and regular meetings with their supervisor. In addition, Friday afternoon teaching sessions and a half day per week for professional development was protected. However, other senior staff we spoke with said they had no protected sessions for continuous professional development agreed, although did have protected time to meet their educational supervisor.

Multidisciplinary working

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

Doctors, nurses, and other healthcare professionals worked together as a team and held multidisciplinary meetings to benefit women and provide good care. Involvement of the multidisciplinary team was documented within women's records we reviewed. Joint working took place between maternity and neonatal teams prior to and post the baby's birth.

Multidisciplinary attendance at twice daily safety huddles took place across the clinical areas within the service. Staff worked across health care disciplines and with other agencies when required to care for women, for example, paediatricians and anaesthetists worked closely with the obstetricians and midwives.

The anaesthetic and obstetric teams worked closely with the intensive care consultant and critical care outreach charge nurse. There was 24-hour availability of anaesthetists in the maternity unit and anaesthetist attended daily handover sessions.

The specialist diabetes antenatal clinic included the diabetes specialist midwife, the consultant, and dieticians.

Midwife sonographers at Doncaster Royal Infirmary completed growth scans.

Midwifery staff worked closely with safeguarding, learning disabilities and mental health teams when supporting vulnerable women, for example, joint working took place between the maternity, neonatal, safeguarding, and paediatric teams. when young women under 16 years of age entered the service.

Staff referred women for mental health assessments when they showed signs of mental ill health.

Domestic abuse discussions took place and were documented in four of the six woman's records we reviewed. Staff confirmed that confirmation of domestic abuse instigated a referral to the safeguarding team, women's GP's, and health visitors.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Women were reviewed by consultant's dependant on their care pathway.

Consultants were resident on call from 8.30am to 5pm and on non-resident from 5pm to 0830am.

Consultant presence on the maternity unit meant emergency/non-emergency admissions were seen within 14 hours of arrival in the hospital.

Consultant anaesthetist cover was available from 8am to 6pm Monday to Friday. Resident anaesthetist or middle grade anaesthetist provided cover from 5pm to 8.30am Monday to Friday. Weekend anaesthetic cover was provided by a consultant anaesthetist who was on call from home and middle grade anaesthetists from 8am to 8pm and overnight from 8pm to 8am.

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

The early pregnancy assessment unit opened from 8am to 5pm Monday to Friday.

Maternity triage was provided by designated staff in the triage unit located within the central delivery suite.

Health Promotion

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

Three specialist midwife's primary purpose was to support and work with women to ensure they received the appropriate care and support, during and post pregnancy.

The maternal medicine specialist midwife primary purpose was to support the development and implementation of pathways and services for women requiring access to specialist care for significant pre-existing medical conditions during pregnancy.

The pelvic health midwife supported and reduced the number of women living with pelvic floor dysfunction in England postnatally and in later life.

The public health midwife role was to develop, implement and manage all elements of the public health agenda to improve women's wellbeing, promote healthy lifestyles and tackle inequalities.

To meet national priorities to improve health the service implemented a comprehensive local maternity network service equity and equality action plan schedule dated March 2023. The action plan identified key deliverables, success measures, trust lead and red, amber, blue, and green rating status. The areas currently rated red related to some data collection and parent information which was currently under review.

Maternity

Clinical areas displayed information promoting healthy lifestyles, health promotion and support.

Free parent education programmes were available for women, partners, birth partners, family, and grandparents to attend across both hospital sites.

Carbon monoxide readings were offered to all women at booking. All women who smoked, or had high carbon monoxide readings, were offered referral to the smoking cessation service.

Staff completed medical, social, and psychological assessments on women to individualise support for each woman. Ongoing assessment reviews took place to monitor changes to health and social status and where necessary safeguards were identified.

Assessment of maternal mental health needs continued throughout, and post pregnancy and women were signposted to support, when necessary, for example, talking therapies, peer support.

Whooping cough and flu vaccinations could be accessed by pregnant women.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit women's liberty.

At the 2019 inspection we found that staff did not demonstrate a good understanding of mental capacity, best interest, and deprivation of liberty. Staff were unable to demonstrate they knew how to support women who lacked capacity to make their own decisions. At this inspection staff were able to demonstrate a good understanding of mental capacity, best interest, and deprivation of liberty.

The trust confirmed that Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) training was part of the adults safeguarding level 2 e-learning module. The trust has identified this was no longer sufficient content to meet the recommendations within the intercollegiate document. As part of the mental health training launch a new package was being adopted. As MCA/DoLs training was combined with L2 adult safeguarding training the trust was unable to report on this separately.

We were told that the ongoing work around MCA and DoLs within maternity would be led by the equality & equity midwife in association with the safeguarding team.

When patients could not give consent, staff made decisions in their best interest, considering women's wishes, culture, and traditions. Staff gained consent from women for their care and treatment in line with legislation and guidance and made sure women consented to treatment based on all the information available. Staff clearly recorded consent in the woman's records.

Staff told us they always asked for verbal consent before providing any care or treatment and documented this in the patient's records.

Maternity

Staff said women's mental health was assessed on entry to the service and throughout their pregnancy. If any concerns about the women's mental health were raised, they referred the woman to the mental health service. Where women had pre-existing mental health needs ongoing liaison took place with mental health professionals.

Is the service caring?

Good

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

Compassionate care

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

Observations of staff interactions with women confirmed that staff were respectful and took time to interact with women. Staff were discreet and responsive and took time to interact with women and those close to them in a respectful and considerate way.

Staff understood and respected the personal, cultural, social, and religious needs of women and how they may relate to care needs. We spoke with six women and their partners. They all said that they had excellent care and spoke highly of the staff and how hard they worked.

One new mum told us that she was grateful that her partner was allowed to stay overnight once baby arrived. Another, women described how caring and kind the staff were, they described good care and confirmed their needs were attended to- quickly.

Staff followed policy to keep women's care and treatment confidential. Women said, and we observed that staff had kept them informed in all care and discharge decisions.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs.

Staff knew how to access medical and psychological support for women with mental health needs.

Emotional support

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

Staff gave women and those close to them help, emotional support and advice when they needed it, and chaperones were available to women.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Bereavement study day compliance for 2023 confirmed 57.8% (111) midwives and 42.6% (32) maternity support workers had completed this training.

Bereavement services were available for all families experiencing loss. Families could make an entry into a special memories book in the hospital chapel if they wished. However, staff were sensitive to their needs and acknowledged that not all women would want a reminder of their loss.

Bereaved parents could access support through the bereavement midwife, the chaplaincy and counselling services. The trust bereavement lead midwife worked across site and was a great support to the wider team. The lead had secured funding to develop the new bereavement suite that was due to open on the ward. Access to this bereavement suite allowed parents to spend time with their baby. A cold cot was available in the room to place the baby in which allowed the woman / parents additional time spent with baby. Memory boxes and clothing for baby was also provided.

The lead told us how they helped families make memories by providing a pram to walk to the baby loss garden. They also secured funding for photo frames, and they make casts of babies' hands and feet for parents to frame and keep.

The lead told us of the recruitment of specialist pregnancy loss nurses for pregnancies below 16 weeks who were based in the early pregnancy assessment unit.

Staff in the early pregnancy advisory unit offered support and counselling to patients following a miscarriage. Information packs were offered to women/couples following a miscarriage.

Guidance was in place for the surrogate pregnancy journey to ensure that plans were in place for antenatal planning, labour, and the postnatal period. The safeguarding team were informed of changes to plans so the families achieved the best outcomes from the arrangements in place.

Understanding and involvement of women and those close to them

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

The maternity service at Doncaster and Bassetlaw Hospitals included a 'Maternity and Neonatal Voices Partnership' which was a group of women, birthing people and their families, healthcare professionals, commissioners, and others who collaborated to make improvements to maternity services. Leaflets informed women and their families about this service and how they could become involved.

Women were also signposted to external information from the Royal College of Obstetricians and Gynaecologists, for example, coronavirus, pregnancy, and women's health and National Institute of Clinical Excellence guidance.

Women were also signposted to information provided through Tommy's pregnancy hub a midwife-led information hub which covered everything about having a safe and healthy pregnancy, from conception to birth. The information was presented in either written or video formats.

Staff made sure women and those close to them understood their care and treatment and supported women to make informed decisions about their care. Staff talked to women in a way they could understand, using communication aids where necessary. We observed clear communication of options discussed with a woman and the multidisciplinary team. The woman's understanding was checked throughout the discussion and questions answered.

Maternity

Women received information and could access a wide selection of information leaflets through a variety of sources, for example, women who attended the pregnancy advisory service were given an information package.

Weekly antenatal workshops advised women of the methods of induction of labour, informed consent and the other options women had should they not want an induction of labour. Staff said currently plans were not in place to present this information in alternative languages.

Women and their families could give feedback on the service and their treatment and staff supported them to do this.

Is the service responsive?

Good

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

Service delivery to meet the needs of local people.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

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

To meet the national priorities to improve health the service implemented a local maternity network service equity and equality action plan schedule dated March 2023. Some key deliverables were specific to core groups, for example, local demographics of women that have complex social factors.

Changes to the service incident form allowed demographic information capture, for example, to add/capture complainants ethnicity, vulnerabilities, and protected characteristics as mandatory field (Deaf, Disability, Non-English Speaking, Decile of Deprivation). This evidence was presented as a blank form which did not confirm the agreement that this change had yet been actioned.

Maternity voices leaflets were displayed throughout the service to encourage parents to join the group to help shape maternity services in Doncaster and Bassetlaw. The January 2023 MVP 'Chairs Monthly Update' confirmed progress made in several areas, for example, community outreach initiatives.

The trust had two maternity units which provided midwifery led care, with the option of a home birth service for low-risk pregnancies. Pregnant people who choose to give birth in hospital will 'book' at either Doncaster Women's Hospital or Bassetlaw Hospital.

Antenatal care was provided in the community setting, in GP surgeries, at home or in one of the four hospitals.

The community midwives told us about the diverse communities they covered and gave examples of how they contacted language line to help with communication. They had an excellent understanding of the needs of all communities in their area.

Maternity

Facilities and premises were appropriate for the services being delivered. The central delivery suite and triage at Doncaster Royal Infirmary (DRI) had undergone a £2.5 million refurbishment. The works began in May 2022 and was completed in March 2023.

The works included a full refurbishment of the suite's birthing rooms, as well as the creation of a new welcoming reception and waiting area, and the opening of the first midwifery led birth centre. The delivery suite included a fully equipped obstetric observation area to support women who required additional observations and a large well equipped Triage department. The new area provides a more comfortable and home-like environment, with the option of a birthing pool.

In addition, the midwife led antenatal assessment unit operated from the unit and opened from 9.00am to 5.00pm Monday to Friday and from 8.30 to 4.30 on Saturday and Sunday. Staff on site included one band 6 midwife and one healthcare support worker.

Ward M1 had a new bereavement suite, which was currently not in use due to the lack of staff. The bereavement suite had a family sitting area, children's books, and a foldable double bed to allow for a hospital bed and a kitchen area. Since the inspection we have been informed that this facility is now in use for antenatal and postnatal women and families. Currently, protocols and a risk assessment are being developed to support its full use.

Funding for some infant feeding support workers was obtained via healthy lifestyle meetings.

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

Managers monitored and took action to minimise missed appointments. Staff confirmed a 'do not attend' follow-up process was in place for those women who did not attend their outpatients' appointments.

Meeting people's individual needs

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

Some staff identified concerns around mothers and babies care having been compromised as mothers did not always receive breast feeding support or help with making their babies bottles.

Staff said the biggest ethnic group in the Doncaster area included the Gypsy and Roma all of which were hard to reach groups. The demographic was 96% white British and white European. Staff said they had worked with these groups to develop leaflets sensitive to their needs as they preferred cartoon images rather than graphic photos.

There was a large deaf community in the area, so the trust had funded sign language training for key staff.

The lead midwife for equality and equity had been involved in the addition of the equality and deprivation index to incident reviews.

Staff said the vulnerable women guideline had recently been updated.

Guidance was in place which related to the disposal of pregnancy remains.

Maternity

The summary report for divisional governance on maternity interpretation services (July 2023) identified several actions required to improve the patient experience in this area. Work was ongoing against some actions, whilst others were completed. Ongoing actions included working with maternity voices to seek service user feedback from targeted groups to understand needs and how this should inform service provisions.

The service had information leaflets available in languages spoken by the women and local community. Information leaflets could be requested in other languages or formats.

Managers made sure staff, women and their loved ones and carers could get help from big word face to face interpreters, telephone language interpreters or signers when needed. Staff described good access to translation services via telephone.

Women were given a choice of food and drink to meet their cultural and religious preferences**.** Wards had hot drinks stations that patients and family could use.

A hearing induction loop and pictorial information was available which staff could access as communication aids to help women become partners in their care and treatment.

Mobility assessments were completed on women with limited mobility to ensure the necessary aids were provided for those women. Women could use their wheelchairs to access the wards and delivery suite.

Staff understood and applied the policy on meeting the information and communication needs of women with a disability or sensory loss.

Staff made sure women living with mental health problems and learning disabilities, received the necessary care to meet all their needs. Women's individual needs such as learning disabilities, autism spectrum, communication or mental health needs were identified when they were first seen at antenatal clinic/early pregnancy advisory unit and were reassessed at each contact.

Staff could access emergency mental health support 24 hours a day 7 days a week for women with mental health problems and learning disabilities. If women showed signs of anxiety or depression staff referred women to the 'Improving Access to Psychological Therapies' (IAPT) services which provided evidence-based psychological therapies to people with anxiety disorders and depression.

Specialist midwives were available to support women who experienced substance abuse, mental health needs and domestic abuse. Flexible clinic times were given to women attending appointments with the substance misuse midwife and vulnerability midwife and if late they were still seen.

Specialist midwives provided teenage pregnancy support, bereavement support, infant feeding support, weight management and diabetes support. Antenatal and new-born screening midwives and clinical specialist midwives for labour and care during birth could be accessed.

When transitional care was required, babies were cared for in the neonatal unit whilst the mother remained on the post-natal ward. The highlight report for transitional care dated July 2023 identified that the programme key milestone status was amber rated and as yet compliance against the key measures identified had not been achieved. A milestone deadline of September 2023 was given.

Maternity

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.

Mothers could self-refer by post, over the phone or online. Completed pregnancy registration forms automatically went to the maternity records department so that the mother to be added to the maternity system. The community midwifery team was notified and arranged booking appointments within two weeks, which was confirmed by an appointment letter sent to the mother-to-be.

Antenatal care through the midwifery services commenced at the woman's initial antenatal appointment which took place from eight to 12 weeks dependent on when the woman initially presented with pregnancy and women with complex medical needs seen earlier.

The booking midwife decided whether the woman was high/low risk against identified criteria which identified whether the women received consultant/midwife led care. For example, if the woman was considered high risk so would receive consultant led care.

During the first booking appointment the community midwife discussed and offered a range of screening tests, including blood tests and ultrasound scans. Tests included blood pressure checks, urine and blood testing and the women's due date was confirmed. These were designed to check the mother's health and baby's health and wellbeing.

Staff made referrals to tertiary centres for cardiac problems, cleft palate, and genetic conditions.

Managers made sure women could access emergency services and ensured they received treatment. Staff supported women and babies who were referred or transferred between services.

We observed escalation processes and critical care support provided through the adult intensive care unit, however, were told that staff did not have midwifery critical care training in the ICU.

The enhanced care room in the new delivery suite had two beds, an incubator, cot, and other equipment which we observed could make it difficult to access the bed in an emergency. Monitoring of women's conditions was via the modified early obstetric warning system, neonatal early warning system scoring and K2 electronic recording of observations. The 'fresh eyes' process was also in place and was supported by a band 7 midwife.

The nurse led early pregnancy assessment unit (EPAU) saw women in the first 16 weeks of pregnancy. Referral to the service was by the GP community midwife or by self-referral. The aim of the service was to see patients either referral day or the next day. Scanning was undertaken in the EPAU following which scan results were discussed with the women.

The dedicated triage area was based on floor 6 within the new central delivery suite. There was immediate access to a consultant, registrar/senior house officer who supported the service. Staff confirmed that three midwives managed midwifery triage during the day and two midwives managed triage at night. The triage saw women whose pregnancies ranged from 17 weeks. The triage admission criteria ensured that women received treatment by the right team in the right place and the calls taken by the community midwife were through a single point of access process. Staff said the triage pathway ensured all high-risk women went to Doncaster Royal Infirmary.

Maternity

Staff said women were triaged over the telephone at Doncaster Royal Infirmary. The service used the Birmingham symptom specific obstetric triage system (BSOTS) a system based on established triage systems in emergency medicine and used an assessment with clinical prioritisation of the common reasons that present within maternity triage. The service had administrative support based at the reception desk.

The triage suite operated 24/7. The waiting area for women was noted to be out of sight of the midwives as the triage office door was closed. The waiting room described the BSOTS but did not advise women what to do if their situation changed and we observed no buzzer system in place which would alert the triage midwife if they were needed. Since the inspection the Trust has confirmed there is a notice advising women what to do if not seen in a timely manner or if situation changes.

The triage comprised of a three-bedded bay which ensured ongoing care was provided to women however, we observed no allocated midwife was stationed in this bay and as the door was closed the women in the bay were out of the line of sight of midwives if they remained in this room. Staff said the K2 technology collected patients' details, recorded phone calls, and recorded red, amber, and green ratings for each contact but the K2 system did not support the BSOTS reporting of grade or risk. We also observed there was no oversight of, cardiotocography (CTG) or clinical scenarios. Staff said the plan was to have central monitoring in place to allow ongoing oversight, however, timescales for this were not given.

The trust shared a BSOTS audit for week commencing 7 August 2023 the outcome confirmed 193 women were booked to be seen, five women did not attend and there was missing data for 38 women. Of the 150 women who had data available, 97% were seen within 15 minutes of arrival to triage however due to 20% missing data during this audit an overall compliance rate of 76% was recorded. The audit outcome confirmed staff shortages had affected achievement of BSOTS targets. Along with no core triage staff on some shifts, which lead to a lack of recording the correct data for the audit. One of the action plans recommendations from this audit was the recruitment of four triage staff.

The induction of labour (IOL) midwife confirmed no delays in admitting women to the antenatal ward; however, delays were experienced when moving the women to labour ward for their artificial rupture of membranes. Bed capacity was assessed 24/7 and women could be asked to come in at any time of the day. Staff said there were reduced beds at Doncaster Royal Infirmary due to the merger of wards M1 and M2 and this was identified on the risk register.

The wards had merged due to the refurbishment which was ongoing for the antenatal ward. Staff from the local maternity services, labour ward and the antenatal ward worked together so women's' induction of labour could commence. Staff said four women had labour induced daily over a six-day period, except for Fridays. Induction of labour was not offered in the outpatients' department only on the inpatient maternity wards.

