Doncaster and Bassetlaw Hospitals NHS Foundation Trust

Quality Report

Armthorpe Road
Doncaster
DN2 5LT
Tel: 01302 366666
Website: www.dbh.nhs.uk

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

Ratings

Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

The inspection of Doncaster and Bassetlaw Hospitals NHS Foundation Trust took place between the 14 and 17 April 2015. We undertook an unannounced inspection on the 29 April 2015. During the inspection we inspected clinical services at Doncaster Royal Infirmary, Bassetlaw District General Hospital, Retford Hospital and Montagu Hospital.

The inspection was part of CQC's scheduled inspection programme.

Overall we judged the trust as requires improvement. Across the 5 key questions, we rated safety, effectiveness and responsiveness as requires improvement; caring and well-led were rated as good. Within these overall ratings there was variation across different clinical services, across different hospital locations.

Our key findings were as follows:

- Staffing levels vary across services. The trust is actively recruiting, but vacancies are impacting on the quality of service provided in some instances.
- Not all staff have received an appraisal or have accessed mandatory training. The trusts systems for recording these also require development.
- The majority of areas we inspected were clean, however we did identify concerns in the critical care unit at Doncaster Royal Infirmary, the sterile supplies departments at both Doncaster Royal Infirmary and Bassetlaw District General Hospital, and the minor injuries unit at Montagu Hospital.
- The majority of staff followed correct infection prevention processes, and hand washing techniques. We did identify some concerns regarding infection prevention practices in the critical care unit at Doncaster Royal Infirmary with regard to nursing patients with infections.
- Patients received appropriate nutrition and hydration whilst an inpatient.

We saw several areas of outstanding practice including:

- The trust managed the Abdominal Aortic Aneurysm (AAA) screening programme across South Yorkshire and Bassetlaw as part of the drive to reduce the number of people who die from the condition.
- Gina's story arose from an incident at the trust, where the trust learnt and shared learning working with patients in an open and honest way. This work was recognised, locally, regionally and nationally and a local University was using the Human Factors and shared learning work from Gina's story into one of their programmes.
- The trust was awarded the 4th National Dementia Care Award for the Best Dementia Friendly Hospital. In addition Stirling Ward was developed as the frailty assessment unit to ensure that people living with dementia were reviewed by clinicians skilled in their management at the earliest opportunity.
- The trust was working with Sheffield University in developing specialty specific training for rehabilitation nurses from Band 2 to 7.

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

Importantly, the trust must as a provider:

- Ensure that the public are protected from unnecessary radiation exposure.
- Ensure that staff receive an effective appraisal.
- Ensure that staff receive mandatory training including adult and child safeguarding training

Additionally at Doncaster Royal Infirmary the trust must:

- Review arrangements for the initial assessment of patients, including the use of streaming and triage, and add streaming / triage to the risk register
- Ensure appropriate numbers of medical, nursing and support staff of the required skill mix are available in the emergency department
- Ensure patient waiting times are reduced to ensure the 95% target for patients seen within four hours is met and maintained
- Ensure patients' pain symptoms are assessed, and pain relief administered promptly for all groups of patients.
- Review nurse staffing of the children's inpatient wards to ensure there are adequate numbers of registered children's nurses and medical staff available at all times to meet the needs of children, young people and parents.

Summary of findings

- Ensure that a clean and appropriate environment is maintained throughout the theatre sterile supply unit, emergency department and critical care unit that facilitates the prevention and control of infection.

At Bassetlaw District General Hospital the trust must:

- Review nurse staffing of the children's inpatient wards to ensure there are adequate numbers of registered children's nurses and medical staff available at all times to meet the needs of children, young people and parents.
- Ensure that a clean and appropriate environment is maintained throughout the theatre sterile supply unit that facilitates the prevention and control of infection.

At Montagu Hospital the trust must:

- Ensure the minor injuries unit is clean and well-maintained.
- Ensure that medicines are safely managed within outpatients and diagnostics.

At Retford Hospital the trust must:

- Audit the Radiation Exposure/ DRLs.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Doncaster and Bassetlaw Hospitals NHS Foundation Trust

Doncaster and Bassetlaw NHS Foundation Trust provides a wide range of health services across four hospitals (Bassetlaw District General Hospital in Worksop, Doncaster Royal Infirmary, Montagu Hospital, Mexborough and Retford Hospital), as well as community locations including Chequer Road Clinic. The trust serves a population of around 420,000 people in the areas covered by Doncaster Metropolitan Borough Council and Bassetlaw District Council, as well as parts of North Derbyshire, Barnsley, Rotherham, and north-west Lincolnshire.

The health of people in Bassetlaw was varied. Deprivation was higher than the England average and about 3,800 children lived in poverty. Life expectancy for both men and women was lower than the average. Rates of deaths from smoking and hospital stays for alcohol related harm were worse than the England average. The health of people in Doncaster was generally worse than the England average. Deprivation was worse than the England average, as was the proportion of children living in poverty. Life expectancy for both male and females were both below the England average. Early deaths from heart disease and stroke, and from cancer were both higher than the England average.

