Care Quality Commission

Doncaster and Bassetlaw Hospitals NHS Foundation Trust

Bassetlaw District General Hospital

Quality Report

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Date of inspection visit: 14 – 17 and 29 April 2015
Date of publication: 23/10/2015

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Bassetlaw District General Hospital was one of the acute hospitals forming part of Doncaster and Bassetlaw NHS Foundation Trust. The trust served 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.

Bassetlaw District General Hospital provided a range of services including medical, surgical, maternity and gynaecology, services for children and young people, end of life and critical care. It had approximately 300 beds. The hospital also provided emergency and urgent care and outpatients and diagnostic imaging.

We inspected Bassetlaw District General Hospital as part of the comprehensive inspection of Doncaster and Bassetlaw NHS Foundation Trust. We inspected the hospital site on 16 and 29 April 2015.

Overall, we rated Bassetlaw District General Hospital as requires improvement. We rated it good for being caring and well-led and requires improvement for responsive, effective and safe care.

Our key findings were as follows:

- We found that most areas at the hospital were visibly clean. However, the theatre sterile supply unit was found to have some areas that required cleaning.
- Staffing levels were reviewed and monitored. There were some areas of the trust particularly in children's services and medicine that were not adequately staffed. We found this had an impact on patient care.
- Patients were assessed for their nutritional and hydration needs and referred to a dietician if required.
- There was a lack of medical staff with the appropriate qualification as set out in the core standards for intensive care units. That is a consultant who is a Fellow/Associate Fellow or eligible to become a Fellow/Associate Fellow of the Faculty of Intensive Care Medicine.
- The Summary Hospital-level Mortality Indicator (SHMI) (1 July2013 to 30 June 2014) showed no evidence of risk. The Hospital Standardised Mortality Ratio indicator (1 July 2013 to 30 June 2014) showed an elevated risk.
- Records indicated compliance with mandatory training and appraisal rates were generally low across the services.
- Within diagnostic imaging, there were some doors with no signage that had unrestricted entry to x-ray controlled areas.

We saw several areas of outstanding practice including:

- The staff support and training packages provided by the clinical educators in all areas where children and young people were seen in the trust

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

Importantly, the trust must:

- 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.
- The trust must ensure that the public are protected from unnecessary radiation exposure.
- The trust must ensure that staff receive mandatory training.
- The trust must ensure that staff receive an effective appraisal.
- The trust must ensure that a clean and appropriate environment is maintained throughout the theatre sterile supply unit that facilitates the prevention and control of infection.

In addition the trust should:

Summary of findings

- The trust should reduce patient waiting times to meet the 95% target for patients seen within four hours.
- The trust should review access to equipment in the emergency department.
- The trust should continue to take steps to support and develop working arrangements between the emergency department and other specialities within the trust.
- The trust should record and monitor daily temperatures of fridges used for storage of medicines.
- The trust should review engagement of medical staff with training, particularly in Mental Capacity Act and emergency planning.
- The trust should review monitoring procedures to record where and why a breach of mixed sex accommodation has occurred and actions taken to avoid a repeat.
- The trust should review the pain evaluation tool incorporated within the NEWS score observations to measure the pain experienced by patients
- The trust should consider the use of a staffing needs acuity tool to record staffing needs more accurately and on a more frequent basis.
- The trust should continue to review staffing on ward C1.
- The trust should review the how toilet facilities can be improved on the cardiology ward to ensure separate designated facilities are maintained for men and women.

- The trust should ensure that they follow best practice in terms of medical staff with appropriate intensive care qualifications.
- The trust needs to ensure that there is appropriate out of hours cover for the critical care unit and that any risks associated with cross cover of services is mitigated.
- The trust should ensure that appropriate delirium and sedation scores are undertaken and recorded.
- The trust should ensure that appropriate access is available from supporting clinical services where required, including pharmacy, dietetics and the ear, nose and throat departments.
- The trust should review maintenance and deep cleaning schedules.
- The trust should review documentation of wastage of Controlled Drugs (CD) on delivery suite.
- The trust should review the provision of the service available from the teenage pregnancy midwife and substance misuse midwife at the hospital.
- The trust should consider employing a specialist diabetes midwife.
- The trust should review 24 hour availability of an obstetric anaesthetist.
- The trust should make sure front line staff are aware of their responsibilities in relation to MCA and DOLS.
- The trust should review the individual risk assessment tools with in the children's service. For example, the service should ensure the initial nursing assessment includes nutritional status and nutritional risk assessments.
- The trust should identify a board level director who can promote children's rights and views. This role should be separate from the executive safeguarding lead for children.
- The trust should agree a system for recording mental capacity assessments for patient's unable to be involved in discussions about DNACPR decision
- The trust should make available appropriate equipment for the care of bariatric patients after death.
- The trust should review equity of access to palliative and end of life care services across both Bassetlaw DGH and Doncaster Royal Infirmary.
- The trust should identify clear systems and processes to evidence post incident feedback, shared learning and changes in practice resulting from incidents.
- The trust should review the audit programme in outpatients and diagnostics to monitor the effectiveness of services.
- The trust should continue improvements to meet the 6 week target referral to treatment target for medical imaging.
- The trust should review the processes for identifying and managing patients requiring a review or follow-up appointment.
- The trust should further develop the outpatient's services strategy to include effective service delivery.
- The trust should identify and monitor key performance indicators for outpatients.

Summary of findings

- The trust should implement plans to ensure radiology discrepancy and peer review meetings are consistent with the Royal College of Radiology (RCR) Standards.
- The trust should consider auditing the call bells within the diagnostic imaging departments.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	There were not enough nurses trained to care for children to provide a nurse on each shift. The shortage of medical staff in the emergency department reflected the national picture. Mandatory training was not up to date within the emergency department. There was no formal major incident awareness or training provided for medical staffing. Medical staff demonstrated poor application of the MCA and of DoLs procedures. Concerns were raised by staff at the non-availability of an ultrasound machine to perform FAST scans. The standard of cleanliness was variable and affected by the building work being undertaken to increase the capacity on Clinical Decisions Unit. The monitoring of fridge temperatures was intermittent. The 95% target for patients seen within four hours had not been consistently maintained at Bassetlaw hospital. An initial clinical assessment of patients was undertaken using a recognised tool. Investigation of incidents was undertaken and there was evidence of lessons learned. Nursing staff were aware of their responsibilities under the duty of candour requirements, however medical staff were not. Systems were in place to safeguard vulnerable adults and children. The department used National Institute of Clinical Excellence (NICE) and College of Emergency Medicine (CEM) guidelines to support the treatment provided for patients. The emergency department contributed to a range of CEM audits which demonstrated a mix of good and poor results. Action plans had been prepared to address variable performance. There was proactive working with the Acute Treatment Centre. However, there was limited interchange with some specialities. Patients were cared for with empathy and with respect to their dignity on most occasions. We did observe that patients were transferred to trollies in the corridor in a way which potentially compromised the dignity of patients.

Summary of findings

The emergency care group operational plan for 2015-17 and the five year plan the trust had developed involved a significant re-organisation of the structure of the emergency department. Senior staff spoke positively about the new leadership team. There was an open culture in the emergency department.

Medical care

Good

We rated medical care services as good for effective, caring, responsive and well led. The safe domain required improvement.

During our inspection we witnessed most staff behaving in a caring and respectful manner towards their patients. Patient buzzers were answered promptly in most areas visited. There was a wide range of national and local audit activity undertaken at Bassetlaw District General Hospital including the trust-wide quality metrics audit framework for ward managers to complete (Ward Quality Assessment Tool). Where required, actions were taken in response to audit outcomes, for example the National Diabetes Inpatient Audit (2013) resulted in strengthening the trust wide clinical resource to support staff in managing diabetes effectively.

On the day of inspection, nurse staffing levels on the respiratory medicine ward (C1) were planned to be four trained nurses during the day and evening shift and three at night. The actual staffing level was three trained nurses on the day and evening shift and two trained nurses at night resulting in a ratio of 14 patients to one trained nurse overnight. We noted that 21 incident reports had been submitted recording staff shortages on C1 between September and December 2014. All were graded as no harm caused; however the reports include reference to medicines not being given on time as well as repositioning of patients, assessment scores and observations not being carried out on a timely basis. Wards A4 and A5 also submitted incident reports about staffing shortages impacting on the standard of care including lack of timely repositioning of patients and managing wandering and confused patients.

Staff were generally positive about the leadership and the levels of engagement with their line management through to executive level. However

junior staff in less well staffed areas voiced less confidence in the leadership and expressed low morale due to the on-going workload pressures experienced on the wards. The impact of the staffing shortages on C1 was evident through documentation in case notes and the incident reporting system. On our unannounced inspection on 29 April 2015, we found that the staffing levels had been reviewed and four beds had been closed. Staff reported this action had a positive impact and they were able to deliver care to meet patients' needs.

On the day of inspection, both bays on the cardiology ward had mixed sex accommodation but in each bay there was a female patient who was no longer on cardiac monitoring. The hospital policy stated that this was not acceptable when "the patient no longer needed Level 2 or Level 3 care and was awaiting a bed on an appropriate ward." The mixed sex accommodation trust policy was discussed with the ward manager and Matron and immediate action was taken to move the two female patients at the earliest opportunity. An email with the policy attached was sent to all members of the cardiology medical and nursing teams to clarify the requirement to move patients once there was no applicable clinical need to keep them in mixed sex accommodation. We revisited this area as part of our unannounced inspection. We found the policy was implemented; there were no mixed sex breaches.

Surgery

Good

We found that surgical services were safe. However, staff in the main operating theatres told us there were no pre-planned maintenance and deep cleaning schedules. We also found that the theatres' sterile supply room had not been adequately cleaned.

We found that surgical services were effective although we had concerns about the level of mandatory training, with the service not meeting the trust target that 85% of all staff should have received mandatory training.

Summary of findings

We found that the service was caring, responsive and well-led. Patient access and flow compliance with the 'referral to treatment' (RTT) targets were affected by the numbers of medical patients admitted to surgical wards.

Critical care

Good

Overall critical care services at Bassetlaw District General Hospital were judged as good.
Within safety, concerns were identified with regard to the lack of pharmacy staff cover, there were no specifically trained intensivists working within the unit, and there was a lack of dedicated medical out of hours cover provided on the unit. We also identified concerns regarding a lack of delirium and sedation scoring and recording in patient records. However we did not identify any specific concerns regarding the levels of nursing staff on the unit, but some staff did comment that they were often moved to the critical care unit at Doncaster Royal Infirmary.
There were, however, many positive aspects to the unit. Caring was good, patients stated they were well cared for and surveys supported this. Care was effectively delivered by the multidisciplinary team utilising best practice. The service was well led locally, though as a relatively new care group unit, further focus was required on the development of the unit and its future use and links to the unit at Doncaster Royal Infirmary.

Maternity and gynaecology

Requires improvement

Overall, maternity and gynaecology services required improvement. Systems were in place for reporting, investigating and acting on adverse events. There had been two clusters of stillbirths from January 2014 to January 2015. A still birth review had taken place and each case was assessed against the National Patient Safety Agency Stillbirth Toolkit. The action plan was due for completion shortly after our visit.
Midwifery staffing ratios were in line with the national recommended ratio of 1:28. Consultant cover at Bassetlaw maternity unit was 40 hours per week in line with the number of babies delivered on the unit per year. There was no dedicated emergency obstetric theatre team at Bassetlaw

hospital during the mornings on weekdays. An emergency team was available at all other times. High rates of sickness were evident on the gynaecology ward.
Completion of mandatory training was at a good level for midwives, midwifery support workers and health care assistants. Mandatory training participation for medical staff was poor. There was a range of specialist midwives in post however neither the teenage pregnancy special midwife nor the substance- misuse specialist midwife had input into vulnerable women at Bassetlaw hospital. There was no specialist diabetes midwife in post. Good evidence of safeguarding vulnerable women was evident. There was limited awareness of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
On the labour ward there was no documentation evidence of wastage of controlled drugs used in epidural procedures.
Normal births were promoted. Since 2010 there had been a high percentage of non-elective neonatal readmissions within 28 days of birth. An action plan was in place and was being monitored. There were no designated scanning facilities in the EPAU at Bassetlaw; women had to go to the Ultrasound department with other 'general' users of the service. Maternity and nursing staff were caring. Patients and women spoke positively about their treatment by clinical staff and the standard of care they had received. There was good evidence of individualised maternity care. Hypnobirthing was available on delivery suite.
We found there was disconnection between ward staff and the board. Most staff were unaware of the vision for the service. We observed strong team working, with medical staff, nurses and midwives working cooperatively and with respect for each other's roles. They told us that Bassetlaw was a 'good place to work'. Most staff we spoke with were positive and enthusiastic.

Services for children and young people

Good

Overall we rated effective, caring, responsive and well-led as good. We rated safe as requires improvement.
The service followed evidenced-based best practice guidance and participated in appropriate national

and local audits. Children and young people had access to appropriate pain relief. Staff were competent to carry out their roles and received appropriate professional development. There was good multidisciplinary working within and between teams and children and families were provided with appropriate information. Consent procedures were in place and were followed.

Children, young people and family members told us they received supportive care and staff kept them informed and involved in decisions about their care and treatment. The service was responsive to the individual needs of the children and young people who used it. The service was planned and delivered to meet the needs of the children and young people who lived locally.

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 in order to try and ensure the needs of the children and young people using the service were met. Nurse staffing levels on the children's ward did not meet current national guidelines; staffing levels on the SCBU complied with current requirements. The service did not have all of the necessary risk assessments in place for assessing children and young people prior to their admission and stay. For example, we found there were no nutritional risk assessments and no moving and handling risk assessments.

However, the management team were committed and feedback from staff was generally positive. There were systems and processes in place to assess and monitor the quality of service children and young people received. Risk management systems were in place.

End of life care

Good

We saw that end of life care services were safe, caring, responsive and well led. However, we saw that improvements were required in order for services to be effective. Mental capacity assessments were not being carried out on patients who were considered to be lacking capacity to be involved in discussions about DNACPR decisions.

Summary of findings

The trust needed to have a more systematic approach to recording mental capacity assessments in relation to DNACPR decisions where patients were unable to be involved in these discussions.
We observed specialist nurses and medical staff providing specialist support in a timely way that was aimed at developing the skills of non-specialist staff and ensuring the quality of end of life care.
Specialist palliative care nurses provided a five day face to face assessment service which was different to the seven day face to face service available at Doncaster. While staff told us the Doncaster on-call nurse could see patients in Bassetlaw if required, this was not widely known by staff at Bassetlaw.
There was an agreement by the trust's corporate investment committee to recruit to a further two end of life care nurses to provide an improved service for patients at Bassetlaw District General Hospital. We were told that staff were caring and compassionate and we saw the service was responsive to patients' needs. There were prompt referral responses from the specialist palliative care team and a good focus on preferred place of care and fast track discharge for patients at the end of life wishing to be at home.
Action had been taken against the issues identified in audits including the National Care of the Dying Audit. The implementation of the last days of life individual plan of care (IPOC) had been closely monitored by the end of life care coordinator with continuous reviews and feedback in place to develop this. A business case had been developed to increase the capacity of the end of life care/ specialist palliative care service and the trust board had committed investment in improving the service as a result. The trust had a clear vision and strategy for end of life care services and participated in regional discussions and collaboration in relation to strategic planning and delivery of services to improve end of life care in the region.