For women who had an elective caesarean section the service had allocated four days for this service where three women had their elective caesarean sections performed. Two theatres and the gynaecological theatre were available for use. Should there be an over capacity of caesarean sections a Thursday list was activated. The booking of caesarean sections was now completed by band 6 staff who were able to assess and schedule women appropriately. These women were admitted directly to the maternity ward after their antenatal pre-assessment.

Staff said the service was suspended the Saturday prior to the inspection on both sites and the escalation process had included the executive team and commissioners. On this occasion, both units were assessed hourly until it was safe to reopen them. Closure was due to capacity and activity over both hospital sites.

Maternity

Learning from complaints and concerns

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

The service clearly displayed information about how to raise a concern in patient areas. Women, relatives, and carers knew how to complain or raise concerns. Patients and families were offered a face-to-face meeting to discuss their complaint.

Managers investigated complaints, identified themes, and shared feedback from complaints with staff and learning was used to improve the service. Staff understood the policy on complaints and knew how to handle them and told us that they tried to resolve patient concerns before they became a formal complaint. Staff said women received feedback from managers after the investigation into their complaint.

The women's and children's division report confirmed 102 complaints throughout 2022/23; the data provided was not broken down to show how many of these related to the maternity service at Doncaster Royal Infirmary. Complaint themes included care, behaviours, and communication issues.

The first claims, complaints and incident data report were published in June 2023. The report reviewed maternity service data to assist the service to direct resources to make the biggest impact in improving safety in maternity services. The complaints section of the report identified 41 complaints received in 2022; from 1 January 2023 – 30 June 2023 the service received 20 complaints across the service. The themes associated with these complaints were not identified.

Is the service well-led?

Requires Improvement ➔➔

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders understood and managed the priorities and issues the service faced. They were not always visible in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Maternity services were within the children and family's division. Clear lines of accountability existed within the maternity service. The lines of accountability included a divisional director, clinical directors, a divisional manager, business manager, director of midwifery, head of midwifery, equity, and equality lead and four midwifery matrons. The four clinical directors were split across the maternity, children, and community services. In addition, supporting services included education and clinical governance leads.

Midwifery matrons worked across site. The midwifery leads included the head of midwifery, community midwifery manager, quality and safety manager, labour ward managers and inpatient matrons.

Specialist midwives worked across the service.

Staff we spoke with were unhappy about the lack of support they perceived to be provided by the senior management teams. Some staff said senior midwives and managers were not visible on the clinical areas. Senior staff said they had additional Microsoft teams calls to staff to try to support staff and answer any concerns. The pastoral team and health and well-being teams were also available to provide staff with additional support. Following the inspection, the Trust confirmed daily planned visits by the matron, twice weekly by Head of Midwifery, plus planned weekly visits from governance team and pastoral team.

Medical staff confirmed that consultants were approachable and said they would return to the trust if they left to work elsewhere.

Leadership development for senior midwifery and obstetric staff was ongoing through the trust leadership course which staff confirmed presented opportunities for training and development into more senior roles. The divisional leadership team were also taking part in the national perinatal leadership culture programme.

The education lead worked closely with the Director of Midwifery to identify professional development needs based on the Trusts strategic plan and succession planning requirements.

Some staff told us that the trust had development opportunities for all grades of staff, with funded courses available for staff to allow for career progression. Staff were supported through Maths and English courses, which resulted in automatic progression to the higher pay band once completed.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust vision was 'to be the safest trust in England, outstanding in all we do.' Four objectives originated from this vision, one of which included to provide outstanding care and improve patient experience. To deliver the four main objectives four breakthrough objectives were identified for 2022/23, for example, objective one was to maintain and improve CQC ratings by achieving improvements in quality and outcomes. The trust vision and values were displayed throughout the maternity service.

The draft maternity strategy (2023-2027) was confirmed by the service to be in line with the three-year delivery plan for maternity and neonatal services (March 2023) and aligned with the Doncaster and Bassetlaw Teaching Hospitals, nursing, midwifery, and allied health professionals' quality strategy 2023-2027.

The maternity draft strategy identified six strategic themes which identified objectives and measures against each theme. Growing, retaining, and supporting our workforce also featured within the strategy.

This strategy had been shared with all senior staff; we were told that the strategy would now be shared with the remaining staff groups so they could input into the strategy. It was suggested that the strategy should be finalised by the end of 2023.

Maternity

Culture

Locally staff felt respected but did not always feel supported and valued by the wider leadership team. They focused on the needs of mothers and babies receiving care but recognised that they could not always accommodate all mother's needs. The service promoted equality and diversity in daily work. The service had an open culture where patients, their families and staff could raise concerns.

Senior staff said the culture and working relationships had improved across the Doncaster and Bassetlaw maternity units over the last one to two years as staff now worked across both sites; band 7 staff worked together when escalation was required to ensure appropriate measures and support were in place. Senior staff said how proud they were of all the maternity staff across both maternity units and recognised the support staff provided by having worked additional hours.

The M2 staff said they were proud of their team who worked well together and were well supported by their ward manager and medical staff described a supportive culture. Staff we spoke with mostly felt supported. However, some staff told us that the staffing pressures meant they were very overworked, and this often made them feel undervalued. Some staff told us that they did not feel well supported by leaders above matron level. They also told us that whilst matrons were often visible on the ward, they did not feel that they actively supported them during times of heavy workload pressures.

Concerns were also raised about the visibility of some of the senior midwives.

Some staff we spoke with raised concerns about their experiences working within the maternity service over the last 12-months. Staff said they felt on occasions they had been shouted at and said only the small stuff was addressed.

Staff said there had not been enough staff; on occasions the antenatal side of M2 had been staffed by an untrained member of staff. Staff said on occasion one staff member worked on the antenatal area on M2 whilst two staff were allocated to the postnatal area. Staff said they struggled to get sufficient staff per shift and at times junior newly qualified band 5 midwives were allocated to the antenatal area on M2; staff felt this was not right as these staff were too inexperienced to work alone.

Staff said a staff meeting had taken place on the 7 August 2023 where staff from across the Doncaster maternity service attended and their concerns were raised at this meeting.

The M1/M2 2023 staff survey identified low staff morale, cultural issues and staff felt they were not always supported. Poor feedback was received on working relationships with managers with scores which ranged from 8.3% (My immediate manager takes effective action to help me with any actions I face); community team feedback on this area was 62.9%. There were higher scores of 50% and 68. 6% for community staff (my immediate manager values my work and takes a positive interest in my health and well-being. In addition, 25% of staff said they had experienced harassment, abuse or bullying from other staff and managers; whilst 66.7% had experienced this from patients and relatives. The staff survey presentation confirmed measures to improve working relationships and to show how staff were valued, for example the star of the month initiative, staff meetings, wellbeing team, counselling services and monthly newsletters.

Most staff were aware of and said they could access freedom to speak up guardians, colleagues and/or managers to raise concerns. However, some medical staff were not aware of the freedom to speak up guardians.

The bereavement lead midwife told us that she was very well supported with her wellbeing and was able to access reiki and alternative therapies through the trust.

Governance

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

We saw evidence of a local maternity and neonatal system which aimed to standardize and share good practice through weekly and monthly meetings. Senior staff confirmed direct access to the trust board and named people were accountable for actions within the governance team.

The head of midwifery oversaw governance with the support of a divisional governance lead. Staff said the maternity neonatal partnership chair attended maternity governance meetings and had recently attended the guideline meeting with the maternity neonatal partnership co-chair.

The director of midwifery oversaw the effective implementation and application of all midwifery related trust policies, procedures, and standards within the service. However, we observed not all policies and procedures were in date which the service had identified as an extreme risk on the Doncaster and Bassetlaw Teaching Hospitals (DBTH) Short Risk Register.

Staff confirmed the governance culture had started to embed within the midwifery team and understood their responsibility for service quality and patient safety and mechanisms to monitor patient safety, measure clinical outcomes and other quality measures were in place. Medical staff said they had been encouraged to attend governance meetings and participate in clinical audit. Cardiotocography (CTG) meetings took place twice weekly.

The monthly maternity clinical audit meeting reviewed local and national standards for maternity services and developed the annual audit programme. Medical staff said they were encouraged to undertake clinical audit.

The trust board had oversight of performance of antimicrobial prescribing and stewardship. Staff said the service was alerted by email. The alert was discussed at the maternity governance and children's and families trust boards following which actions were communicated back to the ward managers and teams.

The midwifery and medical staffing establishments were monitored closely through several committees including the children and families' board. Ongoing staffing updates were documented in the different meeting minutes we reviewed. These meeting minutes included: the divisional clinical governance meeting held on the 12 May 2023, clinical governance committee of the 19 May 2023 and maternity and gynaecology services clinical governance committee minutes dated 23 June and 28 July 2023.

Staff said reporting of 'red flags' was mainly through Birthrate Plus. Currently, the post-natal birthrate plus tool was being redeveloped by the manufacturer these flags were captured through the incident reporting framework. An example of a red flag would be when a supernumerary shift coordinator was no longer supernumerary due to undertaking 1:1 care would be recorded as a red flag.

The community matron attended the operational meetings where any committee issues were raised and later discussed at the maternity governance meeting.

Maternity

Management of risk, issues, and performance

Leaders and teams had systems to manage risk and performance however, we were unable to ascertain whether all risks, issues and performance were managed effectively. Risk escalation processes were in place; risks and performance were discussed at trust board level and plans were in place to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

During the 2019 inspection of the maternity service, we found some area's performance was either not monitored or gaps in monitoring existed. At this inspection we inspected how the service managed risk, issues, and performance again and reviewed the previous gaps identified at the 2019 inspection to ascertain what progress had been made.

Previously, some risks to the service, were not included on the current risk register or recognised by the leadership. These risks included training shortfalls and equipment monitoring / calibration and maintenance shortfalls. At this inspection most equipment had been monitored, calibrated, and maintained as per guidance. However, on M2 there was no evidence of daily checks for suction machines; the most up to date equipment checklist was from January 2022.

On the central delivery suite scavenger systems to remove nitrous oxide (Entonox) gases were now present in all rooms women delivered in and monitoring of nitrous oxide gases had last taken place on the 31 March 2023.

At the 2019 inspection the trust training target of 90% for all staff attendance at mandatory and safeguarding training sessions was not achieved. At this inspection training compliance remained below 90% in most areas.

At the 2019 inspection surgical safety checklist audits had not taken place; at this inspection we saw surgical checklist audits had taken place.

At the 2019 inspection the patient group direction (PGD) paperwork did not clarify which midwives had completed competencies in this area and who were currently approved to carry out this task. At this inspection we received training records for those midwives across the service who had completed PGD competency training. The training documentation did not confirm whether the midwives were based at specific hospital locations.

Although, we saw improvements in how the service monitored risk and performance at this inspection some areas required ongoing improvement. These areas included mandatory training attendance, staff appraisal completion, medicines management and midwifery staffing.

Medical staffing evidence requests were not received despite repeated requests. This meant we were unable to ascertain whether there were risks within these areas.

<u>Risk Management:</u>

The Director of Midwifery oversaw implementation and application of all midwifery related trust policies, procedures, and standards within the Division with professional responsibility for ensuring compliance with the policies. The Director of Midwifery also advised on risks that required escalation onto the trust corporate risk register and advised on actions required to mitigate those risks.

Local and South Yorkshire agreed maternity services network escalation policies were in place.

Staff described no senior support for community midwives out of hours. We were told of a situation where two community midwives handled a home birth emergency without access to senior support. The immediate learning from

the recent incident was that staff were not suitably trained for home birth emergencies. The outcome was for staff to have monthly resuscitation training; however, this had not commenced, and current neonatal life support training compliance for community staff was below 50%. Since the inspection the Trust had confirmed there was always a senior maternity manager on call out of hours. During the incident referred to the senior maternity manager was not contacted.

Risk management guidance was in place at trust level and within the maternity service. The maternity service document was the Maternity Services Risk Management Strategy (v8). The maternity and gynaecology risk register formed part of the specialty Clinical Governance Group and was reviewed and updated monthly at the Maternity and Gynaecology Clinical Governance Forum.

Trust risk registers captured trust wide risks which scored 15 and over. The description, controls, risk level, description of work in place to reduce the risk, review date and risk owner were identified. The risk register was reviewed and updated monthly. We saw and staff confirmed the maternity risks identified on the children's and family division risk register were on the trust risk register. The top three maternity risks identified on both risk registers were: lack of elective section slots at Bassetlaw District General Hospital, Midwifery staffing levels and out of date maternity guidance and policies. The current rating for these risks was 15, 16 and 20 were rated as extreme risks on the children's and family division risk register and high risks on the trust risk register.

Highlight reports confirmed the Quality and Effectiveness Committee were kept informed of progress made against the safety actions identified and how this impacted the Trusts clinical negligence scheme for trusts (CNST) status. The Quality and Effectiveness Committee latest board minutes dated the 7 August 2023 confirmed progress and compliance status against safety actions 1,5,6,7,8, 9 and 10. The milestones identified on the report were red, amber, green (RAG) risk rated.

Action notes confirmed the trust board of directors were kept informed through feedback from the maternity safety champions. The maternity safety champions met to share information, provide a forum for discussion of maternity and neonatal safety issues, agree local actions, and as required escalated safety issues to the board of directors following the bimonthly executive and non-executive director safety champions walk rounds. The maternity safety champion action notes dated 20 July 2023 recorded the concerns raised, actions and updates, the lead person and completion dates. One concern raised related to 'indications for induction of labour do not always follow the unit guidelines.' Part of the agreed action was to continue monthly induction of labour audits and share at governance meetings.

Monitoring of policies was through committees and groups, for example, the clinical governance quality committee (CGQC) was responsible for the operational aspects of clinical risk, clinical governance, and patient safety risks. Divisional or corporate directors and managers had identified leads in risk and training within their respective areas.

The maternity service reported into national reporting systems in the event of an adverse outcome meeting the set criteria; NHS Early Resolution Scheme (ERS), Perinatal Mortality Review Tool (PMRT), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE).

The perinatal mortality and morbidity group met monthly to review incidents within the previous month where mortality or morbidity was highlighted.

Trust wide corporate business continuity, major incident, severe weather, and a pandemic influenza plan were in place to advise staff should any of these events occur.

Maternity

Staff Handovers:

Safety huddle discussions included safeguarding, incident reports, staffing (medical and midwifery) took place throughout the service took place twice daily. However, triage staff said there was no safety huddle in place in their area, instead they attended a cross site staff meeting. This was via a team's link for staff on the Bassetlaw site. Medicines management shortfalls were escalated to the wider teams who were asked to check their clinical areas to ensure these shortfalls were not present and if so to ensure they were actioned.

Information from these meetings informed the staff and senior teams of any potential risks and was used to inform the situation, background, assessment, and recommendation (SBAR) communication tool. SBAR was audited and we observed an improvement from the 2021 audit figures as compliance throughout 2022 for antenatal handovers was 100%.

The operational pressure escalation level (OPEL) status for the maternity unit on day one of inspection was OPEL1 which indicated that patient flow could be maintained, and the trust were able to meet anticipated demand with available resources.

Some staff said the matron of the day also visited clinical areas to identify problems and provide support. However, other staff we spoke with identified that senior midwives and managers were not visible on the clinical areas.

Maternity Dashboard:

The maternity services dashboard was used to monitor performance. The dashboard contained a range of performance measures which were colour coded green, amber, and red dependant on progress made against the target. The current maternity services dashboard (July 2022 to July 2023 confirmed the RAG status and thresholds of 30 key indicators. We observed that 16 indicators were rated red either for the whole of the time or on specific months for that indicator. We looked at each hospital site to ascertain whether there was a trend for the indicators viewed and noted most red ratings at Doncaster Royal Infirmary related to following initiatives:

- Smoking
- Breast feeding at initiation.
- Induction rates for both maternity services were generally above the 32.8% threshold.
- Assisted Birth - 3rd/4th degree birth tear – at Doncaster the range fell between 4.5% (July 2023) to 16.7% (February 2023). The red threshold range was identified as over 6.05%. These statistics were discussed monthly at the governance meeting. The trust confirmed that the professional midwifery advocate led in this area since 2019. A pelvic health lead midwife (0.6 WTE) commenced in post on 4 September 2023, their role was to lead change related to all pelvic health including 3rd & 4th degree tears.

The service introduced the saving baby's toolkit and had identified a 'saving babies' lead midwife. Each element in the toolkit had an identified specialist midwife who led on the action plan and delivered compliance for the area. Staff said the saving baby's toolkit was used as a dashboard and to-date the maternity service had achieved 50% of the key performance indicators associated with the dashboard. The midwifery matrons undertook monthly monitoring through tendable audits, whilst the audit leads audited weekly.

Maternity

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Information was not consistently submitted to external organisations as required.

Medical staffing evidence requests were not received despite repeated requests. This meant we were unable to ascertain whether there were risks within these areas.

The Caldicott Guardian ensured personal information about those who used its services was used legally, ethically, and appropriately, and confidentiality maintained.

The service submitted information to the NHS Resolution Early Notification Scheme. One incident was reported in the time-period 1 April 2022 to 31 August 2023. This incident was to be investigated through the Healthcare Safety Investigation Branch.

K2 technology collected all the relevant patient details right from the start.

Quarterly data was submitted to the Yorkshire & Humber Clinical Expert Group. The monthly dashboard used the K2 electronic record system which rated the key indicators via a colour coded (green/amber/red) traffic light approach.

Information governance and duty of candour were covered within the statutory and mandatory training programme. In addition, all staff had confidentiality statements within their contracts. Patients received a leaflet on duty of candour.

The trust information technology (IT) department supported IT needs. Safeguards were in place to ensure the security of patient information. Access to IT systems was password protected and following discharge women's notes sent to an off-site secure storage facility.

Currently, the figures which related to women undergoing induction of labour were recorded in a paper diary on labour ward which staff said was planned to be moved to an electronic process in the future.

Community midwives had no issues connecting to the internal computer systems when out in the community. Community midwives had mobile phones, dongles, and laptops. If the system failed completely the business continuity plan was to revert to paper, and upload retrospectively.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The 'Maternity and Neonatal voices partnership' (MNVP) was a team of service users, service user representatives, midwives, doctors, and commissioners; a representative of which sat on the local maternity service steering group. MNVP met quarterly to review and contribute to the development of local maternity services, quality standards and clinical risk. The committee ensured women's views were considered in any decisions made about changes in local maternity service. Action plans from complaints and clinical incidents were a standing agenda items at this meeting.

Maternity

Collaboration with local commissioners / stakeholders and local communities took place; the maternity neonatal partnership chair and co-chair were funded for 15 days monthly. These meetings were well attended by some but not all local users. Antenatal education was available for all groups, dads and hard to reach groups. The lead community midwife continued to work closely with the maternity voice's partnership. The equality lead worked closely with travellers and hard to reach groups.

The Picker 2022 Survey Response / Action Plan Update - August 2023 confirmed a response rate of 27% for Doncaster and Bassetlaw Teaching Hospitals (83 responses of a possible 307). For the top five scores the service scores had improved from the 2021 survey with scores that ranged from 73% to 100%. The bottom five scores included having enough information, partner involvement and being offered a choice of where to have the baby. The action plan following this survey was in development.