The trust was inspected as part of CQC's programme of scheduled inspections. We inspected eight core services, and visited four hospitals as part of the inspection. The clinical services we inspected were;

- Medical services
- Surgical services
- Emergency services
- Out-patients and diagnostic services
- Critical care services
- Obstetric and gynaecology services
- Children's services
- End of life services

Our inspection team

Our inspection team was led by:

Chair: Yasmin Chaudry

Head of Inspection: Adam Brown, Care Quality Commission

The team included CQC inspectors and a variety of specialists: consultant paediatrician, consultant obstetrician, consultant anaesthetist, consultant physician, junior doctors, clinical nurse specialist, radiographer, midwife, senior nurses and managers, student nurse and experts by experience.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These organisations included the clinical commissioning groups, local area team, Monitor, Health Education England and Healthwatch.

We carried out an announced visit on 14 -17 April 2015. We talked with patients and staff reviewed patients' personal care or treatment records. We held a listening event on 13 April 2015 in Doncaster and attended a local

Summary of findings

group in Bassetlaw to hear people's views about care and treatment received at the hospitals. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection.

We carried out an unannounced visit on 29 April 2015.

What people who use the trust's services say

People we spoke with during the inspection, including patients, carers and relatives. We also spoke with some families prior to the inspection, but there were no specific themes or trend identified from this information. Patients felt involved in their care and the majority of relatives considered that they were informed of what was happening to their relative. Family and Friend Test results were positive, though in some services there was a low response rate.

Facts and data about this trust

In December 2014 CQC's intelligence monitoring placed the trust in priority band 2 with five elevated risks and 3 risks.

These risks were;

Potential under reporting of patient safety incidents

Patients waiting over six weeks for a diagnostic test

General Medical Council – enhanced monitoring

The elevated risks were;

Dr Foster Intelligence: Composite of Hospital Standardised Mortality Ratio indicators

Maternity outlier alert: Neonatal readmissions

SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator

NHS Staff Survey - KF7. The proportion of staff who were appraised in last 12 months

NHS Staff Survey - KF10. The proportion of staff receiving health and safety training in last 12 months

Between December 2013 and April 2014, the trust reported one never event (an event so serious it should never happen) in maternity services, 119 serious incidents, and 8431 incidents. The trust is judged as a lower reporter of incidents compared with England reporting 7.9 incidents per 100 admissions, compared with 9.3 incidents per 100 admissions for England.

Between April 2013 and November 2014, clostridium difficile rates were lower than the England average, and the trust reported 3 incidents of Methicillin resistant staphylococcus aureus infections.

Clostridium Difficile rates were lower than the England average, aside from a small rise between November 2013 to January 2014, with a peak during May 2014.

The trust had 977 beds;

- 766 General and acute
- 185 Maternity
- 26 Critical care

The trust employed nearly 6000 staff, of which;

- 637.86 WTE Medical
- 2474.97 WTE Nursing
- 2714.15 WTE Other

The trust had yearly revenue of £349m, and did in the last reported year make a surplus of £5.2m

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe?	Requires improvement 

Summary

There was a low level of safeguarding and mandatory training across the majority of sites and the trusts reporting systems were not effective at accurately reporting the number of staff who had received training.

There were concerns regarding staff levels in many areas across the trust. The trust was taking action to recruit, and was in the process of undertaking further overseas recruitment for nursing staff; however across both nursing and medical staffing, vacancies continued to cause concern amongst staff with high levels of agency and bank staff in some areas.

We identified a range of concerns regarding cleanliness and infection prevention and environmental concerns at a number of sites.

There were systems in place for incident reporting and the majority of staff received feedback. Action was taken to reduce risk of recurrence. The majority of staff were aware of the Duty of Candour requirements and the trust had taken action to develop appropriate systems to ensure where the Duty of Candour applied appropriate action was taken to inform the patient or their relatives.

For further detail please refer to the individual location reports for Doncaster Royal Infirmary, Retford Hospital, Montagu Hospital and Bassetlaw District General Hospital.

Duty of Candour

- The executive team and those in senior management positions we spoke with were aware of the Duty of Candour and what it meant for patients.
- We spoke with a wide range of staff and the majority were aware of the Duty of Candour. Those who were less clear were confident regarding openness and transparency when things went wrong and that patients should be made aware when incidents or near misses occurred.
- There was a system in place to meet the requirements, but the trust recognised more work was to be done to ensure it was fully implemented. We noted that information relating to the Duty of Candour was the screen saver on all the computer terminals we saw across all the locations.

Summary of findings

Safeguarding

- There was a mixed picture regarding safeguarding across the trust. The trusts central reporting systems were weak and the reported number of staff who had received safeguarding training was low. However locally held training records indicated that more staff had received training.
- Staff were aware of their responsibilities with regard to safeguarding.
- The current safeguarding training plan was introduced in February 2015, but with current levels of attained training for safeguarding level 2, the 100 training places offered per month would mean a number of years would elapse before the trust hit its target of 90% of staff trained. There are additional training opportunities including a two hour level 1 safeguarding course and induction programmes.
- Although there were safeguarding structures in place, there was no formal named nurse from the summer of 2014 until March 2015. We were told that although the previous named nurse had retired they remained within the organisation and provided advice on safeguarding to the head of safeguarding.