Outpatients and diagnostic imaging — **Requires improvement**

There is a legal requirement to protect the public from unnecessary radiation exposure. We saw that there were some doors with no signage that had unrestricted entry to x-ray controlled areas. This was raised with the trust and referred to the Health and Safety Executive. There were effective systems

Summary of findings

to report incidents. However, in some areas we were unable to identify clear systems and processes to evidence post incident feedback, shared learning and changes in practice resulting from incidents.
The percentage of staff that had undertaken mandatory training and received an annual appraisal was well below the trust compliance target of 85%, particularly within outpatients departments. It was unclear if this was a recording issue, but meant the trust could not be assured staff had the necessary training.
Paediatric resuscitation equipment was contained within the adult trolleys within the CT and main radiology department. Staff were unaware of this which posed a potential risk. We saw patient personal information and medical records were mostly managed safely and securely.
Evidence-based guidance was available however there was limited evidence of audit to demonstrate effectiveness. This included IR(ME)R related audits.
All of the patients we spoke with across the department told us they were very happy with the services provided.
The management team were in the process of reviewing capacity and demand for outpatient clinics and recognised the need to address the rate of clinic cancellations by the hospital. Trust-wide data showed 16.8% of patients waited more than 30 minutes to be seen. Most referral to treatment targets were met including all cancer related targets. Medical imaging was not meeting the 6 week target referral to treatment target; however improvements had been made.
There was no centrally held list of all patients requiring a review or follow-up appointment.
An outpatient's services strategy had been drafted in December 2014. However, this lacked detail. A review of outpatient services had started to audit the current outpatient service delivery and clinical work streams but this was not yet completed. There were limited key performance indicators for outpatients. Radiology discrepancy and peer review meetings were inconsistent with the Royal College of Radiology (RCR) Standards.

Bassetlaw District General Hospital

Detailed findings

Services we looked at

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

Detailed findings

Contents

Background to Bassetlaw District General Hospital

Bassetlaw District General Hospital was one of the acute hospitals forming part of Doncaster and Bassetlaw NHS Foundation Trust. The trust served 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.

Deprivation was higher than the England average and about 3,800 children lived in poverty. Life expectancy for both men and women is lower than the average. Rates of deaths from smoking and hospital stays for alcohol related harm are worse than the England average

Bassetlaw District General Hospital provided a range of services including medical, surgical, maternity and gynaecology, services for children and young people, end of life and critical care. It had approximately 300 beds. The hospital also provided emergency and urgent care and outpatients and diagnostic imaging.

We inspected Bassetlaw District General Hospital as part of the comprehensive inspection of Doncaster and Bassetlaw NHS Foundation Trust. We inspected the hospital on 16 and 29 April 2015.

Our inspection team

Our inspection team was led by:

Chair: Yasmin Chaudry

Head of Delivery: 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?

Detailed findings

- 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, Royal Colleges and Healthwatch.

We carried out an announced visit across the trust on 14 -17 April 2015. During the visit we held a focus group with a range of hospital staff, including support workers, nurses, doctors (consultants and junior doctors), physiotherapists, occupational therapists and student nurses. We talked with patients and staff from all areas of the trust, including from the wards, theatres, critical care, outpatients, maternity and emergency departments. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' personal care or treatment records.

We held a listening event on 13 April 2015 in Doncaster and attended a local group in the Bassetlaw area 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. The team would like to thank all those who attended the listening events.

We carried out an unannounced visit on 29 April 2015.

Facts and data about Bassetlaw District General Hospital

Each year, the hospital treated around 33,000 patients along with 38,000 emergencies in the Emergency Department. There were 102,146 outpatient attendances between January and December 2014 at Bassetlaw District General Hospital.

The maternity service at Bassetlaw hospital delivered 1,142 babies between April and December 2014.

There were 2183 children's admissions to BDGH between July 2013 and June 2014, 99% of which were emergencies, and 1% elective with no day cases. There were 2599 outpatient admissions during 2014 (January - December 2014).

The trust had 5,800 staff which included 600 medical and 2,500 nursing staff and had revenue of £350 million.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	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

Notes

Urgent and emergency services

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

Information about the service

Bassetlaw Hospital emergency department received 44,206 attendances between April 2014 and March 2015, which represented approximately 121 patients per day attending the department on average. Approximately 20% of these patients were children. The emergency department was open 24 hours a day, seven days a week.

The department had three bays for majors and a three-bedded resuscitation area. One bay was designated for paediatric patients. There was a paediatric area, with a central play area from the main entrance reception. There were four bays for minor's patients and three room used by the nurse practitioners for 'see and treat' patients.

The Bassetlaw Clinical Decision Unit was being refurbished and extended to accommodate increased capacity. The current CDU could accommodate up to four patients.

We spoke with 3 patients and their relatives, and approximately 12 members of staff of different disciplines. We observed daily practice, reviewed paper and electronic records and documentation and reviewed information provided prior to our inspection.

Summary of findings

Steps were being taken to recruit skilled nursing staff. There were not enough nurses trained to care for children to provide a nurse on each shift. The shortage of medical staff in the emergency department reflected the national picture. Mandatory training was not up to date within the emergency department. There was no formal major incident awareness or training provided for medical staffing. Medical staff demonstrated poor application of the MCA and of DoLs procedures.

Concerns were raised by staff at the non-availability of an ultrasound machine to perform FAST scans. Personal protective equipment was used and nursing staff followed bare below the elbows policy, although managers and staff visiting the department did not follow this consistently. The standard of cleanliness was variable and affected by the building work being undertaken on CDU.

Between January 2014 and January 2015, the 95% target for patients seen within four hours had not been consistently maintained at Bassetlaw hospital. The percentage of emergency admissions waiting four to 12 hours from the decision to admit until being admitted and total time patients spent in the emergency department were worse than the England average.

There were arrangements to access a link nurse to support patient with learning disabilities. At the time of inspection this was a limited service of three days per week due to sickness. Early senior review was to be

implemented. The trust was in the process of completing building works to extend and increase the capacity of the Clinical Decisions Unit at Bassetlaw hospital. The monitoring of medicine fridge temperatures was intermittent.

An initial clinical assessment of patients was undertaken using a recognised tool. Controlled drugs were stored and stock recorded appropriately. Root cause analysis investigation of incidents was undertaken and there was evidence of lessons learned. Nursing staff were aware of their responsibilities under the duty of candour requirements, however medical staff were not.

Patient records were complete. Systems were in place to safeguard vulnerable adults and children. The department's training staff confirmed that all appropriate staff received safeguarding training, or arrangements were in place for them to attend. However, this was not reflected in trust records so senior staff could not be assured staff had received required training.

The department used National Institute of Clinical Excellence (NICE) and College of Emergency Medicine (CEM) guidelines to support the treatment provided for patients. The emergency department contributed to a range of CEM audits which demonstrated a mix of good and poor results. Action plans had been prepared to address variable performance.

Arrangements were made for patients to receive adequate nutrition and hydration. Food and refreshments were made available to patients. We observed positive practice in the provision of analgesia during the inspection.

Staff had received an appraisal in the last 12 months, or arrangements were in place for them to receive this. Nursing staff felt well inducted into the department and well supported, although induction was variable for locum staff. We observed good working relationships between nursing and medical staff within the department. There was proactive working with the Acute Treatment Centre. However, there was limited interchange with some specialities.

Patients were cared for with empathy and with respect to their dignity on most occasions. We observed that nursing and support staff were caring and compassionate in their interaction with patients. We did observe that patients were transferred to trollies in the corridor in a way which potentially compromised the dignity of patients. Patients and relatives we spoke with told us that staff had provided appropriate emotional support during their time in the department. We saw positive examples of learning from complaints.

The emergency care group operational plan for 2015-17 and the five year plan the trust had developed involved a significant re-organisation of the structure of the emergency department. A risk register action plan for the care group was updated to reflect risks current in the department and action being taken to mitigate these risks.

The arrangements for governance meetings in the department had recently been reviewed to reflect revised departmental structures. Staff found the meetings were supportive and enabled them to start to work together as a team although it was felt the meetings focused on Doncaster Royal Infirmary. Senior staff spoke positively about the new leadership team. There was an open culture in the emergency department.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

Steps were being taken to recruit skilled nursing staff and also support staff and to review skill mix. There were not enough nurses trained to care for children to provide a nurse on each shift.

The shortage of medical staff in the emergency department reflected the national picture. The department were facing significant challenges in recruiting emergency medical staff. The trust planned a development programme for middle grade medical staff. Mandatory training was not up to date within the emergency department. There was no formal major incident awareness or training provided for medical staffing.

Concerns were raised by staff at the non-availability of an ultrasound machine to perform FAST scans. Personal protective equipment was used and nursing staff followed bare below the elbows policy, although managers and staff visiting the department did not follow this consistently. The standard of cleanliness was variable and affected by the building work being undertaken.

An initial clinical assessment of patients was undertaken using a recognised tool. Controlled drugs were stored and stock recorded appropriately. The monitoring of medicine fridge temperatures was intermittent.

There had been no recent never events and the most frequent incident related to pressure ulcers. Root cause analysis investigation of incidents was undertaken and there was evidence of lessons learned. Nursing staff were aware of their responsibilities under the duty of candour requirements, however medical staff were not.

The emergency department used an electronic patient record system widely used in the NHS. Patient records were complete. Systems were in place to safeguard vulnerable adults and children. The department's training staff confirmed that all appropriate staff received safeguarding training, or arrangements were in place for them to attend. However, this was not reflected in trust records so senior staff could not be assured staff had received required training.

Incidents

- Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. There had been no recent never events in the emergency department.
- Between September and December 2014, 337 clinical incidents had been reported at Bassetlaw District General Hospital emergency department. The majority of these (198) related to pressure ulcers.
- The emergency department reported serious incidents using an electronic incident reporting system widely used in the NHS. For a clinical incident to be recorded as completed, mandatory fields within the incident reporting form required signing off, with actions taken as a result of the incident and sections to be completed by the manager for the incident. We reviewed a recent serious incident which showed that the reporting system was used appropriately.
- We found a positive culture around incident reporting. Nursing and medical staffing were encouraged to report incidents.
- Learning was disseminated through teaching sessions and emails, although learning from incidents was not included in the induction program for junior doctors or locum doctors.
- Staff could provide examples of changes to practice as a result of incidents. For example, one incident had resulted in changes to the labelling of medication.
- Monthly clinical governance meetings were held within the department and they reviewed all clinical incidents.
- We found that incident investigation reports were shared with clinical governance and with nursing and medical forums within wards and departments within the emergency care group, as well as being shared with other care groups in the trust. The investigation reports included recommendations, an action plan and arrangements for shared learning.

Duty of candour

- In November 2014 the duty of candour statutory requirement was introduced and applied to all NHS trusts. The trust had in place a policy relating to these new requirements.
- Information to be reported under the duty of candour requirements was included in the electronic incident reporting system.

- We saw that information about duty of candour was displayed on the staff intranet. Nursing staff we spoke with were aware of their responsibilities under the duty of candour requirements. However, this was not evident when we spoke with medical staff.

Cleanliness, infection control and hygiene

- In a national survey of emergency departments conducted in 2014, the trust performed about the same as other trusts for the question relating to the cleanliness of the department.
- Personal protective equipment such as gloves and aprons was available and we observed nursing staff followed bare below the elbows policy, although managers and staff visiting the department did not follow this consistently.
- Mandatory training for staff included infection control, although evidence of staff compliance with training was low.
- We observed that cleaning schedules were displayed. However, although equipment such as commodes appeared clean, they were not labelled as such.
- A cleaning checklist tool was used daily to indicate areas requiring cleaning which was completed by support staff. Results from April 2014 to February 2015 showed good levels of compliance with some areas for improvement such as the cleanliness of blood trolleys and drip stands.
- When we visited the emergency department we observed the standard of cleanliness was variable. For example, the ambulance trolley area contained dusty trolleys and one of the mattresses was damaged. It was noted that building works were taking place. There were no notices encouraging immuno-compromised patients not to access this area.

Environment and equipment

- Building works for the Clinical Decision Unit had recently commenced. Screens were put in place but did not fit completely. Plaster dust was present on the main corridor.
- Concerns were raised by staff at the non-availability of an ultrasound machine to perform FAST scans. Fast scans are rapid assessment scans allowing gross assessment of pathology within the abdomen. Consultants were pro-actively putting themselves through the training program, but were not being provided with the equipment to support the scans. This issue had been raised consistently over 5 years, but the equipment was not provided.
- There was specific room available for use by patients with mental health needs and the mental health liaison team. This room had two exits however these were near to the children's room in fracture clinic. A ligature risk from the door closure was also noted.
- Areas of the department were in need of refurbishment. For example, there was damage around door frame and very marked or damaged floors and walls.
- Storage facilities appeared cluttered. In the store room, boxes were on the floor and in the linen room, laminated shelves were damaged exposing or made of bare wood; so it was difficult to clean.
- In the lobby area in front of temporary screens, crutches were stored in cages with used and new/ clean ones stored next to each other.
- Resuscitation equipment was checked daily by staff.
- Staff reported that any equipment requiring repair was maintained and repaired promptly.

Medicines

- Medicines were stored in locked cupboards or fridges as necessary. Medicines and intravenous fluids were stored in a locked room. Controlled drugs were stored and stock recorded appropriately.
- Stock checks were recorded daily, although times were not recorded
- We saw that fridge and warmer cupboard temperatures were not recorded daily.
- Where incidents related to medicines had occurred, we saw that these were reported and action taken to prevent recurrence.
- Medicines were observed to be appropriately prescribed and administered. Medications within the department were prescribed electronically.

Records

- The emergency department used an electronic patient record system widely used in the NHS. Nursing and medical documentation was electronic within the trust. This automatically captured time stamps and digital signatures of staff completing assessments.
- All staff were provided with smart cards to access the system and provided training on how to use the system.

We found locum staff were also provided with cards to access the electronic system, although the training they received if they were doing shifts out of hours was limited.

- We reviewed the records of patients who arrived in the department. We found the notes were completed.

Safeguarding

- The department had systems in place to safeguard vulnerable adults. Staff we spoke with were aware of their responsibilities and of the appropriate safeguarding pathways to use.
- Staff were automatically prompted through the trust information system to complete safeguarding assessments for children who presented in the department. The system did not allow the member of staff to sign off from assessments unless appropriate documentation was completed.
- Safeguarding training was incorporated within the induction process for junior medical staff, including presentations to be aware of and how to make a referral.
- The trust provided training compliance information which showed that adult and children safeguarding training was up to date for 17% and 83% of nursing staff respectively and 0% and 16% of medical staff. However, the department's training staff confirmed that all appropriate staff received safeguarding training, or arrangements were in place for them to attend.
- Staff at Bassetlaw Hospital had access to a multiagency safeguarding hub where staff could access information and support regarding safeguarding concerns.
- A review of health services for children looked after and safeguarding in Doncaster was undertaken by the Care Quality Commission in September 2014. A number of recommendations to review arrangements for safeguarding children and young people in the emergency department were made and an action plan was prepared. Staff at Bassetlaw were aware of this report. We found that a number of actions from the review were still in progress, particularly relating to the recording of details of adults with parental responsibility as well as the details of adults who accompanied a child to the department. Records were kept if the attendance at the department was related to risk taking behaviours. Nursing staff told us that if they had any safeguarding concerns, they escalated to the nurse in charge and checks were made through the local authority.
- Senior staff were aware of training arrangements being made for staff in relation to safeguarding women or children with, or at risk of, female genital mutilation or associated abuse.

Mandatory training

- Information about levels of compliance with statutory and mandatory training supplied to us by the trust indicated that mandatory training was not up to date within the emergency department at Bassetlaw District General Hospital. Records for nursing staff showed that compliance ranged between 4% for infection control training and 83% for fire safety training against a trust target of 85%. A recorded total of 57 % and 65% of nursing staff had completed adult and paediatric resuscitation respectively.
- Medical staff mandatory training records showed compliance of between 0% for adult resuscitation and 42% for fire safety training.
- We discussed the information with nursing staff. The department had prepared an action plan to improve the level of training compliance.
- Training staff confirmed that the department now operated a dedicated training programme for statutory and mandatory training and arrangements were in place for all staff to attend relevant training sessions. A dashboard for training compliance was used, which was available to managers through the trust information system. We spoke with several members of staff who confirmed the training they had completed in the previous 12 months, and the training sessions which were arranged for them to attend. Staff spoke positively about the impact of the department's dedicated trainers and the training they delivered.

Assessing and responding to patient risk

- Patients arriving through the emergency department were triaged by a qualified nurse in line with the Manchester triage criteria.
- National early warning scores were calculated on arrival, and patient risk stratified accordingly.
- Patients who deteriorated within the major's area of the emergency department were escalated to the resuscitation area within the department.