Patients were encouraged to provide feedback on their experience of the service using a friends and family feedback form. The form asked patients what was good about their care and what could be improved. Monthly friends and family tests results were displayed in clinical areas. Positive feedback was displayed in clinical areas from women and their families.

The 2023 staff survey resulted in a report and action plans specific to the inpatient and community maternity teams; each team had a designated action plan in place. Both maternity teams had identified morale concerns through their responses to the staff survey when asked questions about their job, for example relationships at work are strained. Both action plans were undated and identified no leads for the action areas identified. Staff said staff feedback sessions were given post survey.

Staff said the service had just completed the Safety, Communication, Operational, Reliability and engagement (SCORE) survey. This survey was an internationally recognised way of measuring and understanding the culture that existed within the maternity teams. Following this the service would have structured action plans to inform them of how to proceed.

We were told that night staff meetings took place before the morning handover took place whilst day staff meetings took place after handover. Teams' meetings were held for the Doncaster and Bassetlaw maternity units at 12am. Additional staff meetings had recently taken place due to staff morale issues. Please refer to the detail in the culture section.

Staff said the Head of Midwifery walked around the service once or twice weekly. Teams' meetings were to be introduced so that midwives could attend and speak with senior midwives.

Staff said the maternity safety champion completed monthly walkarounds of the service and the Chief Executive Officer was visible across the service.

Learning, continuous improvement and innovation

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

The central delivery suite and triage at Doncaster Royal Infirmary (DRI) has undergone a £2.5 million refurbishment as the area was updated and modernised. The works, began in May 2022 and included a full refurbishment of the suite's

birthing rooms, as well as the creation of a new welcoming reception and waiting area, and the opening of the first midwifery led birth centre. The delivery suite included a fully equipped obstetric observation area to support women who need additional observations and a large well equipped triage department. The new area provided a more comfortable and home-like environment, with the option of a birthing pool. The area was completed in March 2023.

A new nursing role was introduced to support families with early pregnancy loss. The early pregnancy loss (EPL) role was covered one day per week by specialist nurses who worked closely with the bereavement midwives, patients and their families affected by early pregnancy loss up to 16 weeks. The role included signposting women and their families to emotional support and counselling, as well as practice advice and information on available services and resources.

In 2022, Doncaster and Bassetlaw Teaching Hospitals Charity launched 'The Serenity Appeal', a fundraising initiative to provide a specialist bereavement suite on the maternity ward. On the 15 June 2023 the trust opened the Serenity Suite.

Capital funding had provided monies for equipment replacement throughout the service.

The service has a one-bedded midwife led unit based on level 6 led by a senior midwife at the Doncaster site.

Retford Hospital

North Road
Retford
DN22 7XF
Tel: 01777274400
www.dbh.nhs.uk

Description of this hospital

Doncaster and Bassetlaw Teaching NHS Foundation Trust provides acute services for 420,000 across South Yorkshire, North Nottinghamshire, and the surrounding areas. The trust employs over 6000 staff.

The trust provides a range of outpatient and community services at Retford Hospital. Services provided at Retford include: outpatient department, physiotherapy, speech therapy, chiropody, audiology, child health, community occupational health, community nursing/equipment loans, continence service, dental, genito-urinary medicine, intermediate care and medical imaging.

Diagnostic imaging

Good ↑

Is the service safe?

Requires Improvement →←

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

Mandatory training

The service provided mandatory training in key skills to all staff but did not always make sure everyone completed it. Training for autism had not been received by staff at the time of the inspection.

Staff received but did not always keep up-to-date with their mandatory training, with compliance rates at an average of 87% against a trust target of 90%.

The mandatory training was comprehensive and met the needs of patients and staff. Staff were provided with training specific to their job role, this meant they received the required training relevant to their role.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, and dementia. The trust had appointed learning disabilities ambassadors into each area, these staff received enhanced levels of training and delivered learning sessions in their own teams. They attended overall trust meetings with ambassadors from other parts of the trust. The autism training for staff had not been held yet but was planned to be rolled out later in 2023 for all staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers told us they can view this on a dashboard to see overall compliance in training as well as individual results and due dates.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it, but this was not always kept up to date and was below the Trust training target.

Staff received but did not always keep up to date with training specific for their role on how to recognise and report abuse. The compliance for training across the trust in diagnostic imaging was at 87.5% completion in safeguarding training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. The Trust had a specific safeguarding team that staff could contact at any time for concerns and referrals.

Staff could access safeguarding advice via the trust's lead nurse for safeguarding and staff explained this would be through Bassetlaw site as there was not a specific contact at Retford Hospital for this. Staff explained some vulnerable patients may come to the department with a signed consent form from the referrer if they were unable to give consent themselves. If these patients did not attend (DNA) staff would send a DNA report back to the referrer.

We reviewed the trust's safeguarding adults at risk of abuse and neglect policy which was in date (April 2022), version controlled and had a review date of Feb 2025.

Cleanliness, infection control and hygiene

The service did control infection risk well. Although staff did not use equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean, although there were no cleaning records available for this.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Staff did not provide any records to show cleanliness of equipment had been checked, however they gave us verbal assurance this did happen. We were told that all rooms and public areas were cleaned daily by hospital domestic staff.

Staff followed infection control principles including the use of personal protective equipment (PPE). There was no available hand gel to use at the main entrance or on the journey through the hospital into the department. We raised this on site on the day for this to be changed and had verbal assurances that it would be.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff disposed of ultrasound gels in bottles at the end of every day. Sonographers cleaned and disinfected ultrasound probes before use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

There were no emergency call bells available. Although all patients attending at Retford Hospital were outpatients, so no patients were acutely unwell.

The design of the environment followed national guidance. There was clear signage throughout the departments where x-rays room were used and there were controls to restrict access to patients and staff.

There was no resuscitation trolley in the department for an emergency.

There was level access from the main entrance and clear signage at the main entrance guiding patients to the department. Patient letters advised them which entrance to use, and we spoke with one patient who confirmed this and had felt the department was easy to locate.

Staff carried out daily safety checks of specialist equipment. Staff provided servicing and maintenance documents for all equipment. Staff were able to raise any immediate concerns to managers who took action to rectify faults quickly. We spoke to two sonographers on site, and they confirmed they were responsible for safety checks on machines and shared what their process was.

Staff completed quality assurance (QA) checks on all equipment.

Diagnostic imaging

The service had suitable facilities to meet the needs of patients' families. The waiting area also contained a small, seated area specifically for children. There were no water facilities in the department, we asked staff about this, and they shared if a patient asked for water, they would provide one for them if needed.

The service had enough suitable equipment to help them to safely care for patients.

Sonographers raised with us that there is only one monitor in the scan room, so this made it difficult for staff going between screens. Staff told us this has been raised for some time and there was a second monitor on order.

Sonography equipment had been risk-assessed and portable equipment tested to ensure the safety of staff and patients. Specific testing and reporting on equipment included ultrasound machines.

Staff disposed of clinical waste safely.

We did not receive equipment safety testing records for this site in our data requests, but we did see on site that two computer monitors were out of date for testing with 2016 and 2018 being the due dates.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks.

Patients attending Retford Hospital were all outpatients and none were acutely unwell.

The escalation process for patients who became unwell was to call 999. Although not all staff were able to confidently articulate the escalation process if a patient became unwell or was deteriorating.

We saw a sign on the wall at diagnostic imaging reception advising that the nearest resuscitation trolley was in the outpatient's department. This was a significant walk from the diagnostic imaging department and had 5 sets of double doors before reaching the location of the trolley. The staff in outpatients were also unaware that their trolley was to be shared with another area, and that their department was not always open therefore there could be times the trolley could be locked away in outpatients. We observed this happen during our inspection and the trolley became unable to be accessed as the department had closed.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used a standard document for all ultrasound examinations consistently across all sites. This document was uploaded to the patient record and there was a standardised process to check patient identification.

Staff knew about and dealt with any specific risk issues.

Staff shared key information to keep patients safe when handing over their care to others. Images and reports were made immediately available to all referrers and clinicians. Previous images and reports were also available to help staff check previous findings for clinical checks and comparison.

There were no shift changes and handovers during each day as it was the same staff team daily with 9am-5pm opening hours.

Diagnostic imaging

Staffing

Allied health professional (AHP) staffing

The service had enough staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of staff needed for each shift in accordance with national guidance.

Managers made sure all bank and agency staff had a full induction and understood the service. We saw examples of the this during our inspection on site, with information provided to all staff to ensure they understood the service. Staff were not placed to work at this location if they were newly qualified due to lone working.

Staff told us the service at this location ran clinic times based on staff availability and would need to close if staff were unavailable. There were no records of recent closures for this reason, as the trust had just re-opened this location after a period of closure.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, although not always stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. We saw staff were able to access patient records easily during our inspection.

When patients transferred to a new team, there were no delays in staff accessing their records. The record system was accessible and reliable, and images could be viewed and reported on remotely by all registered clinicians. We reviewed 10 patients records and these were completed appropriately and in line with service and national guidelines.

Records were not always stored securely. Staff accessed records using their own login and password, but we observed a computer left unlocked and directly facing a patient on a scan bed during our inspection.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. This matched the incident policy that the provider had in place.

The service had no never events.

Managers shared learning with their staff about never events that happened elsewhere. Staff attended meetings and discussed learning from incidents across the region.

Diagnostic imaging

Staff reported serious incidents clearly and in line with trust policy. We reviewed the incident log and saw appropriate action had been taken and correct reporting followed.

Staff understood the duty of candour. Staff we spoke with described the duty of candour during the inspection well and understood the importance of putting it into practice.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

Managers investigated incidents thoroughly. We reviewed the radiology incident log and all actions taken were clearly recorded across the trust.

There were no incidents recorded at Retford Hospital over the last year as the site had been closed and had re-opened just before we inspected.

Is the service effective?

Inspected but not rated

We do not rate effective in diagnostic imaging, however we found:

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. All policies and guidelines were stored on the trust intranet. However, not all policies had been reviewed within the timescales they should have been.

Nutrition and hydration

There was no water machine in the department, but we were told by staff that they would give patients a drink of water from the staff room taps if needed and asked for at reception.

Patient outcomes

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

The service participated in relevant national clinical audits.

Managers and staff used the results to improve patients' outcomes.

Diagnostic imaging

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Staff told us they participated in regular audits and that these were shared in team meetings with actions for improvements. However, audits were limited as the hospital had only recently re-opened.

Managers used information from the audits to improve care and treatment.

Managers shared and made sure staff understood information from the audits.

Improvement was checked and monitored.

Competent staff

The service made sure staff were competent for their roles. Managers appraised some staff's work performance although compliance rates were below the trust target. They held supervision meetings with them to provide support and development.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. All new staff followed the trust competency framework where staff must perform several observed procedures to gain competency in that area. Designated supervisors approved and signed off the competency framework. Sonographers told us the department supported them to complete competencies.

The service was committed to developing the skills, knowledge and competence of its students, staff, and managers. Students enjoyed their placements and took up permanent posts once trained. All staff were able to make use of opportunities to learn, develop, and share good practice.

Managers gave all new staff a full induction tailored to their role before they started work. We saw examples from the Head of Imaging of welcome emails sent to new staff. These included a full welcome PowerPoint, including details of the radiology senior management team and the local rules for them to read prior to commencement in their role.

Newly qualified staff told us the department had offered them a good level of competency training.

Managers supported staff to develop through yearly, constructive appraisals of their work, although compliance rates for appraisals were at 71.04% for the trust overall within diagnostic imaging.

The clinical educators supported the learning and development needs of staff.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. There were multiple opportunities to attend team meetings including through Teams. Notes were always available and shared following these meetings.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Mandatory training had to be up to date for staff before additional training could be undertaken.

Managers made sure staff received any specialist training for their role.

Diagnostic imaging

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

There was no staff available on this site with any chaperone training.

Multidisciplinary working

Staff worked together as a team to benefit patients. They supported each other to provide good care.

Staff could contact Bassetlaw Hospital at any time to discuss issues and to get support for sonographers if needed.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff were shared across trust wide locations and regularly worked across the different hospital locations. Staff told us they felt this was beneficial to understanding the ways of working across the trust sites and that they worked better as a result of this.

Seven-day services

Services at this location operated between Monday – Friday 9am-5pm as diagnostic outpatients' clinic only.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas. We specifically saw 'Stop Smoking' information available in the waiting areas.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

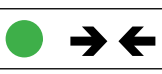
Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained verbal consent from patients for their care and treatment in line with legislation and guidance. Sonographers understood their roles and responsibilities to gain consent for ultrasound.

Staff made sure patients consented to treatment based on all the information available.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Mental Capacity Act and Deprivation of Liberty Safeguards training was part of the Safeguarding Level 2 e-learning module for all staff. The Trust were in the process of changing this to become part of the mental health training being launched and this was in the process of being adopted.

Is the service caring?

Good 

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

Diagnostic imaging

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. All staff including reception staff, were observed to be compassionate and respectful to every patient who used the service. Patients told us that staff were friendly, and we observed this in action during the inspection. We observed that all staff introduced themselves when patients were called from the waiting area, for their appointment.

Patients said staff treated them well and with kindness. We spoke with two patients, and they all felt staff provided caring treatment towards them.

Staff followed policy to keep patient care and treatment confidential. Patient records were kept safe and in line with policy. Conversations were held with patients in private consultation rooms with the door closed. This meant the information regarding the patient was confidential.

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

Staff collected patients from waiting areas and took them to private changing facilities.

Staff spent time with patients and those close to them to give explanations about their care and encouraged them to ask questions.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff giving reassurance to patients in a calm and relaxed manner.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. We observed staff providing care before, during, and after procedures and showing consideration to patient's emotions, allowing them time to ask questions or comply with requests. Staff were aware some positioning could be uncomfortable and allowed patients to be independent or made adjustments where possible.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families, and carers in a way they could understand, using communication aids where necessary. Staff shared with us examples of alternative communication methods such as drawing for ease of understanding in certain patients when needed.

Diagnostic imaging

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There was a box in the waiting area for patient feedback cards.

Patients gave mainly positive feedback about the service. We saw the results of the most recent patient survey broken down by speciality. We saw the results of the most recent patient survey broken down by speciality. Results were mainly all either good or very good in the responses received.

Is the service responsive?

Good

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

Service delivery to meet the needs of local people.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

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

The departments were accessible for people with limited mobility and people who used a wheelchair.

Reporting was electronic, and the department used paperless methods to reduce time and administration.

Managers monitored all targets and reported to the trust board through their overall performance reports.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion.

Facilities and premises were appropriate for the services being delivered.

The service had systems to help care for patients in need of additional support or specialist intervention. There was a hearing loop system in place and systems for interpreting when needed.

Managers monitored and took action to minimise missed appointments.

Managers ensured that families of children or vulnerable patients who did not attend appointments were contacted.

There was a free bus service provided for patients between hospital locations where needed and this was pre-bookable.

Meeting people's individual needs

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

The main waiting area also included a children's seating area.

Diagnostic imaging

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. We saw examples of this during our inspection, and staff were able to tell us about this.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. These were arranged in advance when the requirement was known about, but staff knew how to access this for any requirements on the day.

Access and flow

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

Managers monitored waiting times, but patients could not always access services when needed and did not always receive treatment within agreed timeframes and national targets. Referral to treatment (RTT) rates were measured against national targets for all patients on cancer pathways, two week waits, urgent and planned care, and routine images.

Diagnostic waiting times in the service showed patients waiting longer than national targets set in these areas. Non-Obstetric Ultrasound (NOUS) was performing at 93.99% of its 95% target. Nerve conduction tests were performing at 87.12% and additional sessions have been scheduled in the service with 95% performance expected from this by 31 March 2024.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

Managers worked to keep the number of cancelled appointments to a minimum.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Appointments at this service were booked on a 20-minute basis.

Learning from complaints and concerns

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

Patients, relatives, and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. The hospital had a complaints policy, which staff accessed on the intranet.

Diagnostic imaging

Managers investigated complaints and identified themes. Learning was shared across the hospital in the daily morning huddle, monthly head of departments meeting, clinical governance meetings, and quarterly departmental team meetings.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Retford had no complaints as it had only recently re-opened.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice.

We saw forms were available for providing feedback and that there was information on how to complain.

Is the service well-led?

Good

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Staff described managers as being approachable and available. Staff knew how to contact managers at any point when they needed too and felt able to do this.

Managers provided clear leadership and were highly valued by staff we spoke with. Managers were keen to retain staff and invested in education for staff to progress. There was a radiology manager in post who staff felt supported by and who told us they were keen to support staff progression. An example of this was for the apprenticeships in place in the department, these have been expanded and staff on these programmes have had training opportunities for progression. These staff described to us that they felt confident in their roles and were keen to stay within the trust due to this.

The leadership team understood the current challenges and pressures impacting upon service delivery and patient care.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust vision was ‘to be the safest trust in England, outstanding in all we do.’ Four objectives originated from this vision, one of which included to provide outstanding care and improve patient experience. To deliver the four main objectives four breakthrough objectives were identified for 2022/23, for example, objective one was to maintain and improve CQC ratings by achieving improvements in quality and outcomes.

Diagnostic imaging

There was a vision for what leaders want to achieve and this was in line with the Trust vision. The service promoted training, and staff were aware of the vision for diagnostics and were able to share this with us during inspection. Staff told us about the focus on reduction in waiting times for patients, and also a focus on improving the patient experience in the department.

Staff told us they provided patients with person-centred care and that working well in a team was key to achieving their vision and strategy.

The management team shared they were dedicated to workforce retention and prioritising wellbeing and development across staff groups.

Culture

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

Staff were proud to work at the trust and within their departments. Staff, from students to senior staff were loyal to the trust and chose to develop and progress within the service and across modalities.

All staff we spoke with said they felt able to raise any concerns to colleagues or managers and were aware of how to contact the Freedom to Speak up Guardian.

Managers described how they supported serious incident investigations with specialty colleagues and followed Duty of Candour where appropriate.

Equality and diversity was clearly promoted to patients, students, and staff throughout the service. There were no barriers to progression or development and staff received training in equality, diversity, and inclusion.

Staff were positive and caring towards patients and their relatives who used the service. In addition, we also noted caring and respectful interactions between staff of all grades and disciplines.

Governance

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

We examined various minutes of meetings for the operational governance, clinical governance, and radiation safety committee group. These minutes showed that these meetings were well attended by a wide range of staff and a variety of issues were discussed such as radiation incidents, CT new building update and home reporting.

The radiation safety committee produced an annual report and met twice each year. They linked in with specific subgroups which made them able to work more effectively, these included the radiology clinical governance group who meet monthly and the optical radiation health and safety committee.

All modality areas had a robust quality assurance (QA) programme in place, and this had been brought in since the last inspection and was firmly embedded as business as usual. Each modality area created a full QA report, and we could see these reports were reviewed on a regular monthly basis.