Incidents

- The trust had an electronic reporting system in place for staff to report incidents and near misses. Staff reported that they felt supported to report incidents and there was an open culture within which to do so.
- There had been two clusters of stillborn babies between January 2014 and the end of January 2015 between Doncaster and Bassetlaw Hospitals. Seven of the stillbirths occurred at Bassetlaw. This gave a rate of 4.84 still births per 1000 live births against a national average of 4.7 still births per 1000 live births (Office of National Statistics 2013). A still birth review had taken place and each case was assessed against the National Patient Safety Agency Stillbirth Toolkit. There were some concerns over the recurrent theme of staff not following clinical guidelines. Further information after our inspection from Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) report on 10 June 2015 showed the stillbirth rate had reduced to 4.64 per 1000 births. This was marginally lower than the England average.
- There had been one never event in obstetric services in February 2015. A process for root cause analysis was in place and we found evidence of this approach having taken place for serious untoward incidents.
- The majority of staff received feedback following the reporting of incidents, though this was not the case in some services, for

example diagnostic services at Montagu Hospital. We saw evidence in care group records of sharing learning and actions at staff meetings to reduce the recurrence of concerns in the future.

Staffing

- Whilst staffing arrangements was suitable in some clinical areas, there were many where there was too few staff. Recruitment was taking place across the organisation.
- Gaps in staffing levels were discussed within clinical care groups. Reporting to the board in respect of the Hard Truths reporting requirements described the variance between the total planned hours for nursing staff and the hours actually worked in March 2015, was discussed at the Board meeting in April 2015. Many services had a higher number of hours worked than they had staff available for.
- Some services had moved to a seven day service provision but concerns were raised regarding the number of staff available to provide this level of service. For example staff told us that although a full seven day emergency service was possible in obstetric theatres, there were no dedicated recovery staff, and at night staff would be taken from the main theatres leaving them equally short of staff.
- At Doncaster Royal Infirmary, the midwife to birth ratio was 1:31 against a national recommended ratio of 1:28. We were told that the clinical commissioning group had agreed a ratio of 1:32 in March 2014, but staff were clear that they considered that the unit was in breach of national guidance and that rotas did not always adequately cover shifts. Thirteen percent of all reported incidents in 2014 were related to staff shortages.
- Within children's services, medical and nursing staffing were both found to be significantly under establishment and the risk register showed the service had identified medical and nursing staffing as a risk in April 2012. There was a high usage of medical locum staff and nursing staff were regularly moved between wards, units and sites to cover shortfalls. Nurse staffing levels on the children's ward did not meet current national guidelines; staffing levels on the SCBU complied with current requirements.

Cleanliness, Infection Control

- While the majority of clinical areas we viewed were visibly clean and well maintained we did identify some concerns in different locations around the trust.

Summary of findings

- At Bassetlaw District General Hospital, we found that in the main operating theatres paper notices were stuck on walls with tape, which constituted an infection control and cleanliness risk. The theatres' sterile supply room was not clean and had some areas with visible dust.
- At Doncaster Royal Infirmary, we found that parts of the theatre sterile supplies unit were not clean. In parts of the unit the flooring was patched up with sticky tape and trolleys and autoclaves were dirty, dusty and worn. These areas were brought to the attention of the trust who told us they would investigate and make any necessary improvements.
- In the critical care unit at Doncaster Royal Infirmary, there was a great deal of clutter across the unit, and infection prevention procedures were not always being followed for patients requiring isolation facilities due to infection.
- At Montagu Hospital we found a range of concerns in the minor injuries unit, including high levels of dust in the department. Staff told us that they had domestic cover during the day. However due to staff sickness this was not consistently provided by the same member of staff. Hospital porters cleaned the floors in the evening.
- In the emergency department, patient trolleys were found to be visibly dirty and dusty. Wheelchairs were stored in the resuscitation room, which could provide a health and safety risk, and were dirty. The communal play area in the main waiting room was dirty. We asked to see the cleaning record for this area, but no record was available. Sharps bins were full. In the resuscitation area, no sharps bin was provided.

Environment and Equipment

- Whilst many of the clinical areas we visited were well maintained and equipment appropriately checked, we did identify a range of concerns.
- At Montagu Hospital, in the minor injuries unit, we found a range of concerns, including damaged plaster work, ripped and damaged equipment, a cluttered resuscitation room with boxes being stored on the floor, and dated medical equipment (for example airways) where their expiry date had past.
- In the day unit at Montagu when the unit got busy patients were placed in the adjacent endoscopy unit, there were no pre-planned maintenance or deep cleaning schedules, and no single sex toilets on Rockingham Ward.