- In the national College of Emergency Medicine vital signs audit, the trust performed below CEM standards for documentation of basic observations on admission to emergency. In the severe sepsis audit, a similar delay in recording observations was noted.
- Patients who had suffered a stroke were promptly escalated and transferred to Doncaster Royal Infirmary by emergency ambulance.
- For patients at risk of pressure ulcers, the department used a pressure ulcer traffic light risk assessment and care plan. The pressure ulcer risk status was identified from the assessment as red, amber or green. At initial assessment a registered nurse completed the "Tissue Viability Assessment Pathway." The tissue viability team were providing support for the department in the use of the assessment tool.

Nursing staffing

- Nursing establishment was calculated using the BEST assessment tool. Repeat acuity and dependency assessments using the BEST tool were being undertaken in the Emergency Department at Bassetlaw and results were planned to be presented to the Board of Directors in May 2015.
- The planned staffing levels were that during the day seven nurses were required to staff the rota, with two support staff. At night, five qualified nurses and one support staff were required in addition to a coordinator. An additional support worker was required at weekend nights.
- Interviews had taken place to recruit to current vacancies. Five registered nurses had been appointed and five support workers. Staff reported no problems recruiting to the posts.
- Managers confirmed that once these posts were recruited to, the staffing levels would be sufficient. In the interim, bank and agency staff were planned in advance.
- There was a shortage of staff trained to care for children. At the time of our inspection, there were two nurses qualified to care for children and a minimum of one trained children's nurse on each shift was not achieved. Four staff were currently on an additional course to support them to provide care to children.
- We were informed that operational management conference calls, chaired by the senior manager on call, took place at 8.30am, 12.30pm and 4pm. We observed a handover conference call at 4pm which also involved the Bassetlaw and Mexborough sites.The numbers of patients in the department and waiting times were taken account of in reviewing the availability of nursing staff. Particular concerns as to staff shortages were escalated to senior managers.

Medical staffing

- Our review of national data available from the Health and Social Care Information Centre as to medical staffing and skill mix for the period from September 2003 to September 2013 showed that the trust had a lower percentage of consultant level medical staff (10% compared to the England average of 23%), and junior level medical staff (16% compared to the England average of 25%).
- The shortage of medical staff in the emergency department reflected the national picture. We reviewed the medical staffing on the unit with the consultant and we were informed that there were significant shortages in middle grade and consultant posts in the department.
- Between January 2014 and December 2014, 39% of medical staff at Bassetlaw Emergency department were locum doctors.
- Where possible, long term locums were used to fill in the positions, however short term locums were regularly used to fill in the gaps, and it was common to have unfilled shifts on most days of the week.
- There were six consultants employed, eight middle grade, six FY2 and FY1 doctors.
- The trust were in the process of recruiting to eight middle grades doctor posts. Senior managers informed us that the trust planned a development programme for middle grade medical staff.
- Five consultants worked from 9am- 12midnight. There was always a consultant on call. There was access to senior paediatric medical opinion 24 hours a day from the children's ward.

Major incident awareness and training

- A major incident policy was in place, however there was no formal major incident awareness or training provided for medical staffing. Consultants stated that they were under prepared to deal with a major incident within the local area.
- Nursing staff were aware of major incident guidance and undertook a simulation exercise yearly. Action cards were given at exercise.

- The department had undertaken a simulation exercise for taking a patient with Ebola, however they performed poorly in this simulation. There was no clear action plan in response to the performance.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

The department used National Institute of Clinical Excellence (NICE) and College of Emergency Medicine (CEM) guidelines to support the treatment provided for patients. Although most of the guidelines we reviewed were up to date, some medical guidelines required updating. Medical staff had easy access to evidence based guidelines. The emergency department contributed to a range of CEM audits which demonstrated a mix of good and poor results. Action plans had been prepared to address variable performance.

Arrangements were made for patients to receive adequate nutrition and hydration. Food and refreshments were made available to patients.

The emergency department was open 24 hours a day, seven days a week. Medical and nursing staff could access current information for each patient in the department. The computer information system used in the department and widely used in the NHS was implemented in July 2014. Some change processes related to the implementation remained to be implemented.

Patients were requested for their consent. Nursing staff had received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLs) in the previous 12 months. However, medical staff demonstrated poor application of the MCA and of DoLs procedures.

Staff had received an appraisal in the last 12 months, or arrangements were in place for them to receive this. Nursing staff felt well inducted into the department and well supported, although induction was variable for locum staff.

We observed good working relationships between nursing and medical staff within the department. There was proactive working with the Acute Treatment Centre. However, there was limited interchange with some specialities.

The administration of pain relief had been identified as a concern and pain management in the department had been included in the risk register. The department had initiated work with the pain team, to embed pain assessments and prompt delivery of analgesia into the care delivered within the emergency department. We observed positive practice in the provision of analgesia during the inspection.

Evidence-based care and treatment

- The department used NICE and CEM guidelines, for example the NICE head injury guidance, to support the treatment provided for patients. We found the department used emergency department guidelines which were incorporated within the trust informatics software system. Most of the guidelines we reviewed were up to date; however some of the medical guidelines in particular were last reviewed up to four years ago. When we queried this with the clinical lead, they accepted that they required updating.
- We found junior medical staff in particular, had easy access to evidence based guidelines. The use of clinical guidelines was included in the induction program for all junior doctors.
- Audits conducted in conjunction with the CEM were undertaken in the department. Information provided to us by the trust confirmed the range of audits in which the department participated. For example, the trust scored in the upper quartile compared to all England trusts for patients considered for radiological investigation.
- We saw an audit annual plan for unplanned care which included the emergency department. The audit plan included national and local audits which were completed, ongoing or planned. For example, the audit plan included a range of audits for CEM and NICE, sepsis, stroke, handover, case notes, and mental health in the emergency department.
- Both medical staff and nurses received feedback from the audits undertaken.

Pain relief

- In the 2014 survey of emergency departments, the trust performed about the same as other trusts for the question, "How many minutes after you requested pain relief medication did it take before you got it?" Similarly, the trust performed about the same as other trusts for the question, “Do you think the hospital staff did everything they could to help control your pain?”
- The trust performed worse than England average in relation to analgesia provision in the CEM renal colic audit. Results showed that 58% of audited patients had a pain score recorded. This was below the CEM standard of 100% and in the lower quartile compared to all England trusts. In the fractured neck of femur 2012-13, the trust performed about the same as other trusts for the CEM standard for how promptly after arrival analgesia was provided for patients in severe pain.
- Senior managers identified pain relief as a concern and pain management in the department had been included in the risk register. The department had initiated work with the pain team, to embed pain assessments and prompt delivery of analgesia into the care delivered within the emergency department. We were informed the trust’s acute pain team were working with the department to provide pain specialist nursing and consultant anaesthetist advice and to assess how well managed patients’ pain was. We saw the patient questionnaire used in the department to assess patients’ responses to their pain control. Initial feedback from patients stated they found the form was difficult to complete. We also saw a questionnaire was used with staff to assess their responses in relation to administering pain relief to patients.
- We found that pain assessments were undertaken. We looked at two sets of notes and saw pain assessments were undertaken appropriately and pain relief administered.
- We spoke with nursing staff who said they used a patient group direction (PGD) for administering certain medications including pain relief.
- We saw that were there had been incidents involving pain relief, action had been taken to avoid recurrence.

Nutrition and hydration

- In the 2014 survey of emergency departments, the trust performed about the same as other trusts for the question, ”Were you able to get suitable food or drinks when you were in the A&E department?”
- We observed that food and refreshments were made available to patients if they asked for refreshments. Staff confirmed that food was always accessible and hot meals could be obtained from the restaurant between 07.45am- 19.00pm, if required.

Patient outcomes

- Unplanned re-attendances to the trust’s emergency departments within seven days of discharge were analysed for the period from January 2013 to September 2014. The unplanned re-attendance rate within seven days was worse than the England average between January 2013 and June 2014 however improvement was made from July to September 2014. Re-attendance rates to the emergency department within 7 days ranged from 8% to 9.5% between January 2013 and June 2014. The re-attendance rate dropped below the England average to 7.3% from July 2014 until September 2014. The England average was around 7.5% for the reporting period.
- The emergency department contributed to the CEM clinical audit programme. Information provided to us by the trust confirmed the range of audits in which the department participated, which demonstrated a mix of good and poor results.
- Audits completed in 2014 included children presenting to the emergency department with fever must have vital signs measured and recorded as part of routine assessment. Results showed vital signs were documented 90-100% of the time and recorded within 20 minutes of arrival 54% of the time. Bassetlaw hospital had been commended for the upward trend in the percentage of vital signs measured within 20 minutes of arrival as part of this audit. Actions from the audit were documented.
- The results of the management of asthma in children audit showed only five out of eight children with oxygen saturations below 92% were given oxygen. Less than 100% of children with moderate or severe asthma had a full set of observations as per CEM standards. Peak flow was only checked in 15% of cases. The department did not achieve the CEM standards measured in this audit. The management of anaphylaxis audit findings showed all patients should be triaged and detailed clinical features should be recorded for all patients. Education and training for medical staff was arranged as a result of the audit. The chest pain audit results identified areas to change in documentation.

- We found action plans had been prepared to address variable performance. For example, a review of the renal colic audit was included in the department's audit plan.

Competent staff

- Senior nursing staff were clear about the process and arrangements for staff to receive an annual appraisal. We saw local evidence that approximately 80% of staff in the emergency department had received an appraisal.
- For junior and middle grade and speciality doctors, four hours of protected time for development was provided each week.
- Nursing staff we spoke with felt well inducted into the department and well supported. Staff could raise concerns when they needed to do so. Permanent members of staff received a half day of trust induction and a whole day of departmental induction including a review of complaints, governance, guidelines and specific lectures on child safeguarding and chest pain.
- We found there were variable induction processes used for locum doctors. Doctors who came in during working hours were seen by the secretaries, and were provided with formal induction and an identity badge. There was inconsistent use of this policy out of hours. Locum doctors did not have access to the same learning from incidents compared to permanent staff, and there was no plan put in place to address this.
- A clinical education team specific to the emergency department provided the lead for staff training and signing off staff competencies.
- Managers informed us that all nursing staff had undertaken some paediatric training. Some members of qualified nursing staff were supported to undertake paediatric nursing training.
- Nurse practitioners were qualified as nurse prescribers. If a patient group direction was required, staff were assessed by consultant medical staff and by the clinical education team.
- A tissue viability training programme was coordinated in the department through the tissue viability link nurse and the training staff. The department had set up the programme for staff to work alongside the tissue viability specialist nurse and to declare competence staff needed to correctly classify 12 wounds and achieve above 90%. Most of the band seven staff had competed this training and some of the band five; each member of staff had arranged dates to attend the training.
- We observed that staff worked within their competencies. Staff we spoke with, including support staff, told us they felt confident and competent working within their own protocols. For example, clinical support workers (band three) had received training to undertake observations, to cannulate, and to undertake other similar procedures.

Multidisciplinary working

- We observed good working relationships between nursing and medical staff within the department.
- There had been proactive working with the Acute Treatment Centre. Staff were seconded between the two departments and this supported effective multidisciplinary working. However, there were some concerns raised about multidisciplinary working with some specialities, for example in surgery.
- There was an alcohol liaison team who supported discharge arrangements for patients.
- Staff had access to and could refer to a rapid response team to support discharge back in to the community.
- The service could access child and adolescent mental health services (CAMHS) in a timely manner.

Seven-day services

- The emergency department was open 24 hours a day, seven days a week.
- There was access to onsite radiology services seven days a week.
- Pharmacy services were available Monday to Friday and limited services on Saturdays. An on-call service was available.

Access to information

- The computer information system used in the department and widely used in the NHS was implemented in July 2014. Senior managers told us that some change processes related to the implementation remained to be implemented.
- Medical and nursing staff could access current information for each patient in the department. Staff within the emergency department had immediate access to a patient's medical history and their up-to-date medication history. Staff told us they found it much easier to search for patient information as it was linked to national systems.

Urgent and emergency services

- Consultants and managers received daily performance reports to enable them to have information to deliver and improve the service.
- An information board was displayed in the department which contained comparative data between the emergency departments and recent friends and family test information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were requested for their consent. Verbal consent was obtained before care was delivered. If consent was refused or the patient did not have capacity to consent, this was recorded on the electronic patient record system and may be escalated to a more senior member of staff.
- Nursing staff we spoke with had received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLs) in the previous 12 months. Staff we spoke with mainly demonstrated a clear understanding of the MCA, of their responsibilities and of DoLs procedures. For example, if a patient was not conscious, a decision in the patient's best interests was discussed with a member of medical staff. We found that relatives of the patient were involved in these discussions. However medical staff were not aware of implementation of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLs). They gave an example of practice which demonstrated this lack of understanding.
- Staff told us young people were encouraged to be involved in decisions about their care and treatment.

Are urgent and emergency services caring?

Good

Patients were cared for with empathy and with respect to their dignity on most occasions. We observed that nursing and support staff were caring and compassionate in their interaction with patients. We did observe that patients were transferred to trollies in the corridor in a way which potentially compromised the dignity of patients.

Patients were positive about the care they received. Patients confirmed that the interaction of staff was respectful of their dignity.

Most patients and relatives felt involved by staff in their care and treatment. Patients told us that staff listened to them and had informed them of what was happening.

Nursing, medical and support staff demonstrated good communication skills during the examination of patients. They explained what the patient could expect to happen next and answered their questions.

Patients and relatives we spoke with told us that staff had provided appropriate emotional support during their time in the department.

Compassionate care

- The trust's response rate for the A&E NHS Friends and Family Test was consistently below the England average from December 2013 to November 2014.
- In the Care Quality Commission (CQC) A&E survey 2014 the trust performed about the same as or better than other trusts for all questions relating to caring.
- Patients were cared for with empathy and with respect to their dignity on most occasions. We observed that nursing and support staff were very caring and compassionate in their interaction with patients. Conversations demonstrated an empathetic and caring attitude by staff. However, we did note that a member of the medical team spoke in a way that was not conducive to compassionate care.
- However, we observed that patients were transferred to trollies in the corridor which potentially compromised the dignity of patients.
- We spoke with several patients who were positive about the care they received. One patient told us they had received, "fantastic treatment."

Understanding and involvement of patients and those close to them

- Patients and relatives felt involved by staff in their care and treatment. Patients told us that staff listened to them and had informed them of what was happening; they were happy with staff explanations.
- We observed that staff demonstrated a good level of rapport in their interactions with patients and relatives. We saw that relatives were included in discussions.

Emotional support

Urgent and emergency services

- We observed staff providing emotional support to patients and to relatives. Patients and relatives we spoke with told us that staff had provided support during their time in the department.
- Specialist services such as the liaison staff for alcohol services was accessible to provide additional support for patients.

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

(for example, to feedback?)

Requires improvement

Between January 2014 and January 2015, the 95% target for patients seen within four hours had not been consistently maintained at Bassetlaw hospital. The percentage of emergency admissions waiting four to 12 hours from the decision to admit until being admitted and total time patients spent in the emergency department were worse than the England average.

National data collected showed that the department was performing significantly better than the England average for the handover from ambulance crews to the emergency department teams within 30 minutes.

Early senior review was to be implemented. The trust was in the process of completing building works to extend and increase the capacity of the Clinical Decisions Unit at Bassetlaw hospital.

We saw positive examples of learning from complaints.

Service planning and delivery to meet the needs of local people

- Bassetlaw Hospital emergency department received 44,206 attendances between April 2014 and March 2015, which represented approximately 121 patients per day attending the department on average. Approximately 20% of these patients were children. The emergency department was open 24 hours a day, seven days a week.
- The trust's pathways included effective working between the Assessment and Treatment Centre and the Emergency Department.
- The trust was in the process of completing building works to extend and increase the capacity of the Clinical Decisions Unit at Bassetlaw hospital.