Diagnostic imaging

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Staff described good IT support and no recent breakdowns or failures in the picture archiving and communications system. Images were available at all times to all relevant professionals.

Service leads and managers worked together to provide information to the executive performance meeting. They monitored performance and provided information to the divisional leads, along with identified risks and issues for escalation. Service leads reported a good level of support in planning for the future including finance and workforce planning.

Managers monitored all targets and reported to the trust board through their overall performance reports.

The service had a systematic process, involving staff of all roles and grades, in reviewing and improving the service. This included identifying risks and planning to reduce the level of risk. There was a rolling agenda of meetings to improve quality and patient safety.

There was a robust governance process related to risk with monthly risk meetings. The risks were escalated via the governance meetings and the divisional meetings.

Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact giving a red, amber, green (RAG) rating.

Diagnostic wait times were monitored with initiatives in progress to improve performance for 2023/2024, we could see these wait times were improving and monitored.

There were systems to flag up urgent unexpected findings to GPs and medical staff. This met the Royal College of Radiologist guidelines.

Information Management

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

Staff could find all patient information such as diagnostic imaging records including previous images, and reports, medical records, and referral letters through electronic records.

All staff had access to the trust intranet to gain information on policies, procedures, National Institute for Health and Care Excellence guidance, and e-learning. Some policies we reviewed for staff had not had their review date as recommended in the policy itself, examples of this include the guidance for staff in the use of chaperones and also the employers' procedures under IR(ME)R.

Information governance systems were in place and ensured the confidentiality of patient records.

Diagnostic imaging

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

We saw the staff engagement group met monthly and this covered a wide variety of agenda topics in recent minutes we reviewed. We saw that staff survey questions had been updated to align with the NHS People Promise and that the Trust had asked additional questions regarding the awareness of Trust values. The initial staff survey results showed an encouraging and improving picture in relation to feedback. Work was being undertaken in relation to communication of the results and engagement with local teams, to embed a cycle of year-round engagement.

There was a clear focus on engagement activities to develop a culture of inclusion. The Trust held events for staff from ethnic minority groups.

Learning, continuous improvement and innovation

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

Staff met regularly with all colleagues across the Trust sites to share learning and provide peer support. The service had continued professional development (CPD) lunch and learn sessions, online evening learning sessions and these were based on what was needed following audit results, staff learning, and from staff requests.

The trust logged all compliments and positive praise received in each area and for each location. This was shared with staff and the wider team for learning.

There was a monthly publication of 'General Radiology Newsletter' for staff. This featured 'image of the month' which showed a different x-ray image each month and focus on how to perform this well and potential challenges. This was to improve learning and continuous improvement in staff.

Staff we spoke with told us they felt supported to develop their career. There were apprenticeship training places available that were being expanded year on year for the number of places available on these.

Montagu Hospital, Mexborough

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Tel: 01709585171
www.dbh.nhs.uk

Description of this hospital

Doncaster and Bassetlaw Teaching NHS Foundation Trust provides acute services for 420,000 across South Yorkshire, North Nottinghamshire, and the surrounding areas. The trust employs over 6000 staff.

Montagu is a small non-acute hospital with over 50 inpatient beds for people who need further rehabilitation before they can be discharged. There is a nurse-led Urgent Treatment Centre, open 9am-9pm (final check-in is 7:45pm), each and every day excluding Christmas. It also has a day surgery unit, renal dialysis, a chronic pain management unit and a wide range of outpatient clinics.

Diagnostic imaging

Good ↑

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff but did not always make sure everyone completed it. Training for autism had not been received by staff at the time of the inspection.

Staff received but did not always keep up-to-date with their mandatory training, with compliance rates at an average of 87% against a trust target of 90%.

The mandatory training was comprehensive and met the needs of patients and staff. Staff were provided with training specific to their job role, this meant they received the required training relevant to their role.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, and dementia. The trust had appointed learning disabilities ambassadors into each area, these staff received enhanced levels of training and delivered learning sessions in their own teams. They attended overall trust meetings with ambassadors from other parts of the trust. The autism training for staff had not been held yet but was planned to be rolled out later in 2023 for all staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers told us they can view this on a dashboard to see overall compliance in training as well as individual results and due dates.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it, but this was not always kept up to date and was below the Trust training target.

Staff received but did not always keep up to date with training specific for their role on how to recognise and report abuse. The compliance for training across the trust in diagnostic imaging was at 87.5% completion in safeguarding training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust had a specific safeguarding team that staff could contact at any time for concerns and referrals.

Diagnostic imaging

Staff could access safeguarding advice via the trust's lead nurse for safeguarding. Staff explained some vulnerable patients may come to the department with a signed consent form from the referrer if they were unable to give consent themselves.

Staff attended paediatric multidisciplinary meetings to discuss referrals, images and reports relating to children.

We reviewed the trust's safeguarding adults at risk of abuse and neglect policy which was in date (April 2022), version controlled and had a review date of Feb 2025.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Staff provided records to show cleanliness of equipment had been checked. All rooms and public areas were cleaned daily by hospital domestic staff, and cleaning checklists were available to staff.

Clinical area cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

The service generally performed well for cleanliness. Recent PLACE scores for the hospital shows achieving higher than national average scores in most areas. The latest (2022) Patient-Led Assessments of the Care Environment (PLACE) score was 98.4% for cleanliness.

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

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff disposed of ultrasound gels in bottles at the end of every day. Sonographers cleaned and disinfected ultrasound probes before use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

Patients could reach call bells and staff responded quicky when called. The design of the environment followed national guidance. There was clear signage throughout the departments where x-rays room were used and there were controls to restrict access to patients and staff.

We saw radiation protection supervisor reports showing reviews undertaken against IR(ME)R and learning shared with staff through team meetings and training.

Staff carried out daily safety checks of specialist equipment. Staff provided servicing and maintenance documents for all equipment. Staff were able to raise any immediate concerns to managers who took action to rectify faults quickly.

Staff completed quality assurance (QA) checks on all equipment. These were mandatory (must do) checks based on the Ionising Radiation Regulations 2017 and IR(ME)R 2017 regulations. These protect patients against unnecessary exposure to harmful radiation. All x-ray equipment had been measured by the regional medical physics advisor and had been found to be safe.

Diagnostic imaging

The service had suitable facilities to meet the needs of patients' families. The waiting area was adequate for the patient volumes within the department.

The service had enough suitable equipment to help them to safely care for patients.

There were temperature controls in areas where radiological contrast was stored. Inspectors found contrast stock was well managed and all packages of contrast were within date.

There was guidance for quality assurance and diagnostic reference levels (DRL) for equipment. DRLs were present in main x-ray rooms. Each piece of equipment should have had separate and specific DRLs, and the manager informed us they would contact their medical physics expert for advice.

The resuscitation trolley was well stocked, locked, and tagged. Equipment including suction and oxygen lines were clean. There were anaphylaxis and cardiac arrest kits kept with the trolleys. The checklists for resuscitation trolleys were up to date for the 3 months prior to our inspection visit. Trolleys were due to be checked daily and we saw this was happening.

Staff disposed of clinical waste safely.

We saw the radiation PPE screening report for Montagu Hospital and there were requirements to replace equipment in main x ray due to 6 pieces of equipment flagging as ‘red’ in the report and action needed for replacement as a result of this.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff responded promptly to any sudden deterioration in a patient’s health. The trust had clear policies and guidance in place for managing medical emergencies. Staff received basic life support training as a minimum and there was an emergency crash team who could be called to assist.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used a standard document for all examinations consistently across all sites. This document was uploaded to the patient record and there was a standardised process to check patient identification, contrast safety and World Health Organisation (WHO) safer steps to surgery checks.

Staff knew about and dealt with any specific risk issues. Radiology equipment had been risk-assessed and portable equipment tested to ensure the safety of staff and patients. Specific testing and reporting on equipment included radiographic tubes and generators and ultrasound machines.

Staff asked patients if they were or may be pregnant. There were signs in the department asking patients to let staff know if they may be pregnant. If patients could not be sure, staff ensured a pregnancy test was completed before carrying out any examination involving exposure to radiation. This met with the radiation protection requirements and identified risks to an unborn foetus. Staff followed different procedures for patients who were pregnant and those who were not. For example, patients who were pregnant underwent extra checks and staff completed checklists to record them.

Diagnostic imaging

Staff shared key information to keep patients safe when handing over their care to others. Images and reports were made immediately available to all referrers and clinicians. Previous images and reports were also available to help staff check previous findings for clinical checks and comparison.

Shift changes and handovers included all necessary key information to keep patients safe. Staff attended a “huddle” every morning before the main shift began to exchange information on equipment, expected patients, any identified risks, and to prepare for the day ahead.

Diagnostic imaging policies and procedures were written in line with the Ionising Radiation (Medical Exposure) 2000 regulations. The trust had named and certified radiation protection supervisors and liaised with the radiation protection advisor (RPA). Local rules are the way diagnostics and diagnostic imaging work to national guidance and vary depending on the setting. Staff had written and agreed policies and processes to identify and deal with risks. This met with IR(ME)R 2017.

Staffing

Allied health professional (AHP) staffing

The service had enough nursing and support staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The service had low vacancy rates with 1 WTE band 5 vacancy within radiology which was being recruited into during the inspection.

The service was reviewing the job descriptions of the experienced band 5 staff nurses to recognise the skill set required as a band 6 staff nurse, as they recognised this as a national skills progression.

Managers made sure all bank and agency staff had a full induction and understood the service. We saw examples of the this during our inspection on site, with information provided to all staff to ensure they understood the service.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. Medical staff matched the planned numbers on rotas we reviewed for the three months prior to inspection.

The service had low vacancy rates for medical staff.

The service had low turnover rates for medical staff at 1.41%.

Diagnostic imaging

Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work.

The service always had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records. The record system was accessible and reliable, and images could be viewed and reported on remotely by all registered clinicians. We reviewed 10 patients records and these were completed appropriately and in line with service and national guidelines.

Records were stored securely. Staff accessed records using their own login and password.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. This matched the incident policy that the provider had in place.

The service had no never events.

Staff reported all incidents of repeated or excessive radiation dose to the RPA who advised if any reached a notifiable dose. All incidents reported on datix from Montagu Hospital over the previous 12 months were no or low harm outcomes for patients. There were no specific trends or themes identified from these.

Managers shared learning with their staff about never events that happened elsewhere. Staff attended meetings and discussed learning from incidents across the region.

Staff reported serious incidents clearly and in line with trust policy. We reviewed the incident log and can see appropriate action had been taken and correct reporting followed.

Staff understood the duty of candour. Staff we spoke with described the duty of candour during the inspection well and understood the importance of putting it into practice.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

Diagnostic imaging

Radiologists and reporting radiographers attended monthly discrepancy meetings where findings were discussed, actions agreed, and learning was shared. Reporting radiographers liaised with staff regarding poor image quality and led workshops on making improvements.

Managers investigated incidents thoroughly. We reviewed the radiology incident log which was all datix incidents and all action taken clearly recorded.

Is the service effective?

Inspected but not rated

We do not rate effective in diagnostic imaging, however we found:

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. All policies and guidelines were stored on the trust intranet. As staff received new guidance and directives, the department managers ensured updates to clinical practice.

The departments were adhering to local policies and procedures. The local rules were not displayed in all rooms with latest version of the rules at the beginning of our inspection, but these were changed to the current version in all rooms during our time on site.

We saw reviews against IR(ME)R and learning shared to staff through team meetings and training. The trust had a radiation safety policy, which met with national guidance and legislation. The purpose of the policy was to set down the responsibilities and duties of designated committees and individuals. This was to ensure the work with Ionising Radiation undertaken in the Trust was safe as reasonably practicable.

Radiation protection supervisors (RPS) for each modality led on the development, implementation, monitoring, and review of the policy and procedures to comply with IR(ME)R.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Staff made sure patients had enough to eat and drink. Including those with specialist nutrition and hydration needs. There were water machines for patients and their relatives to use when waiting to be seen.

Staff ensured patients requiring CT examination using contrast were sufficiently hydrated prior to their procedure.

Patient outcomes

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

Diagnostic imaging

The service participated in relevant national clinical audits. We saw an audit had been conducted in March 2023 on the amount of Antero-Posterior' (AP) chest x-rays and postero-anterior (PA) chest x-rays being performed at the Trust. The quality of chest x-rays audit outlined by the Royal College of Radiologists (RCR) published in 2016 and reviewed in 2022 states "Every effort should be made to perform a PA erect chest x-ray". The targets set for this were 75% PA for inpatients and emergency department patients, and 95% AP for outpatients and general practice patients. It was found that radiology was operating below the expected standard suggested by RCR, with 47% of adult emergency department chest x-rays performed PA instead of the recommended target of 75%. We saw this information being shared with staff through the radiology newsletter in May 2023 and a request for staff to change the x-rays performed unless not possible, in which case this was expected to be recorded on the patient records.

Managers and staff used the results to improve patients' outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Staff told us they participated in regular audits and that these were shared in team meetings with actions for improvements. An example of this is quality assurance (QA) annual audit reports completed for each location in the trust. We saw that the tests were carried out daily and the results from each test were held electronically on each scanner. These results also identified any results that were out of tolerance (quality noise and homogeneity).

We saw examples of audits within CT, DEXA, fluoroscopy, MRI, Ultrasound, X-Ray, and nuclear medicine. We also saw examples of the audit results being discussed at the radiation safety meeting.

Annual Medical Physics QA were undertaken by Sheffield Teaching Hospitals in March of every year.

The reports we saw were February 2022 to February 2023 to coincide with the Radiation Protection Annual cycle.

We reviewed the annual dosage audits which showed the values monitored and compared to the previous year's results.

Managers used information from the audits to improve care and treatment.

Managers shared and made sure staff understood information from the audits.

Improvement is checked and monitored.

Competent staff

The service made sure staff were competent for their roles. Managers appraised some staff's work performance and held supervision meetings with them to provide support and development, but this was not always every year.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. All new staff followed the trust competency framework where staff must perform several observed procedures to gain competency in that area. Designated supervisors approved and signed off the competency framework. Radiographers and sonographers told us the department supported them to complete competencies.

The service was committed to developing the skills, knowledge and competence of its students, staff, and managers. Students enjoyed their placements and took up permanent posts once trained. All staff were able to make use of opportunities to learn, develop, and share good practice.

Diagnostic imaging

Managers gave all new staff a full induction tailored to their role before they started work. We saw examples from the Head of Imaging of welcome emails sent to new staff. These included a full welcome PowerPoint, including details of the radiology senior management team and the local rules for them to read prior to commencement in their role.

Newly qualified staff told us the department had offered them a good level of competency training.

Managers supported staff to develop through yearly, constructive appraisals of their work, although compliance rates for appraisals were at 71.04% for the Trust overall within diagnostic imaging.

Managers supported staff to develop through regular, constructive clinical supervision of their work.

The clinical educators supported the learning and development needs of staff.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. There were multiple opportunities to attend team meetings including through Teams. Notes were always available and shared following these meetings.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Mandatory training had to be up to date for staff before additional training could be undertaken.

Managers made sure staff received any specialist training for their role. Staff told us about continued professional development (CPD) opportunities they had requested and had approved. This was across the diagnostic imaging department. Staff were proud to have ensured they can continue in CPD training and that this was supported.

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

Multidisciplinary working

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

Medical staff could contact a duty Radiologist any time to discuss issues and to provide support to other doctors and staff throughout the trust.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Seven-day services

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

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests. This meant there were clear arrangements in place for urgent scans and these would be at Doncaster Royal Infirmary in the trust.

Health promotion

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

Diagnostic imaging

The service had relevant information promoting healthy lifestyles and support in patient areas. For example, we saw 'stop smoking' information, dementia awareness displays and information on being active.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained verbal consent from patients for their care and treatment in line with legislation and guidance. Diagnostic imaging, and medical staff understood their roles and responsibilities and knew how to obtain consent from patients. They could describe to us the various ways they would do so. Staff told us they usually obtained verbal consent from patients for simple procedures such as plain x-rays. In some general cases this was inferred consent. Specialty medical staff obtained consent for any interventional procedures in writing before attending departments and for biopsy procedures.

Staff made sure patients consented to treatment based on all the information available.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Mental Capacity Act and Deprivation of Liberty Safeguards training was part of the Safeguarding Level 2 e-learning module for all staff. The Trust were in the process of changing this to become part of the mental health training being launched under 'SET+' and this was in the process of being adopted.

Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Is the service caring?

Good

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. All staff including reception staff, were observed to be compassionate and respectful to every patient who used the service. Patients told us that staff were friendly, and we observed this in action during the inspection. We observed that all staff introduced themselves when patients were called from the waiting area, for their appointment.

Diagnostic imaging

Patients said staff treated them well and with kindness. We spoke with two patients, and they all felt staff provided caring treatment towards them.

Staff followed policy to keep patient care and treatment confidential. Patient records were kept safe and in line with policy. Conversations were held with patients in private consultation rooms with the door closed. This meant the information regarding the patient was confidential.

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

Staff collected patients from waiting areas and took them to private changing facilities.

Staff spent time with patients and those close to them to give explanations about their care and encouraged them to ask questions.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff giving reassurance to patients in a calm and relaxed manner.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. We observed staff providing care before, during, and after procedures and showing consideration to patient's emotions, allowing them time to ask questions or comply with requests. Staff were aware some positioning could be uncomfortable and allowed patients to be independent or made adjustments where possible.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families, and carers in a way they could understand, using communication aids where necessary. Staff shared with us examples of alternative communication methods such as drawing for ease of understanding in certain patients when needed.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Patients gave mainly positive feedback about the service. We saw the results of the most recent patient survey broken down by speciality. The completion rates for August 2023 look to be very low numbers from patients with 0 received in MRI, 1 in CT and 12 within radiology. Although results were mainly all either good or very good in the responses received. There was 1 response received in August 2023 with poor feedback in radiology.

Diagnostic imaging

Is the service responsive?

Good ➔➔

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

Service delivery to meet the needs of local people.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population. There was a new role to the service of a 'cancer pathway navigator', this post had been created in January 2022. There had just been recruitment to expand this to include a second position for this role who was due to start imminently. The cancer pathway navigators looked for any cancellations on a daily basis and contacted any patients waiting to be seen at short notice to aim to ensure any cancellations were filled. The demand in the local area has increased over the last year, so the service has appointed a second person for this role due to demand.

The departments were accessible for people with limited mobility and people who used a wheelchair.

Diagnostic imaging reporting was electronic, and the department used paperless methods to reduce time and administration.

Managers monitored all targets and reported to the trust board through their overall performance reports.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion.

Facilities and premises were appropriate for the services being delivered.

The service had systems to help care for patients in need of additional support or specialist intervention. There were sufficient facilities to meet the needs of inpatients rooms large enough to wheelchairs and staff accompanied patients from wards.