Summary of findings

- We identified concerns regarding radiation protection and audit across all sites, with a lack of signage, and measures to prevent people walking into areas that would place then at harm to risk of unnecessary radiation exposure. We raised this with the trust and referred the matter to the Health and Safety Executive.
- There were concerns regarding the buzzer systems on three wards at Doncaster Royal Infirmary within maternity and gynaecology services; there was an inconsistent use of them when an emergency occurred to summon support. Whilst there was a business plan in place to rectify this, it was not clear when this would be implemented.
- There were challenges in the design of the critical care unit at Doncaster Royal Infirmary and its compliance with Health Building Note 04-02 Critical Care guidance due to lack of space and layout. This was not on the risk register that we had access to.
- One of the concerns raised by medical and nursing staff was the seventh floor position of the unit. Two main risks from its location were problems associated with evacuating patients in a fire and the physical distance from the unit to other wards / departments such as theatres, accident and emergency (A&E) and imaging, for example, computed tomography (CT) and magnetic resonance imaging (MRI).
- The fire safety risk was on the unit's risk register as a 'red' risk; this was the highest risk category. The risk was described as an inability to evacuate patients from the unit in event of an emergency (i.e. fire). The mitigating statements were that a fire plan was available which included a horizontal evacuation plan.
- At Bassetlaw Hospital, there was no specialist bariatric concealment trolley available for transferring deceased bariatric patients and no bariatric mortuary fridge. We saw that plans to upgrade mortuary/body storage facilities at Bassetlaw included a bariatric fridge. In the meantime, deceased bariatric patients would be transferred to Doncaster. The director of nursing told us a bariatric concealment trolley was on order.
- The theatre sterile supplies area of the Doncaster Royal Infirmary was old and in need of upgrade and repair.
- We discussed the state of the estates at the trust. We were told that a range of audits and assessments had been undertaken, and a wide range of issues identified that needed to be part of the yearly planned maintenance or would require capital expenditure. An action plan was being developed to ensure this was taken forward, and had already been presented to the trust board.

Summary of findings

Are services at this trust effective?

Requires improvement

Summary

Appraisal rates varied but were predominantly below the trusts expected rate. Within maternity services, the Supervisor of Midwives had been used in their supervisory capacity in place of appraisals.

Consent practices that we observed and reviewed were good. However for do not attempt cardiopulmonary resuscitation (DNACPR), for patients who were considered not to have capacity to be party to these decisions, no evidence of any mental capacity assessments were identified. Training for staff on the Mental Capacity Act and Deprivation of Liberty standards was poor, having only been implemented in February 2015, though staff we interviewed were aware of their role and what they would do. We identified examples where independent mental capacity advocates had been utilised. The trust did however, have low levels of applications to the authorising authority.

Staff could access and used evidence based practice, and patient outcomes were good across the majority of clinical services. Improvements were required in stroke services, but most of the patient reported outcomes measures in surgery were better than the England average. Some patient outcomes in maternity services required improvement.

Staff were competent to provide care and could in the main access training; however hotel staff who were required to manage the bodies of recently deceased people received little formal training. Reporting of appraisals and training did not reflect the comments from staff and the trust were aware that it needed to improve its reporting to the board in these cases.

For further detail please refer to the individual location reports for Doncaster Royal Infirmary, Retford Hospital, Montagu Hospital and Bassetlaw District General Hospital.

Evidence based care and treatment

- Staff had access to and utilised evidence based practice and nationally recognised guidance in their daily clinical practice. In many instances staff participated in national studies to help further develop clinical practice, for example childhood nocturnal enuresis and the UK paediatric chronic idiopathic thrombocytopenia registry.
- Staff told us and we reviewed a range of evidence of local and national audit taking place. Results were discussed at clinical governance meetings and we saw examples where care had

been improved as a result of audits. Audits included the World Health Organisation surgical safety check list and national diabetes in pregnancy audit. There was an audit programme in place.

- The trust was aware of the recommended national reference doses for radiation exposure. Diagnostic reference levels (DRL's) were used as an aid to optimisation in medical exposure. The trust policy was to audit radiation exposure against the DRL's, however this was not occurring, and at Montagu Hospital had not taken place since 2002. There were plans in place to undertake these audits but this had not occurred at the time of the inspection.

Patient outcomes

- Staff monitored patient outcomes in the majority of services across the trust. There were exceptions, the most notable in diagnostic services across all three sites.
- Within maternity services, four of the five National Neonatal Audit Programme (NNAP) outcomes at Doncaster Royal Infirmary were below national standards; and three out of five standards at Bassetlaw District General Hospital. The trust had been an outlier for the number of non-elective neonatal readmissions within 28 days of birth since 2010. There was an action plan in place and this was being monitored by the trust.
- At Bassetlaw District General Hospital, other patient outcomes were also causing concern. During the last 3 months of 2014, the non elective caesarean rate was at 17% and well above the trusts own red RAG rating of 13.9%. The number of home births was low dropping from 3.8% in August 2014 to 0% in December 2014
- Surgical outcomes for patients were monitored and were mostly within or better than the national average. Where outcomes were worse than the national average these had been identified and measures were in place to make improvements.
- The trust had taken part in the national care of the dying audit in 2013/2014 and had achieved three out of seven organisational key performance indicators.
- Maternal outcomes were measured, and the proportion of delivery methods was mostly in line with national expectations. Non-elective caesareans section rates were higher than the England average.
- There had been a high level of non-elective neonatal readmissions within 28 days of birth. The trust had taken

various actions, and had identified that there had been recurring issues related to neonates losing weight or who were jaundiced or had low blood sugar levels. Action had been taken and there was regular monitoring of admissions.

- One area where further work was required by the trust was with regard to the Sentinel Stroke National Audit Programme. The trusts overall rating was D in the 2013/2014 audit, with the lowest score being E. The main areas for improvement were staffing levels, specialist assessment, provision of thrombolysis and the discharge process. The trust had an action plan in place outlining actions to improve these services.