Meeting people's individual needs

- Training was available to support staff caring for patient living with dementia, however medical staff had not accessed this.
- There were arrangements to access a link nurse to support patient with learning disabilities. At the time of inspection this was a limited service of three days per week due to sickness.
- The management team identified that the local Asian and Polish communities formed the largest ethnic minority groups. Interpreters were available to assist with communication needs.
- For patients with mental health needs, a room in the department was set aside for this purpose. There was an established relationship with the mental health trust that were co-located in the department and used a dedicated office.

Access and flow

- National data collected showed that the department was performing significantly better than the England average for the handover from ambulance crews to the emergency department teams within 30 minutes.
- Time to initial assessment was analysed. From July 2013 to September 2014 the trust achieved consistently below the England average median time to initial assessment. An analysis of hand-overs delayed by over 30 minutes in the period from November 2013 to March 2014 showed 1560 ambulances were delayed by over 30 minutes. This was in the lower quartile nationally compared to all England trusts. The standard for median time to treatment is 60 minutes. The trust's median time to treatment was below the England average and standard with median times to treatment ranging from 40 minutes to 60 minutes. The median time to treatment was above the standard by 20 minutes in July 2014. The trust performed about the same as other trusts for questions relating to handover from ambulance crew and time waiting to see a doctor or nurse.
- The trust's performance for the number of patients seen within four hours was analysed for the period from August 2013 to January 2015 based on information provided by the trust. Between January 2014 and

Urgent and emergency services

January 2015, the 95% target for patients seen within four hours had not been consistently maintained at Bassetlaw hospital. The target was met in five out of thirteen months. For the period January 2015 to March 2015, the trust's performance was better than the national average; the four hour target was achieved at Bassetlaw District General Hospital in February and March 2015.

- The percentage of emergency admissions waiting four to 12 hours from the decision to admit until being admitted was analysed for the trust for the period from April 2013 to December 2014 and was generally worse than the England average.
- The total time patients spent in the emergency department averaged per patient was analysed for the period from January 2013 to September 2014. For 10 months, the total time spent in the department was better than the England average. Between May 2014 and September 2014 the trust performance was worse than the average.
- Information for patients leaving the department before being seen was analysed for the period from January 2013 to September 2014. The trust's performance was generally worse than the England average. However, data showed that the trust's performance for subsequent months was better than the average for percentage of patients leaving before being seen.
- Pathways were in place to divert patients to and from Doncaster Royal Infirmary and Bassetlaw Hospital when either site was facing capacity and demand issues"The trust also informed us that it had worked with the Emergency Care Intensive Support Team to develop a plan to improve its four hour performance. The department was in the process of implementing this at the time of our inspection. Some actions were not due to be completed until August 2015.
- Paediatric patients were admitted within 15 minutes of arrival wherever possible. The paediatric nurse undertook triage for paediatric patients.
- Early senior review (previously, rapid assessment and treatment) was due to be introduced, involving a consultant or member of middle grade medical staff.
- A flow co-ordinator was employed between 10am to 9.30pm. Staff spoke positively about this role on patient flow.
- There was no dedicated porter in department. Staff felt this impacted on patient flow.
- We found the patient flow through the Clinical decisions Unit was effective with an average length of stay of 24 hours.

Learning from complaints and concerns

- Complaints were submitted and processed using the trust's computer system for complaints incidents. The Patient Advice and Liaison Service responded to complainants and progressed the investigation of complaints.
- The department analysed the outcomes of complaints to identify themes and trends. Over the previous six months, 19 complaints had been received. Communication, particularly with elderly patients and waiting times were the most common themes.
- We saw positive examples of learning from complaints.

Are urgent and emergency services well-led?

Good

The emergency care group operational plan for 2015-17 and the five year plan the trust had developed involved a significant re-organisation of the structure of the emergency department. The joint vision set out by the care group was shared by staff in the department.

A risk register action plan for the care group was updated to reflect risks current in the department and action being taken to mitigate these risks.

The arrangements for governance meetings in the department had recently been reviewed to reflect revised departmental structures. Staff found the meetings were supportive and enabled them to start to work together as a team although it was felt the meetings focused on Doncaster Royal Infirmary. Meetings of emergency department band seven nursing staff were held regularly. Regular drop in sessions for staff in the department were held with the matrons and Head of Nursing.

Senior staff spoke positively about the new leadership team. The executive team were seen as visible and accessible by most staff with exception particularly of junior staff. There were good working relations between nursing and medical staff in the department.

Urgent and emergency services

There was an open culture in the emergency department. The emergency department engaged with patients and the public through the NHS Friends and Family Test.

The department worked jointly with commissioners and an external equipment supplier to develop pressure relieving mattresses for patient trolleys.

Vision and strategy for this service

- The trust summarised its strategic direction, strategic goals and values under a mnemonic "We care" linked to its supporting strategies and its strategic direction for 2013-2017. This was supported by strategic themes and priorities to deliver these.
- The emergency care group operational plan for 2015-17 set out the strategic context and direction for urgent and emergency care system transformation taking account of the national context for emergency departments. The local context for the trust involved working closely with commissioners so that planned changes were aligned with national developments in emergency care.
- The five year plan the trust had developed involved a significant re-organisation of the structure of the emergency department.
- The joint vision set out by the care group was shared by staff in the department. A focus on placing the patient at the centre of decision making was shared by management and senior staff. The involvement of all staff in this vision we concluded was work in progress for the department.

Governance, risk management and quality measurement

- The arrangements for governance meetings in the department had recently been reviewed to reflect revised departmental structures. A clinical governance meeting for the emergency care group met monthly and meetings were minuted. A clinical governance meeting for the emergency department also met monthly and fed back to the main clinical governance meeting on a monthly basis. The department also attended emergency care group governance meetings. We reviewed the minutes of several recent meetings of these groups. The agenda included clinical incidents, complaints, audits and a review of risk registers, although no details were included as to risk registers.
- A risk register action plan for the care group was shared with us. We saw evidence that the risk document was updated to reflect some risks current in the department and action being taken to mitigate these risks. For example the impact of staff shortages were included.
- Medical staff within the department expressed some frustration at needing to escalate issues and these not being acting upon in a timely manner.
- We spoke with senior staff who attended the recently established governance meetings. They told us they found the meetings were supportive and they felt they had started to work well to exchange information within the care group and to share learning. However, staff felt the focus of the meetings centred on Doncaster Royal Infirmary.
- Team meetings were held at Bassetlaw Hospital. Weekly multidisciplinary meetings and monthly band 7 meetings were held. There were daily 'huddles' to communicate key safety issues across the teams.
- Nursing and support staff we spoke with said they would raise any concerns with their line manager and most felt confident to do this.

Leadership of service

- Senior staff worked within the department. Staff commented positively about this.
- Staff felt they now received improved communication from the executive team.
- Nursing staff and support workers were clear about their roles and responsibilities.
- The trust executive informed us that within the emergency care group, recent changes to the leadership arrangements had presented some challenges for urgent and emergency care.
- Senior staff spoke positively about the new leadership team. The care group director and two assistant care group directors were supported by the clinical governance lead, the head of nursing and quality, a team of four matrons, a general manager and two business managers.
- The Head of Nursing held regular open door, drop-in sessions for staff.

Culture within the service

- We found there was an open culture in the emergency department. Representatives of the new leadership

team told us they had spent some time developing the culture and relationships, which was linked to building trust, values and respect and improving communications.
- Staff reported a more open culture and said this had developed and improved over the last two years. Both staff and managers felt the service was focused on the patient.
- Some staff, particularly junior staff, reported that managers and the trust executive team were not visible.
- Staff reported positive team working relationships. This helped to maintain the focus on the patient rather than targets. Several members of nursing and support staff told us they enjoyed working in the department.

Public engagement

- The emergency department engaged with patients and the public through the NHS Friends and Family Test. For February 2015, the department received 138 responses which represented a 6.46% response rate. The net promoter score was 82.6%. For the trust overall, 87% of patients recommended the hospital since the test commenced in 2013.
- We found the trust was introducing text feedback for patients to submit their response to the NHS Friends and Family Test, to make it easier for patients to submit their feedback.

Staff engagement

- The board of governors for the foundation trust were actively involved and consulted in connection with developments in the department.
- Staff reported they could have more actively contributed to the development of the Clinical Decisions Unit.
- There were some concerns about medical staff engagement, demonstrated by the lack of awareness of the Mental Capacity Act and engagement with emergency plans.
- Results from the NHS staff survey 2014 showed that the percentage of staff at the trust reporting good communication between senior management and staff was better than average when compared to other NHS trusts nationally. However, the percentage of staff that were able to contribute towards improvements at work was below average. Staff at the trust were about as likely to recommend the trust as a place to work or receive treatment, when compared with other NHS trusts nationally.
- Weekly drop in sessions for staff in the department were held with matrons.
- We found that information about the developments at Bassetlaw were featured in communication 'foundations for health' newsletter for staff and volunteers.

Innovation, improvement and sustainability

- The trust executive informed us that it had worked with the Emergency Care Intensive Support Team (ECIST) to develop a plan to improve its four hour performance. The department was in the process of implementing this at the time of our inspection. Some actions were not due to be completed until August 2015.
- As part of the trust's approach to reduce hospital acquired pressure ulcers, the department worked jointly with commissioners and an external equipment supplier to develop pressure relieving mattresses for patient trolleys. The development of this equipment was intended to reduce the incidence of pressure ulcers. We were informed that following positive feedback from patients, the use of these trolleys and mattresses was to be extended.

Medical care (including older people's care)

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

Information about the service

Medical care services at Bassetlaw District General Hospital had 85 beds including general medicine, cardiology, stroke and respiratory services and an acute medical assessment unit (Assessment & Treatment Centre) which provided inpatient and ambulatory services. The unit received patient admissions from A&E, GPs, community services and the ambulance service and had 24 beds with quick access to diagnostic tests, enhanced pharmacy and had dedicated social care support.

The medical services received 8,800 admissions July 2013 to June 2014 of which 62% were emergency cases, 2% were elective cases and 36% were day cases.

We inspected all of the medical care services provided at Bassetlaw Hospital and spoke to 19 staff members including medical and nursing staff, pharmacy and housekeeping, two student nurses, 23 patients and six relatives.

Summary of findings

We rated medical care services as good for effective, caring, responsive and well led. The safe domain required improvement.

During our inspection we witnessed most staff behaving in a caring and respectful manner towards their patients. Patient buzzers were answered promptly in most areas visited. There was a wide range of national and local audit activity undertaken at Bassetlaw District General Hospital including the trust-wide quality metrics audit framework for ward managers to complete (Ward Quality Assessment Tool). Where required, actions were taken in response to audit outcomes, for example the National Diabetes Inpatient Audit (2013) resulted in strengthening the trust wide clinical resource to support staff in managing diabetes effectively.

On the day of inspection, nurse staffing levels on the respiratory medicine ward (C1) were planned to be four trained nurses during the day and evening shift and three at night. The actual staffing level was three trained nurses on the day and evening shift and two trained nurses at night resulting in a ratio of 14 patients to one trained nurse overnight. We noted that 21 incident reports had been submitted recording staff shortages on C1 between September and December 2014. All were graded as no harm caused; however the reports include reference to medicines not being given on time as well as repositioning of patients, assessment scores and observations not being carried out on a timely basis.

Medical care (including older people's care)

Wards A4 and A5 also submitted incident reports about staffing shortages impacting on the standard of care including lack of timely repositioning of patients and managing wandering and confused patients.

Staff were generally positive about the leadership and the levels of engagement with their line management through to executive level. However junior staff in less well staffed areas voiced less confidence in the leadership and expressed low morale due to the on-going workload pressures experienced on the wards. The impact of the staffing shortages on C1 was evident through documentation in case notes and the incident reporting system. On our unannounced inspection on 29 April 2015, we found that the staffing levels had been reviewed and four beds had been closed. Staff reported this action had a positive impact and they were able to deliver care to meet patients' needs.

On the day of inspection, both bays on the cardiology ward had mixed sex accommodation but in each bay there was a female patient who was no longer on cardiac monitoring. The hospital policy stated that this was not acceptable when "the patient no longer needed Level 2 or Level 3 care and was awaiting a bed on an appropriate ward." The mixed sex accommodation trust policy was discussed with the ward manager and Matron and immediate action was taken to move the two female patients at the earliest opportunity. An email with the policy attached was sent to all members of the cardiology medical and nursing teams to clarify the requirement to move patients once there was no applicable clinical need to keep them in mixed sex accommodation. We revisited this area as part of our unannounced inspection. We found the policy was implemented; there were no mixed sex breaches.

Are medical care services safe?

Requires improvement

We rated medical care services as requires improvement for safety due to the impact of staffing shortages.

We had concerns about the staffing levels in medical services particularly on Ward C1. An acuity tool was not used on a daily basis to manage staff shortages. We noted that incident reports recording staff shortages on C1 between September and December 2014 included reference to medicines not being given on time as well as repositioning of patients, assessment scores and observations not being carried out on a timely basis. Staff shortages were evident at the time of inspection and the impact on personal care was recorded in the nursing notes, for example failure to provide one to one observation and not having time to wash a patient.

On our unannounced inspection on 29 April 2015, we found that the staffing levels had been reviewed and four beds had been closed. Staff reported this action had a positive impact and they were able to deliver care to meet patients' needs. The levels of sickness and use of temporary staff were higher on the respiratory medicine ward than the remaining medical services wards. Staff shortages also meant that student nurses were not receiving the learning experience required for their training and one reported having to function as a health support worker due to workload pressures.

Incidents

- There were systems in place to report incidents using the electronic Reporting system. Incident reports were reviewed and investigated where required by senior nurses on each ward. Feedback on incidents and shared learning were discussed at the ward managers' monthly meeting with the relevant Matron.
- Nursing staff told us they understood how to use the system to report incidents and that feedback was received from their line manager at team meetings and by email from the ward managers.
- 227 patient safety incidents were reported between September and December 2014 within the medical care services at Bassetlaw Hospital. Five of these were classed as moderate and related to pressure ulcers. The

most commonly reported incidents related to patient falls; however none resulted in serious harm and the rate of falls trust-wide had dropped by 27% over the past year as reported to the Board in April 2015.

- However we were told by a senior nursing staff member on one ward that they felt they did not gain anything by taking extra time to submit reports on staff shortages as these were common and often resulted in working beyond the end of the shift. Discussion with other members of staff and review of the duty rotas confirmed that staff shortages were a regular occurrence. Omitting to report staff shortages via the incident reporting system could mean that any impact on patient care and on staff was not fully picked up via incident reporting analysis.
- There were trust-wide systems in place to ensure that a root cause analysis was undertaken for serious incidents including a Serious Incident Panel and senior nurses interviewed confirmed that they took part in investigations.
- There had been no never events in medical care services at Bassetlaw Hospital from February 2014 to January 2015.
- Reviews of mortality and morbidity by the consultant team were included as part of each specialty clinical governance group within the MSK & Frailty, Specialties and the Emergency Care Group.

Duty of candour

- In November 2014 the duty of candour statutory requirement was introduced and applied to all NHS trusts. The trust had in place a policy relating to these new requirements.
- Information to be reported under the duty of candour requirements was included in the electronic incident reporting system.
- We saw that information about duty of candour was displayed on the staff intranet. Nursing staff we spoke with were aware of their responsibilities under the duty of candour requirements.

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The medical wards recorded the Safety Thermometer information electronically monthly and fed into Trust-wide reporting to the Board.
- Information regarding the results of the Safety Thermometer was displayed on the medical wards. Information relating to the number of days since the last incidence of MRSA, C.Difficile, falls and pressure ulcers was displayed near the nurse station for staff, patients and visitors to see.

Mandatory training

- The Trust had a programme of statutory and mandatory training for all staff.
- Training levels were notably low amongst medical services nursing staff at Bassetlaw Hospital for Conflict Resolution, Equality and Diversity and Infection Control. Recorded training levels for Infection Control varied from 0% to 7% for nursing staff on the medical wards; however most staff were observed to follow the expected infection control practices related to hand hygiene and isolation of infections and monthly infection control audits were conducted on the wards.