Managers monitored and took action to minimise missed appointments. Staff respected inpatient mealtimes and, where possible, organised inpatient imaging to avoid them.

Managers ensured that families of children or vulnerable patients who did not attend appointments were contacted.

The service relieved pressure on other departments when they could treat patients in a day. Reporting radiographers checked suspected fractures straight away and provided results back to the minor injuries department to ensure efficient patient care or discharge.

There was a free bus service provided for patients between hospital locations where needed and this was pre-bookable.

Diagnostic imaging

Meeting people's individual needs

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

The main waiting area was large and airy. Patients attending the department had access to drinks and snack facilities, a café, and a shop.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. We saw examples of this during our inspection, and staff were able to tell us about this.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. These were arranged in advance when the requirement was known about, but staff knew how to access this for any requirements on the day.

There was an x-ray booklet specifically for children available and also for adults with learning disabilities in the waiting areas.

Contact information is provided to patients when they are transferred to other services and all information is sent electronically between services for immediate sharing of information.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Referral to treatment (RTT) rates were measured against national targets for all patients on cancer pathways, two week waits, urgent and planned care, and routine images.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. CT scan figures showed significant reductions in waiting times for patients over the last 12 months. August 2023 showed 91.2% of patients were seen for CT scans within 14 days. MRI scan data showed 80.5% of patients were seen for urgent referrals within 14 days.

Managers worked to keep the number of cancelled appointments to a minimum.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Learning from complaints and concerns

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

Diagnostic imaging

Patients, relatives, and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. The hospital had a complaints policy, which staff accessed on the intranet.

Managers investigated complaints and identified themes. Learning was shared across the hospital in the daily morning huddle, monthly head of departments meeting, clinical governance meetings, quarterly medical advisory committee, and quarterly departmental team meetings.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Good

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Staff described managers as being approachable and available. Staff knew how to contact managers at any point when they needed too and felt able to do this.

Managers provided clear leadership and were highly valued by staff we spoke with. Managers were keen to retain staff and invested in education for staff to progress. There was a radiology manager in post who staff felt supported by and who told us they were keen to support staff progression. An example of this was for the apprenticeships in place in the department, these have been expanded and staff on these programmes have had training opportunities for progression. These staff described to us that they felt confident in their roles and were keen to stay within the trust due to this.

The leadership team understood the current challenges and pressures impacting upon service delivery and patient care.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Diagnostic imaging

The trust vision was 'to be the safest trust in England, outstanding in all we do.' Four objectives originated from this vision, one of which included to provide outstanding care and improve patient experience. To deliver the four main objectives four breakthrough objectives were identified for 2022/23, for example, objective one was to maintain and improve CQC ratings by achieving improvements in quality and outcomes.

There was a vision for what leaders want to achieve and this was in line with the Trust vision. The service promoted training, and staff were aware of the vision for diagnostics and were able to share this with us during inspection. Staff told us about the focus on reduction in waiting times for patients, and also a focus on improving the patient experience in the department.

Staff told us they provided patients with person-centred care and that working well in a team was key to achieving their vision and strategy.

The management team shared they were dedicated to workforce retention and prioritising wellbeing and development across staff groups.

Culture

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

Staff were proud to work at the trust and within their departments. Staff, from students to senior staff were loyal to the trust and chose to develop and progress within the service and across modalities.

All staff we spoke with said they felt able to raise any concerns to colleagues or managers and were aware of how to contact the Freedom to Speak up Guardian.

Managers described how they supported serious incident investigations with specialty colleagues and followed Duty of Candour where appropriate.

Equality and diversity was clearly promoted to patients, students, and staff throughout the service. There were no barriers to progression or development and staff received training in equality, diversity, and inclusion.

Staff were positive and caring towards patients and their relatives who used the service. In addition, we also noted caring and respectful interactions between staff of all grades and disciplines.

Governance

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

We examined various minutes of meetings for the operational governance, clinical governance, and radiation safety committee group. These minutes showed that these meetings were well attended by a wide range of staff and a variety of issues were discussed such as radiation incidents, CT new building update and home reporting.

Diagnostic imaging

The radiation safety committee produced an annual report and met twice each year. They linked in with specific subgroups which made them able to work more effectively, these included the radiology clinical governance group who meet monthly and the optical radiation health and safety committee.

All modality areas had a robust quality assurance (QA) programme in place, and this had been brought in since the last inspection and was firmly embedded as business as usual. Each modality area created a full QA report, and we could see these reports were reviewed on a regular monthly basis.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Staff described good IT support and no recent breakdowns or failures in the picture archiving and communications system. Images were available at all times to all relevant professionals.

Service leads and managers worked together to provide information to the executive performance meeting. They monitored performance and provided information to the divisional leads, along with identified risks and issues for escalation. Service leads reported a good level of support in planning for the future including finance and workforce planning.

Managers monitored all targets and reported to the trust board through their overall performance reports.

The service had a systematic process, involving staff of all roles and grades, in reviewing and improving the service. This included identifying risks and planning to reduce the level of risk. There was a rolling agenda of meetings to improve quality and patient safety.

There was a robust governance process related to risk with monthly risk meetings. The risks were escalated via the governance meetings and the divisional meetings.

Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact giving a red, amber, green (RAG) rating.

Diagnostic wait times were monitored with initiatives in progress to improve performance for 2023/2024, we could see these wait times were improving and monitored.

There were systems to flag up urgent unexpected findings to GPs and medical staff. This met the Royal College of Radiologist guidelines.

Information Management

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

Staff could find all patient information such as diagnostic imaging records including previous images, and reports, medical records, and referral letters through electronic records.

Diagnostic imaging

All staff had access to the trust intranet to gain information on policies, procedures, National Institute for Health and Care Excellence guidance, and e-learning. Some policies we reviewed for staff had not had their review date as recommended in the policy itself, examples of this include the guidance for staff in the use of chaperones and also the employers' procedures under IR(ME)R.

Information governance systems were in place and ensured the confidentiality of patient records.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

We saw the staff engagement group met monthly and this covered a wide variety of agenda topics in recent minutes we reviewed. We saw that staff survey questions had been updated to align with the NHS People Promise and that the Trust had asked additional questions regarding the awareness of Trust values. The initial staff survey results showed an encouraging and improving picture in relation to feedback. Work was being undertaken in relation to communication of the results and engagement with local teams, to embed a cycle of year-round engagement.

There was a clear focus on engagement activities to develop a culture of inclusion. The Trust held events for staff from ethnic minority groups. Diagnostic imaging was included in this, and the manager shared this with us.

Learning, continuous improvement and innovation

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

Staff met regularly with all colleagues across the Trust sites to share learning and provide peer support. The service had continued professional development (CPD) lunch and learn sessions, online evening learning sessions and these were based on what was needed following audit results, staff learning, and from staff requests.

The trust logged all compliments and positive praise received in each area and for each location. This was shared with staff and the wider team for learning.

There was a monthly publication of 'General Radiology Newsletter' for staff. This featured 'image of the month' which showed a different x-ray image each month and focus on how to perform this well and potential challenges. This was to improve learning and continuous improvement in staff.

Staff we spoke with told us they felt supported to develop their career. There were apprenticeship training places available that were being expanded year on year for the number of places available on these.

Urgent and emergency services

Good ↑

Is the service safe?

Requires Improvement →←

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

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff. However, managers did not always ensure everyone completed it.

Nursing staff received mandatory training. However, they did not always keep this up to date. We reviewed the latest overall compliance for unit nursing staff. This was 83.33% which did not meet the trust's 90% target.

On our last inspection in February 2020, we told the trust they must ensure all staff, particularly medical staff complete mandatory and safeguarding training in line with trust policy and relevant to their role.

At this inspection the service had made some improvements, but nursing staff compliance was still below trust target and this was a repeat breach.

Managers monitored mandatory training. However, they did not always alert staff when they needed to update their training.

Leaders told us that mandatory training was not a priority during the COVID-19 pandemic although they had since, recruited two band 7 staff and one band 6 post to support staff with training. Twice weekly sessions covered safeguarding and other focused topics. Leads had introduced lunchtime and breakfast teaching within the department.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia. Staff were asked to complete the Health Education England (HEE) Oliver McGowan training package which was being rolled out across the trust.

Safeguarding

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

Nursing staff received training specific for their role on how to recognise and report abuse. At the time of our inspection divisional compliance across all staff groups was 100%.

However, safeguarding leads identified their training was no longer sufficient content to meet the intercollegiate document recommendations. They had identified a more detailed safeguarding training package due to be adopted as part of the mental health training launch.

Urgent and emergency services

Staff knew how to identify adults and children at risk of, or suffering, significant harm. They worked with other agencies to protect them. Unit staff documented and acted upon safeguarding concerns in patient notes, such as unexplained bruising for a looked after child.

Staff could access safeguarding adults and children teams based at the trust's main ED site for support. Staff had an out of hours number to call if they were concerned or could email for routine referrals. If a child absconded or left the unit alone, staff would ring and leave messages, inform the nurse in charge, social worker and the police depending on risk assessment criteria and severity.

Staff were reminded of their mandatory duty to report female genital mutilation (FGM) and to ask their local safeguarding lead for support if in doubt.

Receptionists in the waiting area knew how to raise safeguarding alerts or concerns to their local authority multi-agency safeguarding hub (MASH).

Staff followed up patients who did not attend or left the unit before treatment with phone calls or correspondence.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Unit staff confirmed they had a safeguarding lead and knew how to contact them.

All staff could explain how they followed safeguarding processes or guidance.

Agency nursing staff said they had to inform the nurse in charge about any safeguarding concerns. They could access the trust intranet to report these themselves.

Staff followed safe procedures for children visiting the unit. All children in this area were accompanied at all times.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection.

Most areas of the unit were clean. Staff were compliant with bare below the elbow standards and adhered to best practice regarding hand washing and disposing of correct personal protective equipment in between patient contact. Staff cleaned equipment after use.

The service generally performed well for cleanliness. Domestic staff carried out cleaning three times daily on the unit, reception areas and toilets.

There was evidence of cleaning audits such as hand hygiene. The unit had procedures or reliable systems to prevent healthcare associated infections.

Staff followed the procedure for the management and isolation of patients with infectious diseases and would inform the infection prevention control team.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always manage clinical waste well. They were trained to use equipment.

Urgent and emergency services

The unit had one resuscitation room with a bed, but this was rarely used more than monthly. The room had a flood barrier under an external side door as the drainage system was outdated. This room was susceptible to flooding and last flooded two months before our inspection. This meant in the event of patients needing emergency treatment, the room and equipment could be potentially inaccessible, unsuitable, or damaged. The trust was aware of this and were taking actions to address it.

Staff told us the unit was not secure as they had been waiting for the installation of magnetic locks on the rear doors so occasionally confused patients wandered in from outpatients. This meant vulnerable patients could be potentially placed at avoidable risk.

Some signage on the unit was outdated. For example, signs giving directions were two years old, and Ebola in West Africa awareness signs were from 2015 in the main entrance area. This information was misleading for patients and may cause them confusion and delays.

The matron had undertaken a monthly audit of MIU in May 2023. This addressed the inappropriate outdated signage from outside the unit which they requested to change. However, at the time of our inspection two months later this was still not updated.

An area just outside the main unit was cluttered and contained potential ligature risks from broken computers awaiting repair or disposal. Patients walked through this area but were usually escorted or overseen by staff.

Staff did not always carry out daily safety checks of specialist equipment. We reviewed resuscitation trolley checklists for adults and children. Staff had missed several dates on the defibrillator daily check sheets for August 2023.

At our last inspection in February 2020, we told the trust they must ensure equipment used by staff in the MIU was clean and properly maintained. On this inspection this had improved.

Theatre staff replaced all adults and children's equipment on the resuscitation trolleys, in line with the division's other ED sites. The trolleys were suitably stocked, and equipment was in date.

All regularly used electrical equipment was safety tested and in-date.

Unit staff completed daily fire safety inspection checks and updated a log. However, none were completed from 1 to 13 August 2023. This meant we could not ensure staff completed all daily safety checks potentially putting patients, visitors and other staff at risk.

The service had some suitable facilities to meet the needs of patients' families. There was a children's seating area within the main waiting room with books, toys and a games console although this was not working.

Staff did not always dispose of clinical waste safely. One sharps bin in a unit storage room was opened in April 2022, had not been disposed of and had no closed date. This meant expired and potentially harmful clinical waste was still on the premises.

However, sharps bins in use were clean, signed, dated and not above the fill line.

Clinical waste bins were separate to domestic or general waste. Domestic and clinical waste was collected 3 times a day.

Urgent and emergency services

Assessing and responding to patient risk

Staff completed risk assessments for each patient and could evidence improvements after incidents.

Staff used a nationally recognised early warning score (NEWS2) to identify deteriorating patients.

The hospital had no resuscitation team onsite, so unit staff rang 999 in the event of cardiac arrest or sudden patient deterioration.

Receptionists had no emergency buzzer so in the event a patient or someone collapsed or became unwell, they would call 999 and alert the unit nurses to respond.

If the ambulance category was two (a serious condition) or three (an urgent problem) with a longer wait, nurses would stabilise the patient until the paramedic crew arrived.

The emergency nurse practitioners (ENPs) were intermediate life support (ILS) and paediatric (PLS) trained. The healthcare assistant was trained to basic life support (BLS) level. Many nurses who worked on the unit also rotated and worked at the Doncaster ED so retained their competencies in resuscitation and the deteriorating patient.

Nursing staff used paediatric advanced warning scores (PAWS) and paediatric observation priority scores (POPS) for the initial assessment of children over one year old and their clinical deterioration. This was a screening tool that evaluated the degree of illness and the likelihood of cross-site transfer to an external paediatric intensive care unit (PICU). Staff recorded follow up actions for patients at risk, whose PAWS and temperature was high.

The trust used the sepsis six care bundle. Staff followed a flow chart to determine if patients were at low, possible, or high risk of sepsis using specific criteria.

At the time of our inspection, staff covered both sepsis recognition and NEWS in a training course with a deterioration element.

Staff completed a 25-point skin inspection for patients on admission. They ensured the pressure ulcer traffic light assessment was completed within a patient's first two hours in the department.

The service had 24-hour access to mental health liaison and specialist mental health support. The unit could access psychiatric liaison any time of day.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. At the time of our inspection the trust was rolling out a new mental health assessment tool for staff use.

Staff shared key information to keep patients safe when handing over their care to others.

Nurse staffing

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

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Staffing levels were adjusted daily according to the needs of patients.

However, the number of nurses and healthcare assistants did not always match the planned numbers. Staff told us there was not always 2 registered staff on duty. On the day of our inspection the unit was fully staffed with two registered nurses and one health care assistant.

In the event of administrative staff absence, the division had an escalation process to provide staffing cover from colleagues.

The service had low and/or reducing vacancy rates. No nurse vacancy rate exceeded 1.5 full-time equivalent (FTE) by July 2023. MIU had lower vacancy rates across for nurses compared to the other trust departments.

Managers limited their use of bank and agency staff and requested staff familiar with the service. When managers needed agency staff, they tried to source those who worked regular shifts.

Managers made sure all bank and agency staff had a full induction and understood the service.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. Patient's medical records were kept locked in trolleys when not in use.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely.

Unit staff checked if patients wore wristbands or asked their details before administering medicines.

Patient group directions (PGDs) on which staff could supply and administer specific medications without a doctor were updated for children and adults.

The unit only stored two controlled drugs (CDs) staff could give patients. These were stored and checked daily. The onsite pharmacy removed expired CDs.

Staff stored and managed all medicines and prescribing documents safely. On our last inspection in February 2020, we told the trust they must ensure the MIU followed guidance for the safe storage of medicines.

Urgent and emergency services

At this inspection all medicines on the unit were correctly stored, refrigerated and in date. We reviewed the drugs fridge checklists for the three months before our inspection and found no dates were missed.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy.

The service had no never events.

Managers investigated incidents and shared learning with their staff about incidents that happened elsewhere in the trust. For example, following a sepsis death in ED at another site, staff had direct teaching sessions.

Staff reported serious incidents in line with trust policy. The unit had no reportable serious incidents from January to August 2023.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Unit staff told us about trust wide incidents learning.

There were evidence changes had been made as a result of feedback. Unit staff could complete a vulnerability screening tool for patients flagged at risk on their clinical patient management system. This reflected key learning from a serious incident in October 2022 at the trust's main ED site.

However, we did see one example where action had not been taken following an incident in May 2022. The action was to install a security door on the unit, but this had not been completed.

Is the service effective?

Good ➔➔

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We observed effective conversations between staff regarding the mental health act which demonstrated a good level of understanding.

Staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Nurses included consideration of patient's mental health and wellbeing in their conversations and would arrange transfer for them if appropriate.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

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

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. This was a five-step nationally recognised and validated tool to identify adults at risk of malnutrition.

Staff completed patients' fluid and nutrition charts where needed.

Pain relief

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

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

Patient outcomes

Staff monitored the effectiveness of care and treatment. The service participated in relevant national clinical audits.

At the time of our inspection the trust had rolled out a new audit and assurance system, to strengthen actions and assurance. Managers planned to use information from the audits to improve care and treatment. They shared and ensured staff understood information from the audits. The trust was still refining the data sets and the reporting processes associated with this system.

Managers and staff used the results to improve patients' outcomes. We reviewed the service's average scores across all areas for the six months from 1 March to 31 August 2023. It showed the unit achieved 100% compliance in controlled drugs, 99.7% weekly assurance and 97.6 in the monthly audit.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

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

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff we asked confirmed their last appraisals were in May and June 2023.

The divisional clinical educators supported the learning and development needs of staff. Staff were complimentary about the support they received.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. For example, staff had completed nationally recognised qualifications such as NVQ levels 2 and 3 in health and social care and attended wider learning and development such as a wound care day.

Managers made sure staff received any specialist training for their role. ENP staff had access to minor injury and paediatric training courses. Staff told us they knew where and how to access training if they wanted.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Unit staff maintained frequent contact and good working relations with cross-site divisional staff in other departments. They could ring ED doctors for help or advice who were available and supportive when needed.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. They could refer patients directly to the division's mental health liaison service based at the trust's other ED sites.

Seven-day services

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

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. The unit was open from 9am to 9pm seven days a week. The only day they closed was Christmas day.

Health Promotion

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

The service had relevant information promoting healthy lifestyles for example, leaflets on smoking cessation were available.

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

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patients we asked said staff sought their consent before any care and treatment.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records.

Urgent and emergency services

Nursing staff received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). This was part of staff's adults safeguarding level 2 e-learning module.

Information was on display in the main waiting areas and throughout the department promoting staff's awareness and understanding of the MCA and its key principles.

Is the service caring?

Good

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

Compassionate care

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

Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff were discreet and responsive when caring for patients.

Staff never carried out examinations or treatment in communal areas to compromise patient dignity. For example, domestic staff waited until cubicles were empty to enter and clean and knocked on the side room door before entering. We observed staff always maintained patient's privacy and dignity. For example, nurses closed cubicle curtains before providing any personal care to patients.