Competent Staff

- The reported levels of staff appraisal and mandatory training were low in many areas of the trust. The trust had identified inefficiencies in their reporting system, and anecdotal evidence from the NHS staff survey suggested that the level of appraisals was higher, though did not meet the trusts overall target.
- Within maternity services at Doncaster and Bassetlaw, the Supervisor of Midwives had been used instead of an appraisal or performance review process. We were told that this had been the case for at least the preceding two years. The Local Supervisory Authority Midwifery Officer told us that this practice had recently changed.
- The trust had a clinical skills laboratory in place where clinical staff were able to practice procedures in a managed and safe fashion.
- Whilst the trust's policy stated that bodies should be received into the mortuary at Doncaster Royal Infirmary by a mortuary technician, when it was deemed to be distressing for hotel services staff, we identified that in reality hotel services staff would be allocated this work on a regular but random basis as part of their overall work programme, via a workload allocation system. Mortuary technician staff were on call out of hours, but staff indicated that it was difficult to access technician staff out of normal working hours.
- Staff from hotel services would visit the mortuary as part of their induction, but would not receive any other specific training or support, and could be allocated these duties as soon as their induction was complete.

Facilities

- We identified some concerns regarding capacity within the mortuary at Doncaster Royal infirmary. Whilst capacity had been increased in June 2014, this had been exceeded during that winter, and bariatric spaces had been used to store two bodies next to each other.
- Whilst we were told this had been as a result of the closure of local crematoriums during the Christmas period. The trust informed us that there were plans in place to extend mortuary provision in the future should this scenario be repeated.

Multidisciplinary working

- Staff reported good multidisciplinary working across and between clinical teams. Various multidisciplinary team meetings took place during the inspection, and we observed a number of these. Interactions between clinical staff planning and reviewing patient care were effective and joined up.
- Where more specialist services were in place, team work extended outside of the organisation and involved other relevant staff and health or social care providers. For example links to and access of services provided by the local child and adolescent mental health services were effective with prompt assessment following referral.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Consent for surgical and other procedures was in place, and there was evidence of audit taking place to assess the quality of the consent process.
- We reviewed a number of do not attempt cardiopulmonary resuscitation (DNACPR) forms, and whilst a number were completed correctly, there were also some that were not. For example of the 16 we reviewed at Doncaster Royal Infirmary, only five indicated that the patient had been involved in the discussion. Of the remaining nine, two were completed in the community, and the remaining seven provided a range of rationale as to why the patient had not been involved. However, we did not identify any mental capacity assessments linked to DNACPR decisions capturing the assessment as to why the patient lacked the capacity to be involved in this decision making process.
- Most staff were aware of the Mental Capacity Act and Deprivation of Liberty standards. However there was a low level of applications made by the trust, where people who lacked the capacity to make their own decisions may have been deprived of their liberty without authorisation.

Summary of findings

- Training on the Mental Capacity Act and Deprivation of Liberty Standards was low across the organisation, having only been implemented in February 2015.
- Some staff, for example, those in the day surgical services were able to describe the consent process for those who lack capacity, and there was evidence of the use of independent mental capacity advocates.

Are services at this trust caring?

Good

Summary

Staff provided caring and compassionate care, ensuring that patients, children and their families were involved in the planning and delivery of their care. Patients reported positively in the majority of surveys about the care they received. As such we rated caring as good for Doncaster and Bassetlaw Hospitals NHS Foundation Trust.

For further detail please refer to the individual location reports for Doncaster Royal Infirmary, Retford Hospital, Montagu Hospital and Bassetlaw District General Hospital.

Compassionate care

- Patients reported and we observed compassionate care being delivered by staff. Results from patient surveys and family and friends tests supported this view, though the number of patients who reported their views via the family and friends test was on occasions low.
- We observed that staff were courteous when caring for patients and were seen responding to patients individual needs in a timely manner.
- Some parents in children's services had made comment on the impact of staff shortages on the continuity of care.
- In the CQC maternity services survey 2013, the results relating to labour and birth, staff during labour and birth and care in hospital after birth were rated 'about the same' of other trusts.

Understanding and involvement of patients and those close to them

- Patients reported and we observed that staff involved patients in discussions regarding their care. Staff spoke with patients with respect checking that the patient and their relatives had understood.
- There was a range of information available to patients both in leaflet form and also displayed on ward and department notice boards about the clinical areas and services provided.

Summary of findings

- Women we spoke with in maternity services told us they were involved in the development of their birth plans and had received sufficient information.
- However, the national children's inpatient and day case survey 2014 identified that the trust performed significantly worse for questions related to the hospital fully telling patients what would happen to their child in hospital; and staff did not provide clear information to parents about their child's care and treatment.

Emotional support

- We observed staff supporting patients, children and their parents. Parents we spoke with on the children's wards all said they had felt well supported during their child's admission.
- Specialist palliative care nurses had all successfully completed the national advanced communications skills training programme.
- Staff in maternity services held 'afterthoughts' sessions where they held debriefing and resolution meetings with women to discuss any concerns relating to their care and treatment, and made any necessary referrals to counselling or other specialist services where required.

Are services at this trust responsive?