Safeguarding

- The Trust had a safeguarding lead nurse, lead clinician and a safeguarding committee where alerts and referrals were reviewed.
- Staff on the medical wards were aware of what to do in the case of a safeguarding concern; however training levels could be improved. The target training level for safeguarding was 85% - the training levels for registered nurses ranged between 50-74% across medical services. We observed evidence of safeguarding sessions being booked for staff for the current year.
- Minutes of the care group Clinical Governance Group meetings demonstrated that safeguarding training levels were being regularly monitored by management.

Cleanliness, infection control and hygiene

- The wards were observed to be for the most part clean and tidy. Patients also confirmed that they felt their environment was clean. Cleaning checklists were seen to be completed by the housekeepers and the outcomes recorded electronically on a central system. Average monthly cleanliness scores for Bassetlaw Hospital were over 90%.
- Monthly infection control audits were undertaken and recorded electronically. Data from the most recent audits showed 100% compliance with for example: hand hygiene and urinary catheter hygiene. This data was also displayed on the wards.

- Personal protective equipment and alcohol hand gel was available at the entrance to, and throughout the wards.
- We observed that staff wore personal protective equipment and most staff applied the principles of infection control. However we observed some instances where gel was not used between patients and an isolation room with the door was left open.
- Equipment was observed to be clean and reported to be cleaned after use. However there was no system in place to identify equipment as clean such as by labelling.

Environment and equipment

- The medical wards were well lit, clean and generally tidy. The Assessment and Treatment Centre opened in 2012 and was a newly refurbished unit whereas the other medical ward areas were in older estate.
- The respiratory medicine ward (C1) was very busy on the day of inspection and the corridors were cluttered with equipment. We returned later in the day and the ward was calmer and the corridors cleared.
- Resuscitation equipment was checked daily with very few exceptions. The resuscitation trolleys were centrally placed and covered with a fitted cloth cover that held a notice indicating the first expiry date to occur for drugs held on the trolley.
- The medical wards were well equipped and members of staff raised no concerns with regards to availability of equipment.
- Equipment was noted to be labelled with the last service date and these were in date. Machines checked included blood glucose monitoring machines, hoists, weighing scales and bladder scanners.

Medicines

- Medicine refrigerators were secure. Temperature records were checked daily to ensure medication was stored at the correct temperature. Records showed that the temperature was at the recommended level.
- Medication was administered according to the electronic prescribing system.
- The electronic prescribing system prompted nurses to ensure the calculation and/or administration of key drugs was witnessed.
- Nursing staff reported that agency staff did not have log-in details so were not able to administer medication; however we were informed by Pharmacy that agency staff who worked regularly on a ward could be assigned log-in details to enable them to medicate patients. This was confirmed as practice on the Assessment and Treatment Centre.
- Medicines were securely held in locked cupboards within a locked treatment room; however we noted a syringe driver containing insulin attached to an IV stand with intravenous fluids hanging left unsupervised in the corridor of a ward.
- Controlled drug cupboards were closed and locked. Controlled stationary was held securely and controlled drugs were counted daily.
- Nursing staff reported that Pharmacy services were limited at the weekend.

Records

- The medical wards used a variety of risk assessment and care pathway documentation.
- Nursing records looked at were noted to be complete. They clearly communicated the plan of care and any changes to that plan such as nursing a patient on a low bed with a mattress on the floor in the case of acting on a falls risk assessment.

Assessing and responding to patient risk

- The (National) Early Warning System (EWS) was in use to identify deteriorating patients. Assessment of the score was seen to be a routine part of recorded vital signs.
- Deteriorating patients had access to the seven-bedded critical care unit in the hospital if required.
- The Assessment and Treatment Centre (ATC) had 21 inpatient beds and an ambulatory care service operating within the ATC. The ambulatory care facility received 20-25 patients a day as urgent referrals from GPs. There were two bays and two treatment rooms in ambulatory care with a seating area for patients waiting to be seen.
- An advanced nurse practitioner triaged the GP calls and the patients on arrival. Patients had access to investigative tests such as electrocardiogram, blood tests and rapid access to scanning.
- Patients could also be followed up for six weeks following treatment being started for deep vein thrombosis to monitor and stabilise the patient on anticoagulant therapy.

- Continuous cardiac monitoring for ATC patients was available in liaison with the Coronary Care Unit based in the ward next door to ATC. Patients were monitored by the CCU staff and the ATC staff were alerted if any problems arose.
- Signs were noted outside bays with the bed number, EWS score and the next time observations were due.

Nursing staffing

- We were concerned about the impact of staffing levels on patients and staff in medical services. Staff shortages were experienced to a varying degree by all areas of medical services. This was particularly evident for respiratory medicine (C1). On the day of inspection, nurse staffing levels on C1 was less than planned and the shift was particularly busy. The actual staffing level for nights was two instead of three trained nurses resulting in a ratio of 14 patients to one trained nurse overnight. Actual staffing levels for health care assistants (HCA) on C1 were also reduced that day, from three HCAs to one on day and evening shift. We were told that Band 6 nurses frequently worked extra to cover shortages on C1 and that many staff on the ward worked over and above their contracted hours. Review of the staffing rotas at the time confirmed this.
- The average monthly staff sickness level amongst nursing staff was noted to be higher on this ward than the remaining medical wards for April to December 2014 at 7.33%. The sickness rate amongst health care assistants was also high at a monthly average of 12.81%. The monthly fill rate of bank/agency on C1 increased throughout 2014, from January (19%) to December (37%). The average bank/agency monthly fill rate was 18.8% on C1 for the period compared to 8.9% on the cardiology unit (C2).
- C1 was reported as being particularly busy and short-staffed by the nursing staff interviewed including a student nurse who felt they had a supportive mentor but that there was little time for learning as they were counted in the numbers and functioned as a health care assistant. The nurse in charge corroborated this and said that it was difficult to teach student nurses as they were needed within the staff numbers.
- There was evidence that personal care was affected by staff shortages, for example, it was noted in nursing documentation that a patient "requires one to one but unable to do due to short staffing, site manager aware." In a later entry it was recorded that "patient not washed as short staffed." This meant that nurse staffing shortages were preventing a patient from receiving the personal care they required. We noted that 21 incident reports were submitted recording staff shortages on C1 between September and December 2014. The reports include reference to medicines not being given on time as well as repositioning of patients, assessment scores and observations not being carried out on a timely basis. The acuity of patients referred to in these reports included patients on BiPAP (bi-level positive airway pressure), patients with chest drains, patients who required end of life care and patients who needed to be transferred to ITU. Wards A4 and A5 also submitted incident reports about staffing shortages impacting on the standard of care including timely repositioning of patients and managing confused patients who needed specialing.
- The trust used NICE (National Institute for Health and Care Excellence) guidance for staffing levels and planned staffing levels were agreed in the 2015/2016 funded establishments. An acuity tool was not in use to assess daily staffing needs at a local level on the medical wards. Expected and actual staffing levels were clearly displayed on each ward.
- Staff shortages were recognised as a risk to the quality of nursing care by the care group management team and had been recorded on the Emergency Care Group and MSK & Frailty risk registers. It was not explicitly referred to on the Specialties Care Group risk register.
- The risk had been escalated to the corporate risk register in January 2015. Actions included a rolling recruitment programme, improved management of sickness absence, introduction of e-Rostering and use of temporary staff. The implementation of these actions was evidenced through discussion with all levels of nursing staff
- We revisited Ward C1 as part of our unannounced inspection on 29 April 2015. We found that the staffing levels had been reviewed and four beds had been closed. This meant there was one registered nurse to six patients during the day and one to eight at night. Staff reported this action had a positive impact and they were able to deliver care to meet patients' needs. We observed that staff attended to patients in a timely manner.

Medical staffing

Medical care (including older people's care)

- Monday to Friday, 9am to 5pm, there was a Foundation Year One (FY1) doctor, two Senior House Officers (SHO) and a Registrar but we were told by a Senior House Officer that a Registrar was not always available.
- From 5pm to midnight, the FY1 on-call covered all the medical wards. An SHO and Specialist Registrar (SpR) covered admissions and the Assessment and Treatment Centre and assisted the FY1 if needed.
- From 9pm to 9am there was one SHO and one SpR with no FY1 after midnight. This meant that the medical team could be busy with admissions on ATC and with ward issues.
- On Saturday and Sunday there was one FY1 who covered the wards. An SHO and SpR covered admissions and reviewed patients on the wards (potential discharges and unwell patients)
- There was a consultant physician working in the hospital, based on ATC for 10 hours a day, seven days a week. During the evenings and weekends, there was also a general medical consultant on-call. However, cardiology consultant presence was Monday to Friday. This was confirmed by a patient on the cardiology ward who said they had been admitted on Good Friday and had not seen a consultant for four days. Nursing staff reported that the discharge of cardiology patients at the weekend could be delayed as the only medical resource was the on-call medical team.

Major incident awareness and training

- Major incident and resilience plans were in place and staff we spoke with were aware of these.

Are medical care services effective?

Good

There was a wide range of national and local audit activity undertaken at Bassetlaw District General Hospital including the trust-wide quality metrics audit framework for ward managers to complete (Ward Quality Assessment Tool). Where required, actions were taken in response to audit outcomes, for example the National Diabetes Inpatient Audit (2013) resulted in strengthening the trust wide clinical resource to support staff in managing diabetes effectively.

Each of the care groups were committed to achieving seven day services as demonstrated in their three year operational plans. General medicine consultant cover was seven days per week with reduced hours at the weekend. Pharmacy and allied health professional services were available seven days a week with limited access at the weekend; however pathology services provided a 24 hour seven day service.

Ambulatory Care services were also available seven days a week with reduced hours at the weekend.

A Mental Health Liaison team was available to assist with mental health and capacity issues. Patients we spoke to confirmed that explanations and choices were given by staff so they could agree to or decline tests or procedures.

Evidence-based care and treatment

- Policies based on NICE guidelines were available to staff and accessible on the trust intranet site.
- Medical staff participated in national and local audits across the medical services and an audit programme was in place. Audit outcomes were discussed at the care group clinical governance meetings held monthly.

Pain relief

- Pain assessments were carried out as part of observations for the early warning score and recorded however there was no specific assessment tool in use.
- Pain relief was provided as prescribed and there were systems in place to make sure that additional pain relief could be accessed via medical staff, if required.
- The patients we spoke with had no concerns about pain control as they confirmed that pain relief was supplied promptly by the nursing staff and was effective.

Nutrition and hydration

- Patients were assessed for their nutritional and hydration needs and referred to a dietician if required.
- Patients were mainly positive about the food provided. They told us there was sufficient food and drink and were offered a choice.
- There were protected meal times on wards and we observed patients being supported to eat and drink and food charts being filled in appropriately.

Patient outcomes

- During 2014/15, Doncaster and Bassetlaw Hospitals NHS Foundation Trust participated in 87.5% of national

clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in according to their 2014/15 Quality Accounts.

- Local audit at BDGH included a re-audit of falls management, an audit of ambulatory/out-patient management of cellulitis requiring intravenous antibiotic therapy, a retrospective re-audit of the appropriateness of Troponin tests, an audit on the management of patients with spontaneous pneumothorax and an audit of venous thromboembolism prophylaxis prescribing in general and acute medicine against NICE Guideline 92.
- There was a trust-wide quality metrics audit framework for ward managers to complete (Ward Quality Assessment Tool). Staff confirmed that they had completed the audits and submitted these electronically. Audits were undertaken to monitor compliance with guidance, such as hand hygiene audits. Results seen showed good levels of compliance.
- The National Institute for Cardiovascular Outcomes Research Heart Failure audit (2012/13) showed a higher (92%) than the England average (78%) input from specialists for heart failure patients at Bassetlaw District General Hospital (BDGH). There was less consultant input than the England average (37%:51%) and less patients cared for on a cardiology ward (21%:50%) but higher (95%) than the England average (91%) percentage of patients received an echocardiogram. 98% of heart failure patients received discharge planning compared to the England average (83%); however 35% of heart failure patients received a heart failure liaison service compared to the England average (59%).
- The Myocardial Ischaemia National Audit Project (MINAP) 2013/14 showed that less nSTEMI (non ST-segment elevation myocardial infarction) patients were seen by a cardiologist or a member of the cardiology team at BDGH than the England average (84.1%:94.3%) but this had risen from the previous year (76.6%). The proportion of nSTEMI patients who were referred for or had angiography during admission was higher than the England average (84.5%:77.5%).
- The National Diabetes Inpatient Audit (2013) showed 10 /16 indicators as worse than the England median. Management had responded to the outcome of the audit and strengthened the Diabetes Specialist Nurse Team and recruited another diabetes consultant. The specialist team were expanding to provide seven day working and there had been changes made to the care pathway for managing diabetes ketoacidosis evidenced by a revised treatment and monitoring chart.
- There was no evidence of risk related to in-hospital mortality outliers.
- The overall average length of stay for patients receiving general medical services was slightly below the England average for 2013/2014; however the average length of stay for stroke medicine at Bassetlaw Hospital was higher (28.1 days) than the England average (12 days). Overall average length of stay for Stroke Medicine for the Trust was also above the England average at 17.7 days compared to 12 days. (Source: HES Jul 2013-Jul 2014).
- Delayed discharges were acknowledged to occur but were commonly felt to be linked with social and community services resources.
- There were slightly more observed readmissions than expected for the medical service: ratio of elective readmissions - 101, ratio of non-elective readmissions – 103. (Source: HES Jul 2013-Jul 2014).
- The rolling 12 month HSMR at BDGH was 112.48 as at March 2015. An action plan was in place to improve the quality of coding and mortality reviews at specialty level together with a review of the emergency pathway and weekend working. Bassetlaw Hospital at night and wider medical pathways were being resourced for review under the DBH2020 strategy. The Trust was also seeking to improve performance through seven day working and nurse role development and this was reflected in the provision of seven day consultant cover for general medicine and plans to expand the numbers of Advanced Practitioner Nurse posts at Bassetlaw Hospital within medical services.

Competent staff

- Appraisal rates for nursing staff within medical services for 2013/14 were reported in December 2014 as less than 15% for each of the medical services areas in the hospital. Appraisal rates were acknowledged as a Trust-wide issue; however systems for recording completed appraisals were recognised at Board level as inaccurate. In the last staff survey, 63% of Trust-wide staff said they had received an appraisal in the last year although the current systems recorded 42%. There was a plan to review the systems supporting the implementation of appraisals.

- The revalidation process was managed by the Deputy Medical Director. In the July 2014 report to the Board, 104 consultants had been recommended and accepted by the General Medical Council for revalidation at that time. A report to the board in April 2015 showed that 90% of medical staff across the Trust completed an appraisal in 2014/2015.

Multidisciplinary working

- Staff from medical, nursing and allied health professional groups were observed to have good working relationships on the wards.
- Multidisciplinary meetings were held weekly and consultant led ward rounds were conducted Monday to Friday. Discharge processes were supported by discharge coordinators.
- Ambulatory Care on the ATC was staffed by an Advanced Nurse Practitioner who liaised directly with the GPs and Accident & Emergency to triage patients for the service and reported that this worked well.

Seven-day services

- Pharmacy and allied health professional services were available five days a week with limited access at the weekend; however pathology services became a 24 hour seven day service eighteen months ago.
- Ambulatory Care services were available 8am to 8pm Monday to Friday and night cover was provided if patients were still in the ambulatory area after that time. On weekend days, the service was available for eight hours per day, 10am to 6pm or 12pm to 8pm.
- General medicine consultant cover was seven days per week with reduced hours at the weekend.
- No on-site cardiologist was available on weekend days except one weekend in six when the consultant was on-call for acute admissions. It was reported that echocardiograms could only be done at the weekend when a consultant was available therefore this only occurred once every six weeks.