Patients said staff treated them well and with kindness. Patients we spoke to said they felt safe, and staff responded promptly if they were in any pain. Patients felt staff were caring and listened to any issues or problems they had with warmth, reassurance and comforting humour.

Emotional support

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

Staff gave patients and those close to them help and could give emotional support and advice when they needed it. We observed nursing staff giving emotional support to children in the unit, particularly if they were crying or distressed.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed an attentive and reassuring staff response to one anxious patient to put them at ease, clearly explaining their treatment.

Patients told us staff always considered and maintained their privacy and dignity. For example, staff gave patients sufficient time to redress before opening the cubicle curtains and spoke softly if the injury related to an intimate part of their body.

Urgent and emergency services

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff had access to quiet and calm areas for patients and their relatives approaching the end of life or for patients who had mental health issues or autism.

Understanding and involvement of patients and those close to them

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

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced and informed decisions about their care. Patients told us staff respected their choices.

Is the service responsive?

Good

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities, autism and dementia. There was information on display for mental health help, support or advice for patients.

The trust's patient clinical management system included a pop-up alert for patients with learning disabilities. Staff could add information to the system about patient's sensory needs and environmental preferences to help them make reasonable adjustments.

Managers ensured patients who did not attend (DNA) appointments were contacted. Reception staff tried to contact patients up to three times who left the unit before being seen. The clinical patient management system recorded and monitored the causes of patients who DNA.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet their needs. Staff could access learning disability ambassadors who provided support to all patients with a learning disability. They wore a yellow badge for easier recognition.

Urgent and emergency services

There was provision in the department for patients with dementia. The trust supported John's campaign. This was a public declaration stating staff always welcomed carers to support patients living with dementia or experiencing delirium.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. The unit had 'This is me' forms for staff to complete information to help them support patients with dementia in hospital.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff could use 'the big word' telephone interpreting service for quick access. Staff we asked reported no delays or issues when they needed this service.

Some staff told us they would use patient relatives as translators if appropriate. They would ensure consent was gained and were vigilant for any potential signs of abuse.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and the local community. An emergency multilingual phrasebook produced by the British Red Cross and NHS was available which nursing staff told us they occasionally used.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards. However, staff could not always support patients when they were referred or transferred between services.

The service made sure patients could access emergency services when needed or receive treatment within agreed timeframes and national targets.

Managers monitored waiting times. The hospital's percentage of patients waiting more than four hours from the decision to admit to admission was consistently lower than the England and Northeast and Yorkshire regional averages.

Montagu MIU saw 2,095 attendances in June 2023, of which 18 were in the unit over four hours before admission, discharge or transfer. This meant performance was 99.14% which met the national standard.

There were no 12-hour breaches in June 2023. However, patients in MIU requiring assessment by mental health services or surgical patients awaiting transfer could experience long waits.

(Source: NHS England - A&E SitReps)

(Source: NHS Digital - A&E quality indicators)

Managers and staff could not always work to make sure patients did not stay longer than they needed to. Unit staff explained often patients were booked in at 8pm or after who had greater acuity than just simple injuries. This meant they did not finish shift until well after their allotted hours, particularly if they also had to cover reception.

Urgent and emergency services

Managers and staff started planning each patient's discharge as early as possible. However, staff could not always support patients when they were transferred between services. Staff told us lack of timely available patient transport service transfers to Doncaster ED added to their cross-site delays.

Managers monitored patient transfers and followed national standards. However, at times patients referred from 111 were inappropriate so had to be transferred to more suitable services. For example, patients who did not have simple injuries.

The unit had started using the navigation nurse streaming model for patients in May 2023. This involved staff navigating the queue to prioritise patients with the worst injuries. When the unit was very busy, staff reviewed the queue for clinical priority as patients could wait up to three hours particularly after a weekend.

Managers monitored that patient moves between services were kept to a minimum. Unit staff could refer orthopaedic patients into the onsite fracture clinic. However, they could not directly refer patients to the onsite eye clinic. Instead, staff had to send or transfer them to Doncaster.

Learning from complaints and concerns

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

Staff understood the policy on complaints and knew how to handle them. Patients, relatives and carers we asked knew how to complain or raise concerns.

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

Managers investigated complaints and identified themes. At the time of our inspection the unit had received no complaints during 2022-2023 for our review and had no Parliamentary and Health Service Ombudsman (PHSO) complaints in progress.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Is the service well-led?

Good ↑

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Urgent and emergency services

The divisional structure was a triumvirate of divisional director, divisional nurse and divisional general manager. They were supported by two emergency and acute medicine clinical director posts, the latter of which was vacant at the time of our inspection.

At the time of our inspection the service had appointed a new divisional nurse. Their role would start from early October 2023. However, there were still divisional gaps in director roles to which the trust was shortlisting and holding interviews in September 2023.

Leaders we spoke to had the skills, knowledge, experience and integrity they needed. They knew what service improvements were needed, and which priorities were outstanding from their revised development plan.

Divisional leads felt they were sufficiently focused on patient care and experience. They attended accountability meetings with senior executives so felt they had a voice and the chance to have important and necessary conversations.

We found positive local leadership of the unit. During this inspection the nursing staff felt well supported and were very complimentary about the lead nurse. They told us in the last 18 months the manager was having a positive impact on cross-department and cross-site working with the trust's other hospitals. There were positive relationships and engagement with a focus on staff opportunities. This made staff feel they had a voice.

Although unit staff said they rarely saw their ED matron onsite, they were responsive and staff could access them when they worked cross-site.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust's vision was 'to be the safest trust in England, outstanding in all that we do'.

The trust had an urgent and emergency care improvement plan in place, in collaboration with system partners. A senior responsible officer was assigned to the individual elements of the improvement programme. **and improvement activities were supported by the emergency care intensive support team (ECIST).**

Managers told us the trust and division's COVID-19 recovery had been slowed by their high turnover of senior and executive and divisional leads.

Divisional leads said their strategic direction was now clearer and consistent due to more stable leadership.

Culture

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

Staff told us they felt they could raise concerns as managers were responsive and would escalate them accordingly. They felt recent leadership changes had improved the culture, but they sometimes felt the other cross-site leads were less visible and accessible to MIU.

Staff were aware of freedom to speak up guardians (FTSU) and ambassadors in the service and wider trust, as they mostly worked in the trust's ED site, they knew how to approach them. At the time of our inspection, they said they had not needed to.

Governance

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

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. These were regularly reviewed and improved. Service leads held divisional clinical governance meetings monthly. Any staff could join or dial in from home.

The MIU lead nurse and other managers disseminated information by email from meetings and other updates. Staff received relevant information from monthly management team meetings.

Arrangements with partners and third-party providers were governed and managed effectively to encourage appropriate interaction and promoted coordinated, person-centred care. Divisional leads worked closely with their external partners on models to improve patient streaming. For example, they had coordinated six sessions with their urgent treatment centre provider supported by ECIST to test and support pathways to reduce delays. Leads had undertaken other specialties work in gynaecology and oncology with external partners to divert patients out of ED.

Divisional leads maintained strong links with their local integrated care partnerships in Doncaster, system partners in South Yorkshire as well as regional and national organisations. For example, leads engaged in specific collaborative work on UEC recovery and to deliver a winter plan. The division's winter plan reflected NHS England guidance issued in July 2023 to identify a national approach.

Staff we spoke to at all levels were clear about their roles and understood what they were accountable for, and to whom.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. However, service leads could not always provide sufficient assurance about risks they faced.

There were not always effective systems for identifying, recording, and managing risks, issues and mitigating actions.

The service had a risk register and there was alignment between the recorded risks and what staff said was 'on their worry list'. We reviewed the latest divisional risk register. The main risks were long waiting times to access care, workforce challenges and delays in patient assessment and treatment. All risks had controls in place and leads reviewed them quarterly.

However, we found that service leads could not always provide sufficient assurance about the risks they faced. During the inspection we found areas for improvement which had not been identified and actioned effectively.

There was a programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. The service's monthly and weekly assurance audits showed good compliance.

Potential risks were taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand. However, service leads did not always anticipate disruption to staffing or facilities. For example, in regard to the resuscitation room flooding. The division had a winter plan for 2023/24. Divisional leads reported they held two workshops for staff to discuss issues and felt plans were progressing well and being put in place much earlier this year.

Divisional leads assessed and monitored the impact on quality and sustainability when considering developments to services or efficiency changes. At the time of our inspection divisional leads had been in post for between 18 months to two years. During that time, they explained from a state of flux they became able to drive required changes despite COVID-19 and other disruptions.

Information Management

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

Information technology systems were used effectively to monitor and improve the quality of care. The trust's main patient records management system worked well and included all relevant patient observations and results on one system. This kept patient records paper-light and gave staff good oversight of patient care.

The service had built in IT safeguards, such as the red, amber, green (RAG) rated 'footsteps' system to support clinical prioritisation of patients.

There were arrangements to ensure data or notifications were submitted to external bodies as required.

Divisional leads told us e-referrals had been piloted for four weeks, which had seen a positive impact on waiting times. They planned to roll this out imminently as part of a pre-winter piloting system.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust performed within the expected range for all nine sections in the CQC Urgent and Emergency Care Survey 2022.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. The division was part of a South Yorkshire UEC alliance which focused on service developments, and system wide areas of focus to local populations.

The staff engagement score in the latest NHS staff survey was 6.1 out of 10. This was 0.7 lower than the trust overall's score.

Urgent and emergency services

Staff routinely thanked each other through a private messaging function. They gave reward and recognition to their colleagues,

Medical care (including older people's care)

Requires Improvement

Is the service safe?

Requires Improvement

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

Mandatory Training

The service provided mandatory training in key skills to all staff, however compliance was below trust target.

Training compliance trust wide for medicine was 87% for nursing staff, which was below the trust target of 90%. Training compliance trust wide for medical staff was 57%, which was below the trust target of 90%. However, there was vast variation between wards with some compliance levels at 22% and others at 100%, this was division wide across all sites.

However, the mandatory training was comprehensive and met the needs of patients and staff. Managers monitored mandatory training on the electronic staff record system and prompted staff when they needed to update their training. Staff confirmed this and we saw red/amber/green (RAG) rated training compliance sheets displayed in some ward manager offices as a visual prompt for nursing staff. Managers we spoke with were aware some staff were behind target and had a plan in place to make sure staff accessed mandatory training in the near future.

There was a clinical practice educator who delivered face to face practical training. For example, staff we spoke with described simulation training designed to develop skills in management of deteriorating patients. Staff told us that training was a mixture of face to face and online. Staff told us they get protected time for training.

Staff told us there was training available to develop skills further, and they were supported to complete extended role training. For example, some nurses we spoke with completed extended training in male catheterisation.

Safeguarding

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

Staff received adult and children safeguarding training. They were compliant for level 1 and 2 training which meant service met the trust target.

Staff we spoke with knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

We saw patients at risk identified in clinical records with an alert icon, which you could then expand to read the safeguarding referral.

Staff we spoke with knew how to make a safeguarding referral and who to inform if they had concerns. For example, the trust named safeguarding lead and local authority safeguarding teams. Out of hours, staff escalated safeguarding concerns to the duty cover. Staff gave specific examples of safeguarding concerns they had raised. Ward staff knew where safeguarding policies were and how to access them. They used online forms to refer safeguarding notifications or queries to the local authority.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

We asked if the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) were included in this training, the trust told us that MCA/DoLS was part of the adults safeguarding level 2 e-learning module. However, the content was no longer sufficient to meet the recommendations within the intercollegiate guidance. The trust was taking action to address this.

The trust had a plan in place to improve mental health training.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

Wards had housekeepers to support staff in maintaining levels of infection control. Environmental cleaning schedules for domestic staff to follow were displayed in some areas, such as sluices.

We saw evidence of cleaning schedules in wards. Ward areas were mainly visibly clean and had suitable furnishings which were clean, wipeable, and well-maintained.

Some wards we visited displayed audits indicating high compliance with environmental cleanliness. However, clinical staff cleaned clinical equipment. Not all cleaned equipment we saw such as stored commodes and toileting aids were labelled with the date when cleaned.

Side rooms were available on all wards. We saw notices displayed on doors where patients with infections were being cared for and doors were closed in line with policy for managing infectious patients.

We observed that staff adhered to ‘bare below the elbow’ guidance and adhered to infection control policy.

We saw posters displayed around the wards we visited about infection prevention and handwashing. Hand washing facilities were available and antibacterial gel dispensers were situated at the entrance of the wards and on corridors. We saw 5-moments of hand hygiene posters displayed.

Patients we spoke with confirmed staff washed their hands before and after treating them. We observed hand hygiene practice. On the wards we saw that staff mostly either washed their hands before and after each patient contact or used hand gel, as recommended in trust and national policy.

The infection prevention reports were discussed at the infection, prevention and control committee and reported to board. From April to August 2023 the 2 wards at Montagu hospital had no cases of healthcare acquired infections.

Medical care (including older people's care)

The trust submitted data as part of the Commissioning for Quality and Innovation (CQUIN) scheme for quarter 4 (January to March 2023). However, there was poor compliance with the uptake of flu vaccinations for front line healthcare workers (47%).

Environment and equipment

The design, and use of facilities and premises kept people safe. Staff were trained to use the equipment. However, equipment was not always maintained, and safety checked in line with trust policy. Substances hazardous to health were not always stored in accordance with regulations.

Access to all wards was via a secure buzzer and camera entry system. All fire exits were free of obstructions. Fire appliances were signposted and tested. The fire alarm was tested weekly.

Patients could reach call bells and staff mostly responded quickly when called.

Equipment was subject to routine planned preventative maintenance as defined by the equipment manufacturer and we saw that portable electrical equipment was not always maintained and safety checked. The trust had systems in place for recording the service and maintenance of equipment, identified through compliance stickers. Most equipment we looked at had been serviced in accordance with trust policy, however some were out of date.

Staff carried out daily safety checks of specialist equipment. For example, records we reviewed for checks of the emergency resuscitation trolleys had no gaps. Staff told us that resuscitation trolleys were checked and stocked by theatre staff and delivered to the ward.

Staff we spoke with said they had enough suitable equipment to help them to safely care for patients. For example, staff told us they had access to the correct equipment for the care of and moving and handling of bariatric patients.

Substances hazardous to health were not always stored in accordance with Control of Substances Hazardous to Health (COSHH) Regulations (2002). For example, on one ward, in the dirty utility room, we saw cleaning solutions left around the ward on desks and in unlocked sluice rooms. This meant there was a risk vulnerable people could access potentially hazardous substances. We made staff aware at the time and it was rectified.

We found multiple examples across all wards of out-of-date equipment, this included cannulas, swabs, and blood sample vials. This was escalated on day one however we found more examples across the following days on all wards we visited.

Staff disposed of clinical waste safely. We saw all clinical waste sharps bins were used and stored in accordance with national guidance.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients (NEWS2). This helped staff to identify and escalate deterioration in a patient's condition. The NEWS2 alert system was embedded into practice with individual electronic ward boards providing oversight of the clinical area. In all of the records reviewed NEWS charts we reviewed were completed correctly, and there was clear evidence of escalation with deteriorating patients.

Medical care (including older people's care)

Staff we spoke with told us they accessed the recognition and management of the acutely ill and deteriorating patient policy via the intranet.

Staff we spoke with told us that doctors responded quickly when patients were escalated and there was a critical care outreach team out of hours to support the medical on-call team.

Shift changes and handovers included all necessary key information to keep patients safe. Staff received a printed handover sheet which included any specific patient risks, for example, falls risk, resuscitation status and identified patients that required assistance with diet and fluids.

We observed staff attending multidisciplinary safety huddles. These were attended by physiotherapists, speech and language therapists, occupational therapists, discharge coordinator in addition to medical and nursing staff.

Nurse staffing

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

Staffing requirements were calculated by ward managers using a recognised safer care process. However, the service did not always have enough nursing and support staff to keep patients safe. For example, on the wards we visited we saw that planned and actual staffing did not always match.

Staff we spoke with told us this was a regular occurrence. There was a staffing escalation process in place. Staff we spoke with explained, when staffing was suboptimal, they reported to the manager on call for medicine. The on-call bleep holder redeployed staff from other wards, requested bank staff and unfilled shifts were offered to staff via a closed social media group. Agency staff were used and allocated where needed on arrival. Staff we spoke with told us they had sufficient rest and meal breaks and usually left duty on time.

The vacancy rate for nursing within the division of medicine was 177.51 WTE as of March 2023.

The absence rate for nursing within the division of medicine was 6.11% FTE at the time of inspection.

The vacancy rate for support staff within the division of medicine was 101.60 WTE as of March 2023.

Managers we spoke with explained the trust was actively recruiting registered nurses and had an extensive preceptorship programme to support staffing entering the organisation.

Medical staffing

The service has enough medical staff with the right qualifications, skills, training, and experience. There was medical cover onsite from 9am to 5pm Monday to Friday but there was no weekend cover.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care. However, records were not always stored securely.

Medical care (including older people's care)

Records were held in paper and electronic formats. Records were comprehensive and contemporaneous. We reviewed 20 sets of patient records across medical wards from all 3 sites and found these were clear and comprehensive. The trust had a system in place to identify and alert staff members as to when risk assessments were due.

The trust had implemented audits of patient records which were uploaded on to an electronic system which could be benchmarked across the division.

Electronic systems for record keeping were used on all wards we visited and these recorded key information about patient risks and treatment, including alert icons for patients living with dementia, learning disabilities, patient acuity and discharge plans. The boards ensured that staff had easy access to key information, such as reviews by other members of the multidisciplinary team and clinical observations.

Records were not always stored securely. We saw examples of paper notes left open and unsecure. We also saw examples of electronic systems being left unattended for long periods of time with patient information on display.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff accessed the incident reporting and investigation policy on the intranet. All staff we spoke with knew what incidents to report and how to report them. All managers we spoke with knew their ward's most recurring top three incidents and gave examples of how these were being addressed and monitored. Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff we spoke with were familiar with the electronic incident reporting system and provided clear examples of incidents and near miss incidents they had reported recently. Managers shared learning about never events with their staff and across the trust.

Staff told us managers explained learning from incidents and these were shared via email or informal discussion.

All staff we spoke with understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

We saw recent patient safety alerts displayed and managers we spoke with explained how these were implemented and monitored. This signposted staff to further information and covered key topics each month, such as learning from falls, prevention of pressure ulcers and incident reporting. Managers also told us of some quality improvement projects their wards were involved in to improve themes of incidents.

Is the service effective?

Good

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

Medical care (including older people's care)

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Staff we spoke with had a good understanding of the Mental Health Act, they followed guidance and could access support if required. Managers we spoke with had oversight on care and treatment and told us they ensured that staff were following guidance. We were told there was extra support available for staff to ensure they were up to date with evidence based practice in the form of a practice development team.

Staff we spoke with explained how they accessed the most current best practice guidance online and trust intranet, for example National Institute for Health and Care Excellence (NICE) guidance.