Requires improvement

Summary

A range of targets were not being met, including the four hour emergency department admission target, and a number of other targets across different clinical services.

There were a high number of delayed discharges from the critical care unit at Doncaster, and a high number of patients being discharge directly home from the critical care unit.

Services were being planned around the needs of local people, and capacity and demand reviews were also taking place. There was good relations with the local commissioning groups and the number of patients not treated within 28 days due to cancellation for non clinical reasons was better than expected.

Medical imaging was not meeting the 6 week target referral to treatment target; however improvements had been made. Services were planned to meet the needs of the patient population, though there were some gaps in staff provision in maternity services for example a specialist diabetes midwife. Systems were in place for the management of complaints, and there was evidence of improvements being made following complaints.

Summary of findings

For further detail please refer to the individual location reports for Doncaster Royal Infirmary, Retford Hospital, Montagu Hospital and Bassetlaw District General Hospital.

Service planning and delivery to meet the needs of local people

- Services were planned around the needs of patients and the local population, though there were a number of services where reviews of capacity and demand were taking place partly as a consequence of the recent move to care groups.
- The trust had good working relations with the local clinical commissioning groups and local authority. There was cross representation of staff on planning meetings.
- The proportion of patients whose operation was cancelled for non clinical reasons was as expected for the trust. The number of patients not treated within 28 days due to cancellation for non-clinical reasons was better than expected.
- There were some services that were less accessible. For example, there were no designated scanning facilities in the Early Pregnancy Assessment Unit (EPAU) at Bassetlaw and women had to attend the general ultrasound department. In addition there was no specialist diabetes midwife in post as recommended in the National Institute for Health and Care Excellence (NICE) in Bassetlaw, and this was an area with high levels of deprivation and people with obesity. Women who were obese and pregnant were more likely to develop diabetes during pregnancy.

Meeting people's individual needs

- Interpretation services were available at the trust. In addition, we saw arrangements in place for patients who had a learning disability. These ranged from pictorial information charts, to planning surgical lists so that people with particular needs could be placed first on the list. Staff were also aware that the patients with a learning disability would have a 'This is Me' booklet with them which would describe the needs, likes and dislikes.
- Parents had raised concerns locally and within the national children's inpatient and day case survey of a lack of facilities for parents or carers. As a consequence staff had engaged with parents regarding the purchase of new parent's beds. The outside play area had recently been improved, and play leaders were available during the week on the wards and on an evening in the emergency department.

- End of life care was individualised to meet the needs of people in the end stages of their life. Staff we spoke with told us they had access information about the different cultural, religious and spiritual needs and beliefs of people to ensure that those who had recently deceased were suitably dealt with.

Access and flow

- Access times and targets were being met across some clinical services; this wasn't the case for all services. At Bassetlaw the gynaecology ward had a high number of outlier patients. This impacted on the response the service gave to gynaecology patients. The trusts target for 18 week referral to treatment was 90%, and at Bassetlaw this had fallen from 84% in January 2015 to 68% in March 2015.
- Within surgery (the data was trust wide not hospital specific); patients waiting to start treatment within 18 weeks were 93.7% against a target of 92%. There was some variation within this, with the best performing service being oral surgery at 97.3% compared to orthopaedics at 89.9%. Overall the 18 week wait from point of referral to admission was 86.7% against a target of 90%. The best performing service was ophthalmology at 93.4% and worse urology at 82.8%. There were a variety of reviews taking place of pathways of care to facilitate and improvement in performance. Access targets for patients with cancer were all being met.
- Both main emergency departments demonstrated difficulties in consistently achieving the four hour target to admit a patient following the decision to admit being taken. In addition, both main departments demonstrated similar positive performance in ambulance handover times.
- Medical imaging was not meeting the 6 week target referral to treatment target; however improvements had been made. At March 2015, 96.7% of patients waited less than 6 weeks from referral for a diagnostics test against a target of 99%.
- Children's services managed the flow of patients well, and had reduced the number of beds from 22 to 14 following a review which indicated that bed occupancy was between 52 and 54%.
- The trust had recently had an external review by the NHS intensive support team who had confirmed that the trust was making good progress towards sustainable achievements of the referral to treatment standards and in implementing the IST recommendations. There was a further recommendation to implement a follow-up patient tracking list and to manage follow-up waiting times. We did identify that there was no centrally held list of all patients requiring a review or follow-up

appointment. Some of the lists were held by individual consultants with in the care groups. Whilst we did not identify any concerns or patients who were 'lost' in the system there was a risk that this could occur.

- Concerns were identified in the critical care unit at Doncaster, where a gap analysis carried out in March 2015 identified that around 53% of patients had a delayed discharge (over four hours) from the unit. In addition to this around 2 patients a week were directly discharged home from the unit. This was not an ideal situation as critical care units do not provide the same facilities for patients as general wards would do.
- Occupancy rates in maternity services were low at between 40 and 43% against a national average of 59%. This was in part due to a triage screening system. The triage system was staffed 24 hours a day and women over 20 weeks gestation could self refer, or be referred by their GP or community midwife. The women would be assessed and appropriate advice or treatment given.