Access to information

- Staff told us there was sufficient information in patients care records to enable them to care for patients appropriately.
- Information leaflets were displayed on the respiratory medicine and cardiology wards.
- Information was displayed on computerised screens by the nurse's station. Staff could access test results, care records and other relevant information about patients on the ward.
- Care summaries were sent to the patient's GP and the patient on discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Ward staff were clear about the processes to follow if they thought a patient lacked capacity to make decisions about their care. If there were concerns about capacity, they would refer the patient to the Mental Health Liaison team for assessment.
- Patients we spoke to confirmed that explanations and choices were given by staff so they could agree to or decline tests or procedures.
- We did not see any patients subject to Deprivation of Liberty Safeguards during our inspection

Are medical care services caring?

Good

During our inspection we witnessed most staff behaving in a caring and respectful manner towards their patients. Patient buzzers were answered promptly in most areas visited but one patient we spoke to was concerned at the length of time buzzers were answered, particularly at night. Some patients were aware of their care plan and treatment objectives and felt fully involved but others were less clear in their understanding. Patients and family members said that medical and nursing staff were approachable and responsive if they did raise concerns. Patients we spoke to described staff as attentive, eager to help and asking if they needed anything on a regular basis. Patients were positive about the staff ensuring that they understood the plan of care.

Compassionate care

- The highest response rate for the Friends and Family Test in medical services at Bassetlaw District General Hospital in May 2015 was 102% for the Assessment and Treatment Centre with 91% of respondents

recommending the services. The lowest response rate was 27% on Ward A4 with 47% of patients recommending the service. Ward A5, C1 and C2 had an average recommendation rate of 98%.

- During our inspection we witnessed most staff behaving in a caring and respectful manner towards their patients. We observed one patient agitated and distressed for 15 minutes after which we informed the ward manager who covered the patient and put her legs back in the bed. It was a further 15 minutes before staff were able to address her needs.
- Patient buzzers were answered promptly in most areas visited but one patient we spoke to was concerned at the length of time buzzers were answered, particularly at night.
- Physiotherapists were observed to be caring and considerate when assisting patients to walk.
- Curtains were drawn appropriately during episodes of care to preserve dignity and respect. Most patients we spoke to felt that they were treated with respect but there was concern from one patient about the attitude of some staff to confused patients. This was also reflected in the feedback from a student nurse and linked by both to stress caused by the workload.

Understanding and involvement of patients and those close to them

- Staff uniforms clearly identified the different roles of nurses and allied health professionals and these were explained on a board at the ward entrance.
- We did not see evidence of information displayed to signpost patients and carers to the PALS or complaints service if they had any concerns but all patients spoken felt confident that they would raise a concern with the nurse in charge if necessary.
- Some patients were aware of their care plan and treatment objectives and felt fully involved but others were less clear in their understanding. Patients and family members said that medical and nursing staff were approachable and responsive if they did raise concerns.
- Patients we spoke to had mixed levels of knowledge of discharge plans.

Emotional support

- We witnessed staff providing good emotional support to a family member during a difficult discussion about the medical deterioration of their relative.
- Patients we spoke to described staff as attentive, eager to help and asking if they needed anything on a regular basis.
- We observed nurses being supportive during a discussion about discharge plans with a patient and their relatives. The nurse demonstrated a caring and personal approach, addressed family members by their first names and conducted a conversation centred on the patient.
- Patients were positive about the staff ensuring that they understood the plan of care. For example, one patient described how the doctor explained to him that he needed a pacemaker, what having a pacemaker would mean and what would happen during the procedure.

Are medical care services responsive?

Good

Medical outliers occupied 13 out of 35 orthopaedic beds at the time of the inspection. It was reported by nursing staff that the medical team visited daily and that on occasion medical patients were admitted directly from A&E. Discharge arrangements were managed by the ward discharge coordinator working with social services, community services and GPs. Discharge dates were reviewed weekly at the multidisciplinary meetings. Discharge delays were acknowledged but were related by staff to the complexity of patient needs.

On the day of inspection, both bays on the cardiology ward had mixed sex accommodation but in each bay there was a female patient who was no longer on cardiac monitoring. The hospital policy stated that this was not acceptable when "the patient no longer needed Level 2 or Level 3 care and was awaiting a bed on an appropriate ward." The mixed sex accommodation trust policy was discussed with the ward manager and Matron and immediate action was taken to move the two female patients at the earliest opportunity. An email with the policy attached was sent to all members of the cardiology medical and nursing teams to clarify the requirement to move patients once there was no applicable clinical need to keep them in mixed sex accommodation. We revisited this area as part of our unannounced inspection. We found the policy had been implemented; there were no mixed sex breaches.

Medical care (including older people's care)

When male and female patients were nursed in the same bay, there were potential issues around dignity as women had to use a designated toilet facility further down the ward while the men used the ensuite in the bay. One female patient informed us that she was too unwell to go to the designated toilet further away and had shared the use of the ensuite in the bay with the men but did not like having to do this. This meant that there were potential difficulties in maintaining privacy and dignity.

Service planning and delivery to meet the needs of local people

- In line with the Urgent Care Model being developed by Bassetlaw Clinical Commissioning Group (CCG), the Emergency Care Group was continuing to work with CCGs, Community Services and Primary Care to develop ambulatory care services both in Doncaster and Bassetlaw.
- Plans to improve services to diabetic patients included strengthening the diabetes specialist team, recruiting another diabetes consultant and providing a more robust diabetes foot care service.

Access and flow

- Medical services at Bassetlaw Hospital received patients with general and acute medical conditions. Discharge arrangements were managed by the ward discharge coordinator working with social services, community services and GPs. Discharge dates were reviewed weekly at the multidisciplinary meetings.
- 66% of patients moved once during their stay, 23% moved twice and 7% moved three times. Inpatient bed moves of four or more accounted for 4% of inpatients.
- Between September and December 2014, the number of medical outliers on Trauma & Orthopaedics increased from 132 to 232 outliers per month which was an average of seven outliers per day. Medical outliers occupied 13 out of 35 orthopaedic beds at the time of the inspection. It was reported by nursing staff that the medical team visited daily and that on occasion medical patients were admitted directly from A&E. The ward was also supported by a nurse practitioner.
- Discharge delays in some cases were acknowledged but were related by staff to the complexity of patient needs.
- This was supported by the analysis of delayed transfer of care data where 32.9% of discharges April 2013 – November 2014 were delayed due to awaiting nursing or residential home placement or a care package / community equipment in their own home. 24% of delays were due to the time taken to complete needs assessments and 13% related to delayed public funding.

Meeting people's individual needs

- There was a palliative care room on the respiratory ward was in use at the time of the inspection. It was a large room with a sofa and space for family to spend time with their loved one.
- The cardiology unit had increased its bed base from 13 beds to 18 beds and was equipped with four fixed monitors and five portable monitors. There were two glass fronted bays near the nurse station where cardiac monitoring was carried out. Due to the level of care received while having cardiac monitoring, these bays were accepted as meeting the requirements of mixed sex accommodation and it was confirmed by staff that the bays were mixed sex on a weekly basis. No mixed sex breaches had been declared by the Trust in recent external reporting.
- On the day of inspection, both bays had mixed sex accommodation but in each bay there was a female patient who was no longer on cardiac monitoring. The hospital policy stated that this was not acceptable when "the patient no longer needed Level 2 or Level 3 care and was awaiting a bed on an appropriate ward."
- The mixed sex accommodation trust policy was discussed with the ward manager and Matron and immediate action was taken to move the two female patients at the earliest opportunity. An email with the policy attached was sent to all members of the cardiology medical and nursing teams to clarify the requirement to move patients once there was no applicable clinical need to keep them in mixed sex accommodation. We revisited this area as part of our unannounced inspection. We found the policy had been implemented; there were no mixed sex breaches.
- When male and female patients were nursed in the same bay, there were potential issues around dignity as women had to use a designated toilet facility further down the ward while the men used the ensuite in the bay. One female patient informed us that she was too unwell to go to the designated toilet further away and had shared the use of the ensuite in the bay with the men but did not like having to do this. This meant that there were potential difficulties in maintaining privacy and dignity.

Medical care (including older people's care)

- Interpretation facilities for patients were available on demand and patient information available in languages if required.

Learning from complaints and concerns

- The trusts captures and monitors all complaints and concerns via their risk management software. Performance in processing and resolving complaints on a timely basis was reported to the Board monthly.
- Staff reported complaints made about medical services were investigated and responded to by the ward manager.
- Complaints and the associated learning were discussed at the care group clinical governance group meetings. The top five reasons for complaints in the MSK & Frailty Care Group were related to nursing, treatment & diagnosis, staff action & behaviour, communication and patient property.

Are medical care services well-led?

Good

Each care group involved in providing medical services had a documented operational plan for 2015-17 which identified current risks, anticipated pressures to the service and planned actions to mitigate the risks. Consultant vacancies and bed pressures were being experienced across medical services; however there had been a focus on medical workforce planning by care group managers and there had been a good response to most areas of medical recruitment.

Since the organisational reconfiguration to care groups, each care group established a Clinical Governance Group which took oversight of patient safety, clinical effectiveness and patient experience within their area of operation. These reported into the Board sub-committees monitoring clinical and non-clinical risk. The Clinical Governance Group agendas were noted to be structured around the five domains of safe, effective, caring, responsive and well-led. We saw from the minutes there were discussions and actions planned around incidents, patient complaints, risks to patient safety and health and safety concerns.

Junior staff voiced concerns in the leadership and expressed low morale due to the on-going workload pressures experienced on the wards. The impact of the staffing shortages on C1 was evident through documentation in case notes and the incident reporting system. On our unannounced inspection on 29 April 2015, we found that the staffing levels on C1 had been reviewed and four beds had been closed. Staff reported this action had a positive impact and they were able to deliver care to meet patients' needs. Senior staff were more positive in their assessment of leadership within medical services, and the links through to the trust's board.

Vision and strategy for this service

- Each care group involved in providing medical services had a documented operational plan for 2015-17 which identified current risks, anticipated pressures to the service and planned actions to mitigate the risks. Consultant vacancies and bed pressures were being experienced across medical services; however there had been a focus on medical workforce planning by care group managers and there had been a good response to the most areas of medical recruitment.
- Ward Managers were aware of the overall strategy for improving services through recruitment of consultants, implementation of seven day services and the planned use of nurse practitioners and advanced nurse practitioners to support medical staff. They were also aware of the recruitment efforts being made by the trust to improve nurse staffing.
- The directors and senior managers of the medical services were clearly passionate about delivering a high quality and safe service to patients and reflected the trust vision of being the best healthcare provider in describing the medical services as the best in the region.

Governance, risk management and quality measurement

- Since the organisational reconfiguration to care groups, each care group established a Clinical Governance Group which took oversight of patient safety, clinical effectiveness and patient experience within their area of operation. These reported into the Board sub-committees monitoring clinical and non-clinical risk. The Clinical Governance Group agendas were noted to be structured around the five domains of safe, effective, caring, responsive and well-led. We saw from the minutes there were discussions and actions planned around incidents, patient complaints, risks to patient safety and health and safety concerns.

Medical care (including older people's care)

- Each specialty had clinical governance leads assigned from the medical staff with members of their groups including nursing allied health professional staff.
- The MSK & Frailty Care Group, Emergency Care Group and Specialties Care Group each had its own risk register which detailed appropriate risks recognised across the group. Senior ward staff were aware of the risk register and how to raise a risk to be included on the register by escalation of issues through their line managers and via the governance structure.
- The trust implemented a Quality Assurance Tool (QAT) in 2014 that reviewed the standards of care provided to patients. The tool brings together patient surveys, staff surveys, matron ward rounds to assess aspects of safety and quality of care. We saw evidence of the outcome of this assessment tool being displayed by wards and spoken about by ward managers with pride, particularly where a good result was achieved.

Leadership of service

- Staff were generally positive about the leadership and the levels of engagement with their line management through to executive level. However junior staff in less well staffed areas voiced less confidence in the leadership and expressed low morale due to the ongoing workload pressures experienced on the wards. The impact of the staffing shortages on C1 was evident through documentation in case notes and the incident reporting system.
- On our unannounced inspection on 29 April 2015 we found that the staffing levels on C1 had been reviewed and four beds had been closed. Staff reported this action had a positive impact and they were able to deliver care to meet patients' needs.
- The ward managers we interviewed felt well supported by their Matrons and Head of Nursing and Quality. There were senior sister meetings held monthly for a full day, one to ones held monthly and team meetings also held monthly to communicate and cascade key messages.

Culture within the service

- The culture of the organisation was one of open communication and this was confirmed by many of the staff we spoke to. For example there had been an issue about medical cover which staff felt able to escalate to the Medical Director and this was addressed.
- Nursing staff were also generally positive about working for the trust and told us they felt comfortable and confident about raising concerns.
- However we were told by several members of staff on less well staffed areas about low morale due to the impact of staffing shortages on work-life balance and the quality of care.

Public and staff engagement

- The trust displayed the NHS Friends and Family Test results on the wards.
- Information from the 2013 national NHS staff survey showed that staff engagement was better than average when compared with trusts of a similar type. However, the data for the division of medicine showed the division was the lowest scoring area of the trust in relation to staff engagement.

Innovation, improvement and sustainability

- The use of IT systems enabled seven surrounding Trusts to have access to diagnostic and pathology results. GPs were also able to access some results through their IT systems.
- There was a project underway to use the ICE system to enable a paperless system for ordering and labelling pathology tests at ward level.
- The Trust had implemented the ward based Quality Assurance Tool (QAT) which included patient surveys, staff surveys and various assessments of quality and safety.

Surgery

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

Information about the service

The surgery services at Bassetlaw District General Hospital were managed by three care groups: Musculoskeletal and Frailty, Speciality Services and Surgery. The care groups managed a surgical ward, and a trauma and orthopaedic ward, along with surgical departments and a suite of operating theatres. In addition there was a day surgery service. There was also an endoscopy suite.

Emergency surgery, excluding patients returning to theatre, was not undertaken at BDGH.

During our inspection we visited the surgical wards and the operating theatres, including the day surgery unit. We spoke with 16 members of staff, 10 patients, and reviewed two sets of patient records.

Summary of findings

We found that surgical services were safe. However, staff in the main operating theatres told us there were no pre-planned maintenance and deep cleaning schedules. We also found that the theatres' sterile supply room had not been adequately cleaned.

We found that surgical services were effective although we had concerns about the level of mandatory training, with the service not meeting the trust target that 85% of all staff should have received mandatory training.

We found that the service was caring, responsive and well-led. Patient access and flow compliance with the 'referral to treatment' (RTT) targets were affected by the numbers of medical patients admitted to surgical wards.

Surgery

Are surgery services safe?

Good

Overall we found that surgical services were safe. We found that systems were in place to ensure that incidents were reported and effectively investigated, and that staff were able to learn the lessons in order to improve practice. However, there was some concern from staff in the main operating theatre that they did not always get feedback concerning all incidents.

We found that the NHS safety thermometer was used in the trust as a measurement tool, with its use audited to improve compliance. The wards and theatres, including the day surgery unit, were visibly clean and well maintained, with staff observing infection control and hand washing procedures. However, there were no pre-planned maintenance and deep cleaning schedules for the main operating theatres. The theatres' sterile supply room had not been adequately cleaned.

We found medicines and records were appropriately managed. Safeguarding systems were in place and the service responded appropriately to clinical risk in patients, although not all staff had received safeguarding or mandatory training. It was not clear if this was a recording issue; however the trust could not be assured that staff had received appropriate training.

There were some shortages of nursing and surgical staff; the trust were aware of this and were actively recruiting to fill their vacancies.

There were systems in place to ensure the surgical service responded to a major incident.

Incidents

- No never events were reported by the trust for this location.
- Between September 2014 and December 2014 there were no serious incidents at Bassetlaw District General Hospital.
- The service used a risk register to record risks. We reviewed the risk register for surgical services based at Bassetlaw which contained four risks. The list included a description of the risk and the actions that had been taken to mitigate the risk.
- Staff explained to us that incidents were reported on the trust's electronic incident reporting system. They were then reported up through the surgical care group and discussed at governance meetings.
- We reviewed the minutes of care group governance minutes that discussed mortality and morbidity, safety incidents and the actions required. These meetings occurred at specialty level within the care groups as well as at the care group level itself. Both senior managers and clinicians attended these meetings.
- We saw evidence of feedback to ward and operating theatre level; although staff in the main operating theatres told us they did not get feedback on all incidents.