Compliance against policy was monitored throughout the year using an annual trust audit schedule.

The trust submitted data as part of the Commissioning for Quality and Innovation (CQUIN) scheme for quarter 4 (January to March 2023). The results showed high compliance for the recording of the NEWS2 score, escalation time and response time for unplanned critical care admissions. This compliance had increased from 50% in Quarter 1.

There was also improved compliance with cirrhosis and fibrosis tests for alcohol dependent patients and was now 98% from 6.6% in quarter 1.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural, and other needs. Staff did not always complete fluid balance documentation when needed.

Staff now made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. For example, staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Where modified diets were required, assessments of a patient's requirements were detailed above their beds and on a whiteboard at the nurse's station. The service provided a wide choice of meals that catered for patient preferences.

We observed staff ensured patients were comfortable and ready to have their meals at a protected time. For patients in need of extra assistance, families and carers were encouraged to come in to help. We observed family members being welcomed at lunch time.

We observed mealtimes on various wards and noted that all staff were involved in serving meals to patients, including senior staff. Patients that needed support with eating their meals were given it.

We observed additional comfort rounds taking place with options for biscuits, juice, tea, and coffee. Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it.

Staff monitored patients' fluid intake throughout the day. However, fluid balance charts in the records we reviewed did not always accurately capture fluid input and output where this was required.

Medical care (including older people's care)

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain assessment was recorded routinely as part of electronic physiological observation recording. The system ensured completion of the assessment was mandatory.

The trust audited pain scores following analgesia to monitor effectiveness. The trust also had plans to review and add to their pain audits to expand on their scope of oversight.

Patients we spoke with told us they received pain relief soon after requesting it. Staff prescribed, administered, and recorded pain relief accurately.

Patient outcomes

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

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers told us that local scheduled audits of different sets of notes on each ward each month, were recorded on an electronic system and uploaded onto the trust computer system. These included medical records audits, hand hygiene observation, sepsis documentation, falls, pressure ulcers (category 3 and above).

The trust developed action plans to improve outcomes. For example, the falls action plan and quality improvement project we were told about was developed in response to the findings from the audit of inpatient falls. In addition, other audits undertaken such a medication and risk assessment audits were used to extract emerging themes alongside incident reports, patient feedback and complaints.

We saw audit quality metrics displayed on wards indicated high compliance. The audit results were reflective of our observations of records.

Managers told us the implementation of electronic prescribing with mandatory fields had improved compliance and the trust had seen an overall improvement in accurate prescribing and administering of medications.

The trust held mortality and morbidity meetings to discuss learning from deaths.

Competent staff

The service made sure staff were competent for their roles. There were systems for managers to appraise work performance, but appraisal rates were below the trust target. Managers held supervision meetings with staff to provide support and development.

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

Managers gave all new staff a full induction tailored to their role before they started work. Staff we spoke with who were new to post, told us they felt well supported by their managers and peers. For example, they were allocated a 'buddy' and shadowed colleagues on supernumerary shifts. We were told there was an extensive preceptorship programme and additional support if required from practice development nurses.

However, staff told us they did not always have one to one meetings. Staff we spoke with told us managers supported nursing staff to develop through regular, constructive clinical supervision of their work, though this was informal and not always recorded. Established staff also told us they did not regularly have one to one meetings with their managers.

Appraisal rates varied between hospital sites. The appraisal rate at Montagu hospital within the medical division for medics, nursing and support staff and allied healthcare professionals was 79% on 1 ward and 97% on the other ward. In July 2023, the service did not meet the trust target of 90% as 70% of consultants had their job plans signed off. Managers told us that they were confident poor performance was identified promptly and there were mechanisms in place to support staff to improve.

The clinical educators supported the learning and development needs of staff.

Managers told us that team meetings did not happen regularly, however information on development and training was disseminated in other less formal ways.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. For example, we observed MDT board rounds which included consultants, junior doctors, physiotherapists, and nurses. We saw good communication, and a methodical approach through physical, mental, and social needs of patients.

Patients had their care pathway reviewed by relevant consultants. For example, when patients that were on general medical wards required review or input from specialist consultants liaised with each other effectively.

Nursing and medical staff we spoke with told us there was good teamwork across all disciplines and managers were approachable. Staff said they felt empowered to challenge colleagues' practice if they were concerned.

Staff liaised with the multidisciplinary team directly. For example, they referred to diabetes specialist nurses, dietitians, learning disability staff, elderly care psychiatric team and therapies colleagues.

Seven-day services

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

Patients were reviewed by doctors depending on the care pathway. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Managers we spoke with told us they received support from clinical in-reach services, for example, speech and language therapy, however, this was not available 7 days a week.

Medical care (including older people's care)

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards. For example, we saw leaflets containing information on chronic diseases such as diabetes in patient areas. There were posters displayed to raising awareness of mental health which signposted families and carers to sources of practical help.

The trust website patient and visitors section had links to health promotion information, including leaflets in easy-read format.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

People who used the service were supported to make decisions in line with relevant legislation and guidance.

Staff we spoke with told us they received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) incorporated within mandatory adults safeguarding training. However, the content was no longer sufficient to meet the recommendations within the intercollegiate guidance. The trust was taking action to address this.

Staff we spoke to knew how to access the policy and get advice on MCA and DoLS.

Staff described a multidisciplinary team approach to making best interests decisions. For example, they involved clinicians, safeguarding team, patients, and their family/carers.

The safeguarding team were responsible for the auditing of MCA and DoLs records.

Is the service caring?

Good

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients we spoke with said staff treated them well and with kindness. Staff followed policy to keep patient care and treatment confidential.

Medical care (including older people's care)

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. Staff we spoke with gave examples of adapting care to meet the needs of people with religious beliefs.

We observed patients sitting out of bed, and staff told us they encourage families and carers to bring in patients own clothes.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

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

Wards had visiting times however were flexible with these for patients who required extra family support. Staff told us this improved patient's eating and drinking and also their morale.

Understanding and involvement of patients and those close to them

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

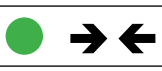
Staff made sure patients and those close to them understood their care and treatment. Staff talked with patients, families, and carers in a way they could understand.

Patients and their families gave positive feedback on the service and their treatment. Staff we spoke with told us they received positive feedback from patients and their carers.

We requested the most recent friends and family feedback for medicine. The trust provided us with data. The collection response rate was low for medicine with some wards collecting zero feedback in the format. Wards which had collected friends and family feedback were generally positive.

Staff we spoke with described how families and carers were encouraged to participate in care if they and the patient wished to. Staff now utilised therapeutic care staff to sit and ensure patients nearing end of life or patients in need of additional supervision were not left alone if their carers were away.

Is the service responsive?

Good 

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

Medical care (including older people's care)

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

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

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

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Facilities and premises were a challenge for the services being delivered. Investment in the estate was ongoing, but senior leaders were aware of the estate challenges currently.

The service had systems to help care for patients in need of additional support or specialist intervention. The service relieved pressure on other departments when they could treat patients in a day.

The service had systems to help care for patients in need of additional support or specialist intervention. Due to staffing shortages, additional one to one care was not always fulfilled on the, however staff took action to mitigate against potential risks by cohorting patients. We saw several examples of this system happening during our visit.

We saw that staff had access to additional specialist equipment such as bariatric hoists and chairs.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet their needs.

Staff supported patients living with dementia and told us they accessed advice from a learning disabilities and dementia specialists when required.

Patients were identified on the electronic white board. Patients identified as requiring 1 to 1 supervision were allocated this when staffing allowed.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff accessed interpreters when required.

Staff had access to information leaflets available in languages spoken by the patients and local community.

Patients were given a choice of food and drink to meet their cultural and religious preferences. We observed a meal service during inspection and saw examples of different food options available.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Medical care (including older people's care)

Managers monitored patient transfers and followed national standards. Managers worked to minimise the number of medical patients on non-medical wards and made sure they had arrangements for medical staff to review any medical patients on non-medical wards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. However, given the significant strain on capacity in services it was not always possible to do this.

Staff were required to monitor the number of delayed discharges and review how to manage these effectively.

Managers and staff worked to make sure patients did not stay longer than they needed to. Senior leaders were aware of the pressures within the service. Managers and clinical leaders participated in site meetings held regularly throughout the day, every day. We were told during these meetings managers discussed the number of patients waiting to be provided with beds within the service, the number of discharges planned for patients, and plans on how to manage shortfalls between the two.

Learning from complaints and concerns

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

Patients, relatives, and carers knew how to complain or raise concerns. For example, they discussed with staff directly and contacted the trust patient advice and liaison service (PALs).

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

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Staff we spoke with understood the policy on patient and carer experience (complaints) and knew how to handle them. The 2 medical wards at Montagu Hospital had 0 complaints.

Is the service well-led?

Requires Improvement ↓

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

Leadership

Leaders had the skills and abilities to run the service. However, they did not always manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Medical care (including older people's care)

The divisional structure was a triumvirate of a divisional director, divisional nurse, and divisional general manager. They were supported by two emergency and acute medicine clinical director posts, the latter of which was vacant at the time of our inspection. The service had appointed a new divisional nurse, their role would start from early October 2023.

Managers had the right skills and abilities to run the service.

Staff spoke positively about their leaders and felt respected. Staff we spoke with told us about the senior nurses within the organisation were accessible and visible. The senior leadership from above divisional lead level were present and supportive, and staff felt there was good communication and feedback mechanisms. Staff felt that senior leaders were performance-orientated, but also understood the challenges staff faced, for example the length of stays due to complex social circumstances delaying discharges.

Divisional leads we spoke with felt they were focused on patient care and the patient experience. They attended regular meetings with senior executives and felt listened to with the challenges the medicine division faced.

Staff we spoke with told us how management had supported them to take on more senior roles such as ward management and also stroke nurse practitioners.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust's vision was 'to be the safest trust in England, outstanding in all that we do.' The service's vision was 'aspiring to be the BEST.' BEST was an acronym for building partnerships, efficient and effective, sustainable services, and transformational ambition.

Some staff we spoke with were able to describe the overarching vision and strategy for the trust. We observed the trust's quality priorities displayed on posters in areas we visited. Wards also displayed their own vision for the service. There was no strategy specifically for medicine however a new trust wide nursing, midwifery and allied healthcare professionals' strategy had been launched.

All staff we spoke with told us they felt there had been ''significant improvements'' over the last 12 months. Staff told us whilst they recognised things were not perfect, there had been a lot of changes made recently and concerns had been listened to and they had felt well supported to make the required changes at ward level. Staff we spoke with felt positive about the care provided and described it as safe with major improvements in the patient's experience.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.

All staff we spoke with were proud of the organisation as a place to work and spoke highly of the culture. Staff told us they felt respected and valued.

Medical care (including older people's care)

Staff at all levels were actively encouraged to speak up and raise concerns. Staff we spoke with described an open culture where they could raise concerns with their line manager, divisional leads, or senior leadership team. They felt there was a flattened hierarchy and spoke positively about this.

There was a freedom to speak up policy to enable staff to speak up if they had concerns about colleagues' professional behaviours. Most staff we spoke with were aware of this.

Patients we spoke with were positive about their experience and interactions with staff, they told us they felt confident and comfortable to raise concerns, though they had not needed to during their inpatient stay.

Managers did not always give staff appraisals and career conversations with only 67% of staff having had appraisals in the designated timeframe, this was below the trust target of 90%.

Governance

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

We reviewed clinical governance meeting minutes. The governance structure had recently changed. Leaders we spoke with felt positive about this. Staff we spoke with felt the structure was clear, and the local leadership team had plans in place to address risks to the service, with access to information, such as monthly performance reports to maintain quality.

Staff told us that ward meetings were not consistently held, however they with told us information about incidents and quality performance indicators were emailed or disseminated informally by the ward managers and deputy managers.

Staff we spoke with were aware that senior management colleagues attended monthly safety and quality meetings. Minutes we reviewed discussed incidents and the learning outcomes however staff we spoke with below matron level told us they did not receive copies of the minutes.

Management of risk, issues, and performance

Local leaders did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks to senior leaders. They did not always identify actions to reduce their impact. They had plans to cope with unexpected events.

Local leaders were not aware of all the risks and challenges we found on inspection. For example, we found equipment which had expired their safety check date and unsafe storage of controlled substances hazardous to health (COSHH) such as cleaning chemicals. Records were not always stored securely, and we found risks within medicines management. In addition, we found no action had been taken for increasing the compliance of mandatory training.

Although there were systems in place to allow staff to escalate risks to senior leaders, some risks we found on inspection had not been identified, escalated, or listed as a risk on the risk registers within the medicine division or trust risk register.

There were systems to allow staff to escalate risks. Records of governance meetings showed that risks were considered and discussed at these meetings. The divisional leads attended a monthly Performance Overview and Support meeting which was chaired by the Chief Finance Officer. The division was held to account for performance, patient experience and quality of care.

The trusts winter and escalation plans for 2023/24 were still in the planning phase and going through governance processes.

The risk register had 49 risks documented, this included 4 extreme risks, 14 high risks, 24 moderate and 6 low risks. All risks were RAG rated. We asked service leads about their main risks which aligned with the divisional risk register. They included workforce challenges and equipment. However, it was not clear what mitigating actions in place for all identified risks on the register.

Information Management

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

The trust's main patient records management software worked well and included all relevant patient observations, assessments, and results. There were some paper records. Staff told us they had enough computers and handheld devices; however, the internet connection was prohibitive in accessing information quickly.

The service had built in IT safeguard improvements to this software, such as the red, amber, green (RAG) rated 'footsteps' system to support clinical prioritisation of patients.

Most data was stored securely however we did observe some omissions in this area in some of the wards we visited.

Staff told us there was a backup in the event the IT system failed and there was a procedure for medication administration during any downtime.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff told us the matron and divisional leads did walkarounds. Staff told us they felt leaders openly engaged with them and were receptive to feedback and suggestions. Staff told us that the divisional leadership team supported several quality improvement projects to help improve services, for example there is a current quality improvement project for falls reduction.

We heard staff routinely thanked each other through a private messenger group application.

Staff also told us there was a therapy husky dog to provide comfort and support to colleagues, as well as patients trust wide.

Staff told us the trust had invested in staff wellbeing and staff could access reiki sessions, and physiotherapy as part of the wider wellbeing drive.

Medical care (including older people's care)

The NHS Staff survey 2022 results showed the service had all slightly lower or similar scores than the average for the hospital and comparator average. There were no significant differences. Most of the scores were mid-range. For example, they scored 7.16/10 for being compassionate and inclusive and this was just below the hospital average of 7.32/10 and the same as the comparator average. There were some lower range scores for appraisals 4.63/10 which matched the inspection findings. They scored 4.40/10 for burnout, but this was following the COVID-19 pandemic.

Learning, continuous improvement and innovation

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

The trust was working in partnership with other trusts in South Yorkshire to implement a new, dedicated orthopaedic hub for the people of South Yorkshire, with health professionals undertaking hip and knee replacement inpatient procedures alongside foot and ankle, hand and wrist, and shoulder day case surgery.

The Montagu Elective Orthopaedic Centre (MEOC) would feature two state-of-the-art theatre units, two anaesthetic rooms and a recovery suite, in addition to 12 inpatient beds in a dedicated orthopaedic facility. The development would also benefit from its placement within Montagu Hospital, co-located with rehabilitation services and with access to the planned Community Diagnostic Centre, which would enhance local diagnostic capacity for illnesses such as cancer.

In the first year of operation, it was expected that the centre would undertake over 2,000 orthopaedic procedures on behalf of the three partner trusts, equating to about 40% of the current orthopaedic waiting list locally.

Staff received learning specific to their ward which captured learning after significant events and safety reminders.

Staff we spoke with told us how managers had supported them to develop their career. For example, they attended courses to extend skills such as male catheterisation and cannulation.

Healthcare assistants told us they were supported to commence registered nurse training.

The hospital supported student nurses from a local universities though structured placement. Student nurses we spoke with told us they got good levels of support and some of them had jobs on the wards they worked on.

They told us that they were involved in improvement projects such as pressure ulcer reduction and felt that local level leaders were open to suggestions and ideas.

Surgery

Requires Improvement ↓

Is the service safe?

Requires Improvement ↓

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

Mandatory training

The service provided mandatory training in key skills to staff.

Nursing staff received and kept up to date with their mandatory training. The nursing staff achieved an overall completion rate of 90.1% against the trust target of 90% compliance.

Medical staff were not up to date with their mandatory training. The medical staff compliance rate was 68.4% across the surgical division, against the trust target of 90%.

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

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. Nursing staff told us managers gave them warning through the trust's electronic training system that they needed to update a training module and that they were always given support to access the training.

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse. The compliance figures for nursing staff were at 93.3% overall for Safeguarding Level 2 training for adults and 88% for children, against the trust target of 90% completion.

Medical staff received training specific for their role on how to recognise and report abuse. The compliance rates for medical staff were at 71.4% overall for Safeguarding Levels 2 adults and 65.2% for children, across the surgical division, and this was below the trust target of 90% completion.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Theatre staff demonstrated a good knowledge of safeguarding and had completed the appropriate levels of safeguarding training. They understood how to support patients from abuse in their surgery department.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff discussed safeguarding risks during patient handovers and staff huddles.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were aware of safeguarding procedures, how to make referrals and access advice; there were safeguarding leads throughout wards and a head of safeguarding in place. Ward staff knew where safeguarding policies were for support. They used online forms to refer safeguarding notifications or queries to the local authority multi-agency safeguarding hub. Nursing staff said they would inform their nurse in charge or matron depending on the severity of their concern.

We reviewed the trust's safeguarding adults at risk of abuse and neglect policy which was in date (April 2022), version controlled and had a review date of Feb 2025.

Staff told us matrons produced safeguarding reports where any learning for staff was included.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

Ward areas were mostly clean and had suitable furnishings which were mostly clean and well-maintained. On the Rockingham day unit there was visible dust on top of patient storage cupboards and on windowsills. All patient chairs on this unit were damaged from cleaning products.

Hand hygiene points were visible at the entrances of each unit. Empty bed spaces had checklists completed to indicate they were clean and ready for the next patient.

Across the surgical division the service generally performed well for cleanliness. Cleanliness audits scored between 81% and 99.2% in the previous 6 months before inspection. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

The latest (2022) Patient-Led Assessments of the Care Environment (PLACE) score was 98.4% for cleanliness.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were seen to wash hands, use antibacterial gels and PPE. Masks were worn in line with trust policy. Some patients told us that staff always washed their hands and wore PPE.

Staff worked effectively to prevent, identify, and treat surgical site infections.

Data on infection rates was also collected monthly for each ward. This included information on MRSA, clostridium difficile, pseudomonas, Escherichia coli (E. coli) and methicillin-susceptible Staphylococcus aureus (MSSA). In the period September 2022 to March 2023, data showed that the infection rates for all surgical wards across the trust were low.