Learning from complaints and concerns

- The trust had systems in place to deal with complaints and concerns in a timely fashion. Staff were aware of how to deal with complaints or concerns when they were raised directly with them.
- We saw a range of information from governance and staff meetings sharing information from complaints with learning and improvements to services. For example the implementation of staggered admission times on surgical wards following a complaint.

Are services at this trust well-led?

Good

Summary

There was a clear vision and strategy in place for the organisation. Staff were aware of this, but were less clear on the impact on their individual services. Some strategies required further work to refine and develop them.

Risk management processes varied; systems were in place to share, report and manage risks. Governance systems had changed in the organisation with the recent reorganisation into care groups, and there was variation in staff knowledge of the governance and risk management systems in place.

Summary of findings

Leadership and culture were in the main good despite all the recent changes, and the majority of staff reported good local leadership and a supportive open culture. Public and staff engagement took place, and there was evidence of improvements to services using patient stories.

For further detail please refer to the individual location reports for Doncaster Royal Infirmary, Retford Hospital, Montagu Hospital and Bassetlaw District General Hospital.

Vision and strategy

- A five year plan had been developed and published after extensive consultation (Looking Forward to our Future). The plan included multiple strands of development of the organisation as a whole including infrastructure needs, sustainable services delivered 7 days a week and elective and non elective care.
- Associated with this were a number of strategic aims, including 'to provide the safest, most effective care possible', and a focus on innovation for improvement.
- Supporting the Looking Forward to our Future vision and strategy, was a governance structure and project management office arrangements, with upward reporting arrangements to the Looking Forward to our Future programme board.
- In conjunction with the strategy and five year plan, the trust had developed its values in consultation with staff, under the banner of 'We Care'. Values included a commitment to quality, always care and considerate and being responsible and accountable.
- In addition to the main Looking Forward to our Future vision and strategy, a number of other enabling projects and strategies had been developed including the i-Hospital programme (the development and implementation of various information technology programmes), and extensive site development plans particularly at Doncaster Royal Infirmary.
- Work plans and objectives for the executive team flowed out from the strategies against which they would be measured, and these were cascaded down to the direct reports of the executive directors. The plan for the organisation was to further cascade these objectives to all staff in the organisation, though at the time of the inspection there was variation as to the impact of this.
- Staff knowledge of the trusts vision and strategy varied, though the majority were aware. We were provided with a range of information and promotional material regarding the vision with further information available via the trusts intranet.

- Clinical services had their own visions in place, but they were at varying stages of completeness. For example the outpatient's service strategy lacked detail and senior managers agreed it required further work to improve it. There was a children and families care group operational plan in place for 2015-2017, but staff in maternity and gynaecology were not familiar with the document or its key objectives, and senior managers were not clear on their strategy as to the utilisation of Bassetlaw District General Hospital.
- Some staff working in the smaller hospitals, for example Retford or Montagu were less clear on how the various visions and strategies would affect them in any overall change programme.

Governance, risk management and quality measurement

- The trust, during its recent reorganisation, set up care groups to deliver clinical services through. As part of the reorganisation refreshed governance arrangements were put in place for reporting through the care groups.
- There were reporting arrangements and governance systems in place up to the board. There was regular and detailed reporting to the board. However, this was not the case in the recent past prior to the current stability of the board. There had been a lack of belief in some data, and we were given examples by some non executive staff where they would seek their own triangulated evidence to assure themselves that the information they were being given was correct. This situation has changed in the last 3 years and the board as a whole had confidence in the data they received, and were aware of the gaps in assurance for example safeguarding. We identified a number of issues where reporting and assurance were limited in their effectiveness.
- Within radiology, radiology discrepancy and peer review meetings were not consistent with Royal College standards, and there had been a lack of clinical and IR(ME)R audits that could impact on safety in the departments.
- In other clinical areas and services, there were records demonstrating regular reviews of risk and mitigating actions at care group level as well as within the clinical services. However not all staff were familiar with this.
- The changes at leadership within the organisation in recent years had impacted on some areas of risk. For example, the chair had had to become involved in the tissue viability programme to ensure that it progressed. A pressure ulcer prevention programme had been developed in 2010, but had not been implemented until 2015. At the time of our inspection, we identified with tissue viability staff 36 patients who were

waiting for a dynamic pressure relieving mattress. Discussions with tissue viability staff and the director of nursing indicated that there was not a clear system in place that all staff were aware of by which staff could access pressure relieving equipment.

- One area of concern in the staff survey was that of appraisal rates, which was well below the England average (67 vs. 84). The trust were aware of this, and had identified its reporting arrangements as partly at fault for such low numbers. Anecdotal evidence from staff reported during other regulatory inspections indicated that more staff received appraisals than were being reported on the trusts systems. For example the trust was reporting 27% of staff as having had an appraisal, whilst in the last staff survey 67% of staff reported as having received an appraisal. New reporting systems formed part of the i-Hospital programme.
- There was a cost improvement process (CIP) in place. All cost improvements were reviewed by the nursing and medical directors. We saw evidence of CIP's being challenged and rejected if it was felt they would impact on quality and safety.

Leadership of the trust

- There had been major changes at the board over the last two years. There was a relatively new chief executive in post in addition to the director of nursing and chief operating officer. Prior to this existing board, members described a time of frequent changes in senior managers, and the consequent lack of leadership that this brought.
- In the last two years since the appointment of the current chief executive, and other appointments there had been greater stability. The chair of the organisation had been able to focus on leading strategically and not operationally, and the trust had completed a period of restructure.
- Great effort had been placed on the involvement and integration of the board of governors for the trust, who were fully integrated and involved in the development of the organisation. The governors were able to describe and provide evidence of their involvement in quality monitoring, having access to senior managers and their consultation and involvement in the DBH 2020 vision and strategy.
- The board had also in the last 2 years further developed and enhanced their working relations with external partners and commissioners, with cross cutting involvement of partners in the development of the trusts strategy as well as involvement in delivery and development meetings to further enhance working relations.

Summary of findings

- Despite all the recent changes at care group level, staff reported that they felt well supported and knew who to report to and where they could seek support from. Leadership at a local level was described as good.

Culture within the trust

- The culture of the organisation was open and supportive. Staff did not report any concerns or difficulties reporting incidents, or a fear of blame.
- Staff working at Retford and Montagu Hospitals were proud of their local hospital and the part it played in the local community.
- In the main staff were proud to work for the trust and felt supported to work at the organisation. Some staff in children's services reported that morale was low, but this was not a universal concern that was raised. In addition some staff spoke of challenges between Bassetlaw Hospital and Doncaster Royal infirmary, but on the whole staff felt part of one organisation.
- Sickness absence rates, whilst fluctuating were generally below the England average. As at January 2015 3.6% against 4.0%.
- Of the 11 subject areas in the General Medical Council survey in 2014 all were within expectations.

Fit and Proper Persons

- The trust had in place a policy that covered the requirements of the fit and proper persons test. This included regular reviews of applicable individuals.
- We asked to see the human resource files for the senior managers of the organisation, and randomly selected 8 to review including existing staff and recently appointed staff. All had the appropriate checks in place including professional registration checks, DBS checks and assessment of leadership skills amongst others.

Public engagement

- There were a range of opportunities to engage and learn from members of the public, patients, carers and relatives. The board heard patient stories at the beginning of board meetings. The trust had implemented a range of changes following one particular serious untoward incident, which has subsequently been shared through NHS England.
- There were a variety of means through which the trust and individual services sought patient and carer feedback and input

into service development. The trust utilised both patient surveys as well as the family and friends test. There were well developed links with the board of governors at the trust who provided public engagement and input into developments.
- There was a maternity services liaison committee where women who had used the service, parents to be, and grandparents from the local area met with midwifery staff monthly to discuss and influence the development of services. One outcome of this was being able to have more visitors on the delivery suite.

Staff engagement

- The NHS staff survey results from 2013 identified six measures that were worse than expected, and one positive finding. The remaining 21 were all within expectations. The overall engagement score in the 2013 survey was 3.7, having risen from 3.5 the previous year, and in line with national expectations.
- The trust continued to engage with staff, replicating elements of the NHS staff survey, and had in place short and long term actions to continue the improvement journey.

Innovation, improvement and sustainability

- The trust managed the Abdominal Aortic Aneurysm (AAA) screening programme across South Yorkshire and Bassetlaw as part of the drive to reduce the number of people who die from the condition. AAA mainly affects men aged 65 to 74 and appointment letters were sent to all men across South Yorkshire and Bassetlaw between these ages inviting them to attend for a free scan. There were 28 clinics across South Yorkshire and Bassetlaw where this service could be accessed.
- Following the development of grade 3 pressure ulcers in patients with casts, individual assessment and review plans had been developed in fracture clinic which had seen the problem eradicated.

Overview of ratings

Our ratings for Doncaster Royal Infirmary

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

Overview of ratings

Our ratings for Bassetlaw District General Hospital

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

Our ratings for Montagu Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Good	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Good	Good

Overview of ratings

Our ratings for Retford Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement

Our ratings for Doncaster and Bassetlaw Hospitals NHS Foundation Trust

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

Notes

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients and diagnostic imaging.

Outstanding practice and areas for improvement

Outstanding practice

- The trust managed the Abdominal Aortic Aneurysm (AAA) screening programme across South Yorkshire and Bassetlaw as part of the drive to reduce the number of people who die from the condition.
- The trust was working with Sheffield University in developing specialty specific training for rehabilitation nurses from Band 2 to 7.

Areas for improvement

Action the trust MUST take to improve

- The trust must ensure that the public are protected from unnecessary radiation exposure.
- The trust must ensure that staff receive an effective appraisal.
- The trust must audit the Radiation Exposure/ DRLs.
- The trust must ensure that staff receive mandatory training including adult and child safeguarding training

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18(2) (a) Persons employed by the service provider must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Staff had not received mandatory training and/or appraisals in accordance with trust requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17 (2) (a), (b) & (c) Systems and processes must enable the registered person to assess, monitor and improve the quality and safety of the services provided, assess, monitor and mitigate the risks and maintain securely an accurate, complete and contemporaneous record in respect of each service user including a record of the care and treatment provided and decisions taken in relation to the care and treatment provided. There were some doors with no signage that had unrestricted entry to x-ray controlled areas; there were no radiation exposure audits; there was a lack of information recorded for minor surgical procedures, including no allergy status recorded or evidence of safety checks.