Duty of Candour

- Duty of candour prompts and recording was incorporated into the electronic incident reporting system. Information about the duty of candour was also displayed on screen-savers at the hospital

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The surgical wards recorded the Safety Thermometer information electronically monthly and fed into Trust-wide reporting to the Board.
- On the wards we visited we saw evidence of the measurement of the four high volume safety problems: pressure ulcers, falls in care, urinary infection (in patients with a urinary catheter), and treatment for new venous thromboembolism (VTE).
- Audits of compliance with the 'safety thermometer' had also been undertaken, and were displayed on notice boards.

Cleanliness, infection control and hygiene

- Within surgical services, across the whole trust, there had been eleven cases of Clostridium Difficile, and zero cases of MRSA (Methicillin-resistant Staphylococcus Aureus) infection during the period January 2014 to December 2014.
- Personal protective equipment (PPE) was available for staff in the two surgical wards, and in the operating theatres, and infection control procedures were in place.

- However, 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.
- In the day surgery unit theatres, we found that the unit was clean with hand washing sinks and PPE readily available. There were also disposable curtains in use.
- On the two surgical wards, hand gel dispensers were readily available. However, on the general surgical ward they had been removed from the corridor as people had been taking them. They were available elsewhere in the ward and were being replaced by gel which did not contain of alcohol.
- Standard operating procedures were in place for hand washing, as they were for the deep cleaning of the theatres and day unit.
- We found that infection control audits were regularly undertaken and the results displayed on the walls for both patients and staff to view.
- The operational plan for musculoskeletal and frailty services reported in the care group's action plans for 2015-2017 that they had invited an external reviewer to undertake an audit of infection control practice in orthopaedics. This followed an initial meeting held in December 2014 where a business case for the provision of new cordless drills and other equipment had been discussed. The intention was to reduce infection rates, and thereby reduce readmission rates and improve discharge planning.

Environment and equipment

- Staff in the main operating theatres told us there were no pre-planned maintenance and deep cleaning schedules. It is necessary to have regular maintenance and deep cleaning so that the environment is safe and clean.
- We found the day surgery unit ward and theatres to be a purpose built unit that was uncluttered.
- There was single sex accommodation, which included single sex washing facilities and toilets. There were also en-suite washing and toilet facilities in two side rooms.
- We found that the general surgical ward, and the trauma and orthopaedic wards shared equipment. Nursing staff told us that this did not create any problems.
- The matron on the general surgery ward told us they had recently started using patient-led assessments of the care environment (PLACE). These assessments involved local people assessing how the environment supported patient's privacy, dignity, food, cleanliness and general building maintenance.
- Resuscitation trolleys we viewed were checked and fully stocked. In the areas we visited we found that medical devices that were being used were in good working order and had been regularly maintained. We also found that staff were trained an competent in their use.
- We also found that electrical systems had been "portable appliance tested" (PAT).

Medicines

- We found that medicines, including controlled drugs, were appropriately stored in secure environments.
- There were temperature gauges on the drugs' fridges and the temperature was regularly checked and recorded.
- We found that fluids used for infusions were appropriately stored and kept within date.
- There were non-medical prescribers on the wards at Bassetlaw District General Hospital. These staff were advanced nurse practitioners, some of whom rotated from the Doncaster site.

Records

- We found that there was a mixture of paper and electronic records.
- On the wards we reviewed patient records. We found these to have been appropriately completed and included the required risk assessments.
- In the operating theatres we found that the World Health Organisation (WHO) operating theatre safety checklists were completed. These were regularly checked to ensure they had been completed correctly.

Safeguarding

- We spoke with staff who told us what actions they would take in the event of witnessing an incident they believed required reporting under the trust's safeguarding procedures.
- They also told us they had received training in safeguarding adults and children and children, and were aware of the trust's safeguarding policy and procedures.
- We found that not all staff had completed safeguarding training. Trust data showed that 10% of qualified

nursing staff in the operating theatres had undergone safeguarding children training against a compliance target of 85%. For safeguarding adults 13% of qualified nursing staff had undergone the training.

- No areas had achieved the trust target: the highest recorded percentage of staff was in the endoscopy unit where 71% of nursing staff had completed safeguarding training.
- These figures did not give the level of the training which could have been either at levels 1, 2 and 3

Mandatory training

- We reviewed the trust records for mandatory training which showed the majority of staff groups had not met the 85% target for the percentage of staff who had undertaken mandatory training. For example, figures showed 25% of nursing staff in the theatres had received adult resuscitation training and 63% fire safety training. However only 4% were recorded as having received infection control training.
- The figures were unclear with some staff groups being counted more than once.
- However, staff we spoke with told us they received mandatory training on a regular basis with at least one day a year dedicated to the provision of training to staff. Staff in the day surgery unit told us that their mandatory training levels were at 100%. This was not reflected in the trust figures; the trust could not be assured that staff had received appropriate training.

Assessing and responding to patient risk

- We found that appropriate assessments were undertaken prior to admission, and on the day of admission.
- We found that on the general surgical ward there was a theatre assessment unit where patients were assessed and prepared for surgery by an advanced surgical nurse practitioner.
- We found that National Early Warning (NEWs) charts were used for recording patients' clinical condition and responding to risk. NEWs scoring charts are a recognised system for assessing and managing patients' conditions, and responding to risk.
- We discussed with nursing staff the systems the service had for the management of the deteriorating patient. They explained that this included a system of warning scores which identified when a doctor should be contacted, and when half hourly observation should be initiated. There were also indicators for when the critical care outreach team should be contacted.

Nursing staffing

- The trust board in April 2015 discussed the staffing needs assessments and establishment levels across the organisation as part of the programme to meet the hard truths staffing levels.
- This data outlines the assessments of staffing need using recognised tools, and the number of hours available from the staff employed. For the surgical care group there were 30,409 planned hours of nursing time required against 29,161 that were available.
- For the musculoskeletal and frailty care group there were 41,108 planned hours of nursing time available against 43,837 that were available, and for the speciality services care group there were 27,437 planned hours of nursing time available against 27,309 that were available.
- We saw evidence that recruitment was taking place.
- On the surgical ward we found that nursing staff had recently moved to a 12 hour shift system.

There were four qualified nurses and three health care assistants on the day shift for 31 beds; whilst there were three qualified nurses and three health care assistants on the night shift. This gave a staffing ratio in accordance with national guidance. In addition there was a qualified nurse who worked between 7pm and 3pm in the adjacent theatre assessment unit.

- With regard to vacancies, two recently appointed full-time equivalent qualified nurses were due to start work. This meant there was one full-time equivalent nursing vacancy. This situation is alleviated in that five beds on the ward are closed at weekends.
- On the trauma and orthopaedic ward, staffing ratios the staffing ratios during the day were due to increase by one registered nurse during the day shift from May 2015 following a 'safer staffing' review. There was also the addition of a supernumerary sister/charge nurse working 3pm to 11pm. Staffing levels were in accordance with national guidance on minimum staffing levels.
- At the time of the inspection, there were four whole time equivalent vacancies for nursing staff on the ward; interviews were due to be held at the end of April.

Surgery

- Staff in the day surgery unit told us that all vacancies had been filled and there were enough staff to allow them to do their job safely. There had been minimal turnover of staff and they had not used bank or agency staff for six months.
- In their operational report for 2015 – 2017 the musculoskeletal and frailty care group reported that they were finding it difficult to recruit qualified nursing staff, including experienced orthopaedic scrub nurses.
- In the operating theatres we found that staffing levels for nursing staff and operating department practitioners (ODP's) were based on the Association of Peri-operative Practice (AfPP).
- We discussed staffing levels with staff in the recovery area who told us the staffing was good and to the national standard.
- There were concerns regarding the provision of a fully staffed seven day service in the obstetric theatres. Staff told us that although a full seven day emergency service was provided there was no dedicated recovery staff in the obstetric theatres. They said that this could prove problematical at night when recovery staff were taken from the main operating theatres, which could lead to them being short of recovery staff for emergency surgical cases in the main theatres, as there were only two recovery staff on duty at night. Staff told us this had been reported on the electronic incident reporting system and was on the risk register.
- The operational plan documents for the surgical care groups reported that in line with the trust's "Safer Nursing Care" review they were working towards inpatient ward ratios of one nurse to eight patients. This was based on The National Institute for Health and Care Excellence (NICE) guidance.
- This work was reflected at ward level in discussions with nursing team leaders.

Surgical staffing

- We found that the trust had vacancies for surgical staff, although they were aware of this and were actively recruiting to these posts.
- Senior managers and senior consultant surgeons had identified they were not sufficiently staffed at the middle grade level. This included trainee specialist registrars, and non-training grades such as associate specialists, and staff grade doctors.
- To mitigate this the trust was in the process of developing advanced nurse practitioners who could undertake some of the duties previously undertaken by junior medical staff.
- They also told us there had been a recent campaign to increase the number of consultant surgeons. This was also shown in the surgical care group's operational plan for 2015 -2017. The report showed ten consultant vacancies, four middle grade vacancies, and ten vacancies for junior doctors.
- The speciality services care group's operational plan for 2015 – 2017 reported that the breast surgery service had submitted a business plan for two whole time equivalent (wte) consultants to manage complex surgery and increasing outpatient demand.

Major incident awareness and training

- Major incident and resilience plans were in place that included the use of staff from the surgical care groups across all three trust sites.
- We found that staff took part in major incident training.

Are surgery services effective?

Good

We found evidence-based care and treatment and local audit activity on the wards and departments. There was a system for the provision of pain relief to patients although it was brought to our attention that there were delays at times in the provision of analgesia to patients on the day surgery unit. There were effective systems for the provision of nutrition and hydration to patients. Patient Reported Outcome Measures and national audit data showed Bassetlaw District General was mostly better or the same as the England average.

With regard to mandatory training the trust records showed that not all surgical staff had received mandatory training and that compliance with the 85% target for achievement of this was poor. However, this did not correspond with the views of staff, with the majority of those we spoke with telling us they were up-to-date with their mandatory training. There were systems in place for yearly appraisal.

Surgery

There was evidence of effective multidisciplinary working. There was also evidence of there being systems in place for consent, and for the measurement of capacity under the terms of the Mental Capacity Act.

Evidence-based care and treatment

- We found widespread evidence of the use of local audits on the wards and departments. These included audits of patient observations, infection control and of the patient safety thermometer.
- We found that wards had monthly half-day audits with ward staff fully involved.
- We reviewed a list of environmental audits which had been undertaken since April 2014 in the hospital's theatres, endoscopy units, and wards. These showed overall compliance scores, with 100 being the highest score. In the wards the results were between 92 and 100, whilst in the theatres they were between 60 and 100. The lower scores being for the recovery unit of the operating theatres. In both areas the majority of the scores were at 100.

Pain relief

- We found there was a procedure for the provision of pain killers, including opiate analgesia, with such drugs prescribed to be used when required.
- On the wards we found staff used the National Early Warning (NEWs) scoring charts to record pain scores. NEWs scoring charts are a recognised system for assessing and managing patients' conditions, and responding to risk.
- We found that on the wards audits had been undertaken into the provision of pain relief to patients.
- Patients we spoke with told us they got pain relief within a reasonable time-frame after requesting it.
- However, staff on the day surgery unit told us that it was sometimes difficult to get a junior doctor to come after 5pm to prescribe pain relief medication.

Nutrition and hydration

- Bedside menus were available in coloured brochures with pictures of food choices. There were also articles about healthy eating. The brochure was easily readable, accessible and informative.
- We found that meal times on the wards were protected, and patients were supported when eating their meals when assistance was required.
- Patient's food and fluid intake was recorded.
- We found that the wards used the malnutrition universal screening (MUST) tool to identify patients who required support with their nutrition and hydration.
- The wards audited the use of the MUST tool, as well as nutrition and hydration generally.

Patient outcomes

- Patient Reported Outcome Measures (PROMS) for surgical services showed the majority of indicators as being better than the England average.
- The National Hip Fracture Database annual report for September 2014, produced by the Royal College of Physicians, compared Bassetlaw District General Hospital performance against the overall performance of other hospitals in England, Wales and Northern Ireland.
- With regard to patients with a hip fracture having surgery on the day of, or the day after admission 76.9% of patients at the hospital met this standard against an overall performance of 71.7%.
- With regard to patients presenting with a fragility hip fracture being offered a formal hip fracture programme 53.3% of patients at the hospital met this standard against an overall performance of 50.5%.
- With regard to best practice standards that aim at surgery within 36 hours, shared care by surgeon and geriatrician, assessment by a geriatrician within 72 hours of admission, multidisciplinary rehabilitation, and a bone health assessment, the service scored 72.5% compliance against the overall score of 60.6%.
- The length of stay of patients at the hospital was 20.9 days against 19.8 days overall nationally.
- There was a lower amount of pressure ulcers within the service than in the overall national findings in that there were no pressure ulcers within the patient population of Bassetlaw District General Hospital audited,
- With regard to deaths within 30 days the hospital recorded 10.2% of patients dying within this time frame compared with 8.4% nationally.
- Overall the findings showed that the service at Bassetlaw District General Hospital was comparable with the national overall findings for England, Wales and Northern Ireland.
- The results of the national lung cancer audit, 2014, which examined the treatment of 288 patients, showed that the percentage of patients who received surgery

was marginally higher at 16% than the England average of 15.4%. However 100% of patients were discussed at a multidisciplinary team meeting as compared with the England average of 95.4%.

- The results of the national bowel cancer audit, 2014 for colorectal cancer management showed that out of 205 patients treated by the service 96.1% were discussed at a multidisciplinary team meeting. This compared with an overall average for England of 99.1%. With regard to patients who underwent surgery this stood at 85.4%, which was worse than the England average of 63.7%.Other results were higher than the England overall average; with 96.9% of patients being seen by a clinical nurse specialist, and 96.6% receiving a CT scan as compared with an overall England average of 89.3%.
- With regard to the national bowel cancer audit results for the 175 patients who had major surgery 80% had the less invasive laparoscopic surgery. This compared with an overall England average of 54.8%. The length of stay over five days was also better than the overall England average being at 57.9% as compared with 69.1%.
- Other national bowel cancer audit reports relating to major surgery were around the overall England average.
- We spoke with the matron on the surgery ward who told us that the monitoring of emergency surgical readmission rates had been positive, and not identified any areas of concern.

Competent staff

- There was a learning environment trainer on the wards who assisted in the training of new staff.
- Staff also told us that they received yearly appraisals. However, clinical supervision was undertaken on an informal basis with peers.
- Staff in the main operating theatres told us that mentorship courses for theatre staff were not easily available. However, we found there was a system of peer to peer staff teaching in the operating theatres.
- We spoke with the matron for the surgery ward who told us that they were in the process of implementing nurse revalidation, which they expected to be in place by the end of 2015. She told me that they were moving to a system, similar to the medical model, where there would be full 360 degree supervision for nurses.
- We found that the trust provided an induction checklist for agency staff that were new to the organisation. In the operating theatres this included descriptions of the layout of the department and where they could find the emergency equipment. This checklist was signed by the staff member, who also had to record how long the induction had taken.

Multidisciplinary working

- The results of the national bowel cancer audit, 2014 for colorectal cancer management showed that out of 205 patients treated by the service 96.1% were discussed at a multidisciplinary team meeting. This compared with an overall average for England of 99.1%.
- The results of the national lung cancer audit, 2014 showed that out of 288 patients treated by the service 100% were discussed at a multidisciplinary team meeting. This compared with an overall average for England of 95.4%.
- We found that there was a joined-up multidisciplinary team approach to the holistic management of patients with a fractured neck of femur. This included liaison with orthogeriatricians (specialists in the care of elderly patients with orthopaedic conditions), physiotherapists and occupational therapists.

Seven-day services

- Elective surgery took place six days a week, and there was a seven day service for patients who needed to return to theatres. However, emergency surgery was centralised at the Doncaster Royal Infirmary location.
- Five beds on the general surgery ward were closed at weekends.
- There were surgical ward rounds seven days a week.
- There was seven day access to radiology services.

Access to information

- We found that information was readily available for patients on the wards we visited. This included information on specialist surgical procedures on the specialist surgical wards, as well as chart and graphs that gave details of compliance with infection control and hand washing procedures. Results from the "Friends and Family" test and the "Safety thermometer" were also available to view.
- Laminated information posters were placed on patients' bedsides giving basic information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Surgery

- We found that a system for the obtaining of consent from patients, was in place at the trust. The forms we reviewed included all relevant information.
- We spoke with nursing staff who were knowledgeable about the procedures for obtaining consent. This included for patients who had impaired capacity.
- On the surgical ward we found that patients were assessed for capacity by nursing staff in the adjacent theatre assessment unit prior to surgery.
- They also told us when it was appropriate to use the provisions of the Mental Capacity Act, and the associated Deprivation of Liberty Safeguards. Staff in the day surgery unit told us that if they were concerned about capacity and a patient had signed the consent form, they would not sign to confirm that consent. They gave an example where they had taken this action, before discussing the matter with the family and the patient's consultant.
- There was also evidence of the use of Independent Mental Capacity Advocates (IMCAs), who are independent professionals who represent the interests of people who are felt not to have capacity

Are surgery services caring?

Good

Overall we found that the surgery services were caring and that patients received compassionate care. Our observations of the provision of care, and our discussions with patients, showed that patients were involved in the care provided to them. We also observed emotional support being given to patients who also told us they had received such support whilst at the hospital.

Compassionate care

- The "Friends and Family" test results for March 2015 showed that on the surgical ward 65% of patients completed the survey, with 100% saying they would recommend the ward.
- On the trauma and orthopaedic ward 54% of patients took the survey with 93% of them saying they would recommend the ward.
- We found that the "Friends and Family Test" results were displayed on the wards we visited.
- Staff in the day surgery unit told us that the they had come third out of 51 areas in the trust, for the "Friends and Family" test.
- During our observations of staff interactions with patients we found them to be compassionate, caring and respectful. This included patients' curtains being used to protect their privacy and dignity.
- We also observed nurses responding to call buzzer activations by patients in a timely manner.

Understanding and involvement of patients and those close to them

- On the wards we visited we found information was available for patients and their relatives. This included information on surgical procedures and surgical conditions; as well as information about how the wards and the trust were performing with regard to the control of infection, and the "Friends and Family" test.
- We observed a doctor discharging a patient from the surgical assessment ward. They clearly explained to the patient the system for follow-up appointments, treatments and investigations.
- There were also laminated leaflets which were placed on patients' bedsides. These included information on nutrition, cleanliness, pain management, and how to make a complaint.
- The patients we spoke with told us they had received sufficient information prior to, as well as after surgery. They also told us that communication from staff was good
- However, one patient we spoke with was concerned that his consultant had not taken his views properly into consideration.

Emotional support

- We observed nursing staff providing emotional support to patients.
- Patients, and their relatives, we spoke with felt they were offered emotional support by staff.
- One patient told us that staff; "Went the extra mile," whilst another patient told us that when they were on the ward staff were "fantastic" and "brilliant."

Surgery

Are surgery services responsive?

Good

We found evidence of service planning and delivery to meet the needs of local people.

In February 2015, the percentage of patients waiting to start treatment (incomplete pathway) within 18 weeks from point of referral to treatment was better than the national target. The number of patients who had to wait longer than 18 weeks from referral to treatment (admitted) breached the operational standard.

The proportion of patients whose operation was cancelled for non-clinical reasons was as expected for the trust and better than expected for treatment within 28 days of last minute cancellation. Emergency admissions led to operations being cancelled because of a lack of beds. The trust had worked collaboratively to manage this risk.

We found that the trust had systems in place that assisted in meeting the needs of people who used the service; including people with a learning disability, and those who could not communicate in spoken English. There was a system in place for the investigation, management and resolution of complaints. We found evidence of learning from complaints.

Service planning and delivery to meet the needs of local people

- The proportion of patients whose operation was cancelled for non-clinical reasons between October to December 2014 was as expected for the trust. On the general surgical ward nursing staff told us that fewer patients were now being cancelled prior to surgery than was previously the case.
- The number of patients not treated within 28 days of last minute cancellation due to non-clinical reason between October to December 2014 was better than expected.
- Emergency surgery, excluding patients returning to theatre, was not undertaken at BDGH.
- Senior managers we spoke with told us there were plans in place for the construction of a new education centre, which was intended to improve the training of nursing and other clinical staff, especially in advanced roles. Although based at Doncaster this would involve staff from all sites.

Access and flow

- At the time of the inspection, the most up-to-date available results for referral to treatment waiting times were for February 2015.The information was trust-wide data.
- For patients waiting to start treatment, the maximum time of 18 weeks from point of referral to treatment (incomplete pathway) was 93.7% against a target of 92%. The best results for patients "waiting to start treatment" were in oral surgery where 97.3% of patients, against a national target of 92%, waited no longer than 18 weeks. The lowest results were in trauma and orthopaedics where 89.9% of patients waited no longer than 18 weeks.
- In February 2015, the trust had achieved 86.9% against a target of 90% for the maximum time of 18 weeks from point of referral to treatment for patients who were admitted. The best results for patients who had completed their pathway and had started "admitted treatment" were in ophthalmology where 93.4% of patients waited no longer than 18 weeks. The lowest results were in urology where 82.8% of patients waited no longer than 18 weeks. The speciality services care group's operational plan for 2015 – 2017, identified increases in referrals across their services of between 3% and 13%. This was a trend expected to continue into 2015/16. This had an effect on their ability to meet their referral to treatment waiting times. Speciality services included the surgical specialities of breast, urology and vascular. Reviews of pathways were taking place in order to improve performance.
- With regard to cancer waiting times there is a national operational standard that 93% of patients should have no longer than a two week wait from GP urgent referral to first consultant appointment. Across the trust 95.2% of patients were seen within two weeks in quarter three of 2014/15. In quarter two this was 93.5%.
- There is also a national operational standard that 96% of patients should have no longer than a one month wait from a decision to treat to a first treatment for cancer. Across the trust this standard was met for 98.6% of patients in quarter three of 2014/15. In quarter two this was 97.9%.

- The operational standard also states that no patient should have no longer than a two month wait from GP urgent referral to a first treatment for cancer. Across the trust this standard was met for 87.1% of patients in quarter three of 2014/15. In quarter two this was 89.3%.
- Results which fell below the standard were ascribed by trust to the pressure of emergency admissions, which led to operations being cancelled because of a lack of beds.
- We visited the B6 general surgery ward which took elective surgical patients, as well as emergency surgical admissions from the accident and emergency department (A&E) and direct from GP's (GP admissions). We spoke with senior staff on the ward who told us that their service to emergency surgical patients was constrained by the admission of medical patients. Over a recent Bank Holiday there were 16 medical patients out of a total of 31 beds on the ward.
- Staff stated junior staff from the medical teams (physicians), such as senior house officers, were often on the ward seeing their patients it was less easy to get assistance from middle grade doctors, such as specialist registrars and SAS (staff and associate specialist) doctors. It was only these middle grade doctors, and consultants who had the authority to discharge patients. Therefore situations occurred when although patients might be ready for discharge they had to wait for a medical doctor to discharge them. Consultant physicians did ward rounds, but this was often quite late in the day, and therefore prevented the admission of elective surgical patients for the next day's operating lists.
- There was a similar situation on the orthopaedic and trauma ward which took both elective and emergency cases. Although on this ward, a bay had been recently created for the exclusive use of elective orthopaedic patients. These "ring-fenced" beds had been created following meeting between orthopaedic and medical consultants and managers who had jointly agreed on these changes.
- The surgical care group's operational plan for 2015 – 2017, stated that the care group was on the right trajectory to improve their referral to treatment waiting time position, and that this had been agreed with the clinical commissioning group. The clinical commissioning group are their service commissioners.
- The musculoskeletal care group's operational plan for 2015 – 2017, described an action plan to increase theatre productivity in order to improve patient access and referral to treatment times. As part of this work a full review of orthopaedic theatre usage took place in January 2015 which identified spare capacity at Bassetlaw District General Hospital and Montagu Hospital. This work was continuing at the time of the inspection.
- It was also stated that there had been a 25% increase in referrals to Bassetlaw District General Hospital.

Meeting people's individual needs

- We found that if a patient had a learning disability special arrangements were put in place. These involved putting the patients first on the operating list, and allowing a family member or carer to stay with them in the anaesthetic room.
- Staff were aware that patients with a learning disability could arrive for surgery with a "This is me" booklet which would describe their needs, and their likes and dislikes. This booklet would be used to help staff care for the patient.
- We found that nursing staff we spoke with had knowledge of caring for patients living with dementia and had undergone dementia training.
- In the trauma and orthopaedic ward we were told that they were in the process of turning one of the bays into a dementia friendly bay.
- We found that the trust had a system in place where staff were able to book on-line translation services for patients who could not speak English. Systems were also in place to allow for the booking of sign language interpreters for patients who were profoundly deaf and used sign language.
- Staff we spoke with were aware of the systems in place for obtaining translation and interpretation support.

Learning from complaints and concerns

- Staff we spoke with were aware of the complaints' procedures and who they should report patient complaints to so they could be appropriately investigated.
- Information about how to report a concern was included on laminated bedside information leaflets provided to all patients. However, we did not observe complaints' leaflets on display, and the laminated leaflet referred to concerns rather than complaints.

- We found that learning from complaints were shared at team meetings where these were held. However, as not all wards held minuted team meetings they were also shared through communications bulletins, and on notice boards.
- We found examples of learning from complaints. For example, in response to complaints the day surgery unit had brought in staggered admission times for patients.
- At a care group meeting held in February 2015 there was a discussion of complaints related to what patients saw as a poor attitude from some doctors and nurses. Following this meeting there was an "action notes" log which stated that these complaints would be broken down to the level of the person involved and discussed with them at their appraisals.
- At a surgical specialty group meeting, also in February 2015, there was discussion of a particular case where a junior surgical doctor had given important information about their condition to a patient when the family had not been present, which had caused distress to the family. The minutes said that the doctor had apologised and learning from this incident had been communicated to other staff.
- There were further discussions of complaints issues at care group meetings held in January and March 2015.

Are surgery services well-led?

Good

The surgical care groups were well-led with a vision and strategy for the service. There were systems of governance, risk management and quality measurement in place.

There was a new system of care groups as a framework for the management of surgical service. Although these were well connected across clinical leaders, including medical and nursing, who linked in well with senior managers this was not fully replicated for all staff in the operating theatres.

Communication with staff took the format of ward meetings. However, staff in the main operating theatre told us that the senior management had not fed back to them on issues of concern they had raised. These included night recovery staffing for the obstetric theatres. There was also evidence of engagement with the public in the use of patient-led assessments of the care environment (PLACE) teams.

Vision and strategy for this service

- We found that the trust's vision, and the local visions for the wards and departments we visited, were displayed on notice boards.
- Staff we spoke with in the wards and theatres were aware of the trust's vision and felt they reflected their work caring and treating patients.

Governance, risk management and quality measurement

- We found that governance, risk management and quality measurement took place at the care group level, as well as at the level of surgical specialities.
- We reviewed clinical governance minutes from both the care group and surgical speciality levels. These meetings were attended by senior clinicians and senior managers.
- Although the discussions at these meetings were shared with the individual ward and department levels, this was not done in a consistent manner. Whilst in some wards and departments minuted meetings others relied on reports at handover, or bulletin boards in staff areas.
- We found that quality dashboards and ward audits were displayed on notice boards.

Leadership of service

- There are three care groups that manage the surgical specialties. These are Musculoskeletal (MSK) and Frailty; Speciality Services; and Surgical. Each of them were led by a triumvirate consisting of a care group director, who is a consultant surgeon; a head of nursing and quality; and a general manager. They were assisted by assistant care group directors, a clinical governance lead, matrons, business managers, and a human resources (HR) business partner. The care group directors were part of the trust management board that reported up to the trust executive board.

Culture within the service

- We found that there was an open culture with staff able to bring their concerns to the attention of their managers.

- However, not all staff felt that the executive leaders of the service were sufficiently visible.

Public and staff engagement

- On the two surgical wards we found that monthly meetings were held with nursing staff on the ward.
- In the day surgery unit there were monthly all-day meetings, with set agenda items. Minutes of these meetings were cascaded to staff. There was also a communication book,
- However, staff in the main operating theatre told us that the senior management had not fed back to them on issues of concern they had raised. These included night recovery staffing for the obstetric theatres.
- On the general surgical ward we found that nursing staff had voted to move to 12 hour shifts. A system which had only recently been implemented. They told us that they found the new system less stressful. This showed staff involvement in the manner in which they were rostered. Nurses on the trauma and orthopaedic ward had voted to keep the shorter three shift system. This showed evidence of the views of staff being taken into account, and acted on.
- Information on performance and audit was displayed on bulletin boards in the wards.
- The trust had recently started using patient-led assessments of the care environment (PLACE). These assessments involve local people assessing how the environment supports patient's privacy, dignity, food, cleanliness and general building maintenance.

Innovation, improvement and sustainability

- Staff on the general surgical ward told us they were part of a project developing electronic tablets to record patient records, and staff interactions with patients. They informed us that these electronic tablets would automatically record patient observations.
- In November 2014 following a review of vascular services by NHS England it was found that the service did not have the recommended minimum population to provide the service. In order to increase the population covered the trust started providing out-of-hours services to patients in Lincoln. They were also working to develop further collaboration to increase the population covered and the workload.

Critical care

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

Information about the service

The critical care unit at Bassetlaw District General Hospital comprised 7 beds, a 5 bedded bay and 2 single rooms. Bed occupancy was lower than the England average for adults at around 70%.

Summary of findings

Overall critical care services at Bassetlaw District General Hospital were judged as good.

Within safety concerns were identified with regard to the lack of pharmacy staff cover, there were no specifically trained intensivists working within the unit, and there was a lack of dedicated medical out of hours cover provided on the unit. We also identified concerns regarding a lack of delirium and sedation scoring and recording in patient records. However we did not identify any specific concerns regarding the levels of nursing staff on the unit, but some staff did comment that they were often moved to the critical care unit at Doncaster Royal Infirmary.

There were however many positive aspects to the unit, caring was good, patients stated they were well cared for and surveys supported this. Care was effectively delivered by the multidisciplinary team utilising best practice. The service was well led locally, though as a relatively new care group unit further focus was required on the development of the unit and its future use and links to the unit at Doncaster Royal Infirmary.

Critical care

Are critical care services safe?

Requires improvement

Overall we judged safety as requires improvement. The main areas of concern were with regard to a lack of pharmacy staff cover, no specifically trained intensivists working within the unit, and a lack of dedicated medical out of hours cover provided on the unit. We also identified concerns regarding a lack of delirium and sedation scoring and recording in patient records.

There were suitable and sufficient numbers of nursing staff and staff were able to access training. Performance data for the unit was acceptable with most within acceptable limits or demonstrating an improving trajectory.

Incidents

- There were no reported never events or serious incidents for critical care between February 2014 and January 2015.
- We requested incident data for the previous 12 months. During these dates there were a total of 39 incidents, 26 affecting patients. There were 13 classed as 'no harm', 12 'low harm', and one as 'severe harm'. 50% of reported incidents were pressure sores, the majority were classed as no harm or low harm.
- Nursing staff we spoke with were aware of the process for reporting incidents and this was done via an electronic report system known as Datix.
- Opportunity was taken to learn from incidents staff we spoke with described how learning from incidents, particularly from serious incidents, was disseminated to staff; this was often via team meetings and / or handover.
- The medical staff we spoke with confirmed that all cases of mortality and morbidity were reviewed; these took place at all monthly team meetings. We reviewed the minutes of a number of the mortality and morbidity reviews which provided detail of the reviews that had taken place.
- There was awareness within the multidisciplinary team (MDT) to be open with patients about incidents and the suggested