The Rockingham day unit displayed an infection, prevention, and control (IPC) noticeboard. This showed positive 98% compliance rate for IPC from an audit completed in May 2023.

We observed hand sinks in every room with a poster above every wash basin about hand washing hygiene. Handwashing and gel available at every entrance and all pedal bins were foot operated.

We observed appropriate use of personal protective equipment (PPE).

All curtains were disposable and labelled with date fitted and date to be changed. The wards used 'I am clean' stickers.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use them. Staff managed clinical waste well. The servicing and safety testing of some equipment had expired.

The design of the environment followed national guidance. Wards, theatres, and units were easy to find. There were 4 theatres.

Staff did not always carry out daily safety checks of specialist equipment. We found that over a 3 month period (June to August 2023) there were 10 occasions when resuscitation equipment records checks had not been completed. Following the inspection senior leaders confirmed that 6/10 occasions were weekend dates when the unit was closed and therefore no checks were required.

On one ward kitchen we found equipment such as toasters and microwaves which had expired their safety check date, and some had never been safety tested. We also found Control of Substances Hazardous to Health Regulations (COSHH) chemicals which had not been safely and appropriately, stored.

On the Rockingham day unit all plugs attached to patient beds still showed an old safety sticker which had passed its expiry date for example the oldest sticker related to 2015. These old stickers had not been removed when the beds had been re-tested. However, a new label had been attached to the front of the bed.

Theatre storage cupboards and drawers did not always close properly as some hinges were old and damaged.

Patients could reach call bells and staff quickly responded most of the time when called.

The service had suitable facilities to meet the needs of patients' families. However, the Rockingham day unit had an easily accessible back door which was not safety locked which meant that patients who were vulnerable could easily exit the unit.

The service had enough suitable equipment to help them to safely care for patients. Wards had access to specialist mattresses and chairs to reduce the risk of pressure ulcers for those patients who needed them.

Staff disposed of clinical waste safely.

There was no signage on any entrance or exit doors warning staff not to allow members of the public into unit before checking the appropriateness.

There were processes in place for the management of faulty equipment.

Staff did not always record actions taken when fridge temperatures were out of range. For the kitchen fridges we found 55 occasions in June and August 2023 when staff had not recorded any actions when the temperature of ward fridges were out of range between 1 and 5 degrees Celsius. We found 61 occasions in June and July 2023 when the staff had not recorded any actions when the temperature of theatre fridges were out of range over 8 degrees Celsius. This was not in line with trust policy. In addition, staff reset all fridge temperatures every day instead of only on the days it was out of range.

Staff told us they measured the ambient room temperatures for the storage rooms where fluids were being stored. However, they did not record these temperatures.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The trust supplied data to demonstrate that an audit programme took place to ensure that staff followed the trust's early warning and sepsis scoring protocols.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

Staff knew about and dealt with any specific risk issues. Where an indicator of sepsis was identified, the trust followed a national pathway (Sepsis 6) to provide testing and treatment to patients within one hour. We reviewed the trust sepsis assessment form and noted that the trust used an SBAR approach (situation, background, assessment, and situation) to review patients following an acute episode of deterioration.

There were no inpatient facilities on the Rockingham day unit and patients who required overnight care were transferred to the trust or neighbouring hospital sites.

In an emergency situation staff had access to a cardiac resuscitation trolley and would follow policy and dial 999 emergency services.

The service had 24-hour access to mental health liaison and specialist mental health support via direct referral, if concerned about a patient's mental health. Staff we spoke with knew how to access the mental health support. There was access to specialist nurses and crisis teams.

Staff shared key information to keep patients safe when handing over their care to others. The wards had daily safety briefings which highlighted potential risks to patients. The agenda included points such as 'patient specific risks', capacity in the ward, staffing levels and a review of patients coming to the unit.

Shift changes and handovers included all necessary key information to keep patients safe. Handovers were supported using briefing documents to ensure consistent messages across shifts. The nursing handover document included key information regarding individual patients which included a plan of care, key risks, and discharge plans.

Surgery

Staffing

The service had enough staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

The service had enough staff to keep patients safe. However, staffing had continued to be a challenge across the trust. Nursing staff turnover for the surgical services at the time of the inspection was 8.3%.

The percentage of shifts filled against the planned nurse staffing across the trust was 96% at the time of the inspection. Overnight average fill rates for staffing were at least 100% for the three months before inspection.

Managers accurately calculated and reviewed the number and grade of staff which included nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The ward manager could adjust staffing levels daily according to the needs of patients.

The service sickness rates for nursing staff were 6.3%.

Managers made sure all bank and agency staff had a full induction and understood the service.

The Rockingham day unit was a nurse led unit. Nursing staff had access to medical doctors for advice and guidance.

Medical doctors worked to support the theatre and outpatient activity. Please see other location reports for vacancy, turnover, and sickness rates for medical doctors.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. We noted that records were fully completed, accurate and legible. Those assessments that the trust required to be done on admission were always completed.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Patient records showed good documentation of patient's allergies including positive documentation of no known allergies.

Records assured us patients were receiving their medicines as prescribed.

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

Surgery

Staff usually stored and managed all medicines and prescribing documents safely. Controlled Drugs fridge temperatures were recorded daily, and no concerns were noted by the inspection team.

Staff stored and managed all medicines and prescribing documents safely. Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff completed medicines records accurately and kept them up to date.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with trust policy.

Managers shared learning with their staff about never events that happened elsewhere.

Staff reported serious incidents clearly and in line with trust policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.

Is the service effective?

Good ➔➔

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

Surgery

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The trust had comprehensive policies, procedures and guidance which were aligned with that of national bodies such as the National Institute for Health and Care Excellence (NICE) and specialist bodies. Staff demonstrated awareness of the policies and knew how to access them.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers. Handover meetings showed individual needs of patients were discussed. Our patient records reviews showed that patients' psychological and emotional needs were recorded.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Nursing staff asked patients about any food intolerance or allergies as part of their pre-assessment. This also included specific dietary or cultural requirements, such as vegetarian or halal. This information was passed to the catering team so suitable food could be provided for the patient during their stay.

Specialist support from staff such as dietitians and nutrition assistants were available for patients who needed it.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Malnutrition Universal Screening Tool (MUST) scores were completed on admission and then again 24 hours post operatively.

Patients waiting to have surgery were not left nil by mouth for long periods. We reviewed the Trusts standard operating procedure (SOP) for surgical patients who were nil by mouth. The policy had information to support staff with a protocol for intravenous fluids and information for pre fasting guidance for patients before surgery.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and usually gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The trust used differing methods to assess patient pain levels which included FLACC assessment, Burford thermometer and Visual analogue scales (VAS) score.

Patients usually received pain relief soon after requesting it.

Staff prescribed, administered, and recorded pain relief accurately.

Surgery

Patient outcomes

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

Montagu Hospital undertook low risk surgical procedures for hand, wrist, shoulder, and elbow. This meant there was no requirement to submit information to national databases.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

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

Managers gave all new staff a full induction tailored to their role before they started work. All staff working at the hospital had an induction programme relevant to their role and the department they worked in. New staff were required to complete e-learning and face-to-face training.

The clinical educators supported the learning and development needs of staff.

Managers supported staff to progress through regular development meetings and yearly constructive appraisals of their work. Staff had the opportunity to discuss training needs and were supported to develop their skills and knowledge. Nursing staff appraisal rates across surgical services were 91.2% at the time of inspection.

Staff told us they found the appraisal process useful, and they were encouraged to identify any learning needs they had, and any training they wanted to undertake. Staff were supported by their managers to improve their practice where indicated.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. To ensure effective services were delivered to patients, we saw different teams and health professionals working with staff at the service as a multidisciplinary team (MDT).

We saw a variety of staff working together, such as nurses and support workers, to benefit patients. Nursing staff said they had good communication between theatre and ward staff.

We could see from the handover sheets and records we examined that there was detailed communication between staff of different grades and roles.

There was a discharge team who had links with local services, local authorities, and care providers.

Surgery

We saw therapist input and contributions to patients' discharge. The patient input into care was included throughout and involvement of family member as the patients next of kin was also present.

Seven-day services

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

Pharmacy staff were available Monday to Friday.

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

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units. We saw displays on wards we visited through our inspection on healthy lifestyles and health promotion. There were leaflets available for patients to take on a variety of topics including diabetes, weight loss, stop smoking and stress.

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

There were guidelines in place to support patients withdrawing from drugs or alcohol.

The multidisciplinary team provided health and self-care advice to patients to support them to manage their own conditions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records.

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards as part of their safeguarding training. Nursing staff had met the trust target for compliance, but medical staff were below the target of 90% with a compliance rate of 71.3%.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, and Mental Capacity Act 2005 and they knew who to contact for advice.

Surgery

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Is the service caring?

Insufficient evidence to rate

At the time of the inspection there were no patients receiving surgical treatment and therefore we had insufficient evidence to rate caring.

Is the service responsive?

Good ➔➔

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

Service delivery to meet the needs of local people.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

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

There was engagement with the integrated care system to identify transformation and development opportunities which enhanced the services for Doncaster and Bassetlaw communities and staff. Transformation programmes included the Bassetlaw Emergency Village and the Montagu Elective Orthopaedic Centre. The trust had started this construction which was due to be competed December 2023.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. There had been no breaches on any surgical wards.

Facilities and premises were appropriate for the services being delivered.

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

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Support was available for patients with physical and learning disabilities. Staff said they treated every patient as an individual, which meant they made reasonable adjustments to meet the needs of patients with a learning disability or who were living with dementia and their family members.

Initiatives to enhance the care of those with a learning disability were in place. Health passports were in use. These detailed personal preferences, triggers, and any interventions which were helpful in supporting individuals during difficult periods.

Staff recognised the importance of involving relatives and carers for any patient with additional needs. The patient records that we reviewed reflected that individual needs were assessed, and care planning was informed by this.

Staff supported patients and those close to them during referral, transfer between services and discharges. Staff always informed patients of possible changes to their care before it occurred. Before discharges staff informed the patient and their family of where they were to be discharged to and what expectations to have of the services being provided.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff knew how to access interpreting services for patients whose first language was not English. Translation could be provided face to face or over the telephone. Communication aids such as letter boards were also available.

Access and flow

People could access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients met national standards.

Montagu Hospital undertook low risk surgical procedures for hand, wrist, shoulder, and elbow. These were all day case admissions. Managers monitored these waiting times.

In terms of the trust's elective recovery in October 2023, the 18-week consultant led referral to treatment times for all patients was 61.5% against a goal of 92%. This had deteriorated over the last few months.

The service's 18 week performance from August 2022 to July 2023 showed the compliance against the planned orthopaedics cases was 83%. This was better than other surgical specialisms.

Managers and staff started planning each patient's discharge as early as possible.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them.

Staff supported patients when they were referred or transferred between services. Managers monitored patient transfers and followed national standards.

Learning from complaints and concerns

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

Patients, relatives, and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Surgery

Managers investigated complaints and identified themes. The service had 7 complaints received in 2022/2023.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Is the service well-led?

Requires Improvement

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

Leadership

Leaders had the skills and abilities to run the service. However, they did not always manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Surgical services had managers with the right skills and abilities to ensure the service was providing high quality care. The divisional structure currently had 6 tiers.

At the time of the inspection there were 2 deputy divisional nurses overseeing the division reporting to the Chief Nurse. The divisional nurse role had been recruited to with a start date in September 2023.

Leaders were inspiring a shared purpose and were focussed on delivering and motivating staff to succeed. Managers were keen to retain staff and invested in education for staff to progress.

The leadership team understood the current challenges and pressures impacting upon service delivery and patient care. However, senior leaders were not aware of all the risks we found on inspection.

The clinical leadership team were visible and approachable. Staff said they had confidence in working together, and in leaders understanding issues and working better to improve them.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a vision for what leaders want to achieve in surgery and this was in line with the trust vision. The service promoted training, and staff were aware of the vision for surgery and were able to share this with us during inspection.

The trust planned expansion of elective and diagnostic capacity including the establishment of a Community Diagnostics Centre. In addition, development, and implementation of the Mexborough Elective Orthopaedic Centre (MEOC) and development and implementation of a sustainable trauma business case.

Surgery

Divisional service development priorities included improving the utilisation and throughput of elective recovery theatres and out-patient transformation. There were plans to address resources and pathways to manage and address backlogs as well as Day Case Arthroplasty service development. Priorities included creating the ophthalmology hub with data sharing and single point of access.

The trust had identified a number of divisional challenges and priorities, such as, achieving a full establishment of medical, nursing, and administrative workforce. This included ensuring that specialty and specialist (SAS) doctors had career development pathways and that nursing staff had improved skill mix, training, that there was contingency planning and clear career development opportunities.

In addition, the trust aimed to increase nurse endoscopists and non-clinical / medical endoscopists through recruitment and training programs. This included robust inductions, preceptorship, and clinical development plans for new and developing staff.

The trust had plans for recruitment and retention programs- Breast, Dental, ENT, General Surgery, Ophthalmology, Trauma & Orthopaedics as well as administrative recruitment and retention support and strategies.

Staff told us they provided patients with person-centred care and that working well in a team was key to achieving their vision and strategy.

The management team shared they were dedicated to workforce retention and prioritising wellbeing and development across staff groups.

Culture

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

Staff were positive and caring towards patients and their relatives who used the service. In addition, we also noted caring and respectful interactions between staff of all grades and disciplines.

The care and service delivered showed a strong team approach to work. Staff from all disciplines told us they felt valued in their roles and were very much part of the team. Staff we spoke with expressed pride and commitment in their work.

There was a clear focus of patient centred care and teamwork, support between colleagues was strongly evident throughout the different areas we visited for both nursing and medical staff.

The service promoted equality and diversity in daily work. We found that 85.3% of medical staff and 99.4% of nursing staff across the service had completed Equality, Diversity, and Human Rights level 3 training.

The surgical and cancer division had a “speaking up” partner who escalated concerns, where appropriate, to the Freedom to Speak Up Guardian.

Governance

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

Staff at all levels of the organisation understood what to escalate to a more senior person, and this happened for reporting low staffing levels. Ward managers told us that they had the option to report red flags when staffing levels were low. The number of red flags were reported monthly to the board.

We saw a performance board showing examples of audit results from January 2023 and showed when an action was required, progressing, or resolved. It also showed pictures of when things had not been compliant.

We saw many examples of 'you said / we did examples' such as when a patient raised a concern about long medication waits. The trust worked with doctors and pharmacy to highlight patients that were potential for discharge the day before, so that they could ensure medication was ordered and discharge letters completed.

Management of risk, issues, and performance

Leaders and teams did not always use systems to manage performance effectively. They identified and escalated relevant risks and issues or identify actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had a systematic process, involving staff of all roles and grades, in reviewing and improving the service. This included identifying risks and planning to reduce the level of risk. There was a rolling agenda of meetings to improve quality and patient safety.

However, senior leaders were not aware of all the risks and challenges we found on inspection. For example, ensuring premises and environment were safe and secure. We also found equipment which had expired their safety check date some had never been tested and unsafe storage controlled substances hazardous to health (COSHH) cleaning chemicals. These were not listed on either the surgical or trust risk register.

There was a risk management process related to risk with monthly risk meetings. The risks were escalated to the divisional meetings.

Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact giving a red, amber, green (RAG) rating. The Surgical and Cancer service risk register contained 24 extreme risks and 20 high risks. We reviewed divisional governance meeting minutes and saw that extreme and high risks were appropriately reviewed and updated on a monthly basis.

All serious incidents (SI), incidents and moderate harms were reported to the Surgery and Cancer Division Clinical Governance Meeting and progress reports discussed. There were 8 outstanding SI action plans for the division in July 2023. There had been several serious incidents resulting from patients being lost to follow-up or review.

There was a rolling agenda of meetings to improve quality and patient safety.

Quality and performance dashboards highlighted that overall, the Surgery and Cancer division were performing well in all but 2 areas. The two weaker areas were lower than target appraisal rates and low Friends and Family Test (FFT) response rates. All other areas, which included number of complaints, falls with severe harm, falls with moderate harm, and MRSA rates were all low or zero. There were low number of pressure ulcers (category 2) and no pressure ulcers graded category 3 across the division for the last quarter.

There was effective oversight of performance regarding antimicrobial prescribing and stewardship. We saw monthly meeting minutes which evidenced ongoing audit of medicine management compliance and antibiotic prescribing data. Antibiotic prescribing varied across the surgical wards depending on speciality, as expected.

Information Management

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

Staff had access to the IT equipment and systems needed to do their work. However, the trust was developing data to ensure divisions had the systems to understand performance make decisions and improvements.

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. Systems were in place to collect data from wards and teams.

Information governance systems were in place and ensured the confidentiality of patient records.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

We saw the staff engagement group met monthly and this covered a wide variety of agenda topics in recent minutes we reviewed. We saw that staff survey questions had been updated to align with the NHS People Promise and that the trust had asked additional questions regarding the awareness of trust values. The initial staff survey results showed an encouraging and improving picture in relation to feedback. Work was being undertaken in relation to communication of the results and engagement with local teams, to embed a cycle of year-round engagement.

The response rate for the staff survey was 65.2% and the comparator average for acute trusts using the same provider was 43%. The trust was a leading acute trust for the response rate amongst comparable trusts and achieved the highest ever response rate for the survey at the trust, which is a positive sign of engagement. However, the information received did not show statistic broken down for the Surgery and Cancer Services division.

There was a clear focus on engagement activities to develop a culture of inclusion. The trust held events for staff from ethnic minority groups.

The patient satisfaction survey results for the surgical outpatient department were positive with a response rate of 130 patients. Out of the 130 responses 113 patients had an excellent experience, 15 had a good experience and 2 people did not answer.

It was noted in the June 2023 Surgical and Cancer division governance minutes that the friends and family test (FFT) response rates were not at the level required. However, improvements had been noted and further spot checks were planned.

Surgery

Learning, continuous improvement and innovation

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

Working in partnership with two additional trusts, Doncaster and Bassetlaw Teaching Hospitals (DBTH) were leading the programme to implement a new, dedicated orthopaedic hub for the people of South Yorkshire. Surgical procedures would include hip and knee replacement inpatient procedures alongside foot and ankle, hand and wrist, and shoulder day case surgery. In the first year of operation the centre planned to undertake approximately 2,200 orthopaedic procedures on behalf of the three partner trusts, equating to about 40% of the current orthopaedic waiting list locally.

Known as the Montagu Elective Orthopaedic Centre (MEOC), the facility would feature two state-of-the-art theatre units, two anaesthetic rooms and a recovery suite, in addition to 12 inpatient beds in a dedicated orthopaedic facility. This development would be based at Montagu Hospital, co-located with rehabilitation services and with access to the planned Community Diagnostic Centre.

In the previous financial year as part of the elective recovery programme the 'My Planned Care' patient platform was launched with the purpose of enabling patients to be kept better informed about how long they may be waiting for procedures. The Patient Advice and Liaison Service (PALS) were the designated contact point, and a dedicated email inbox had been set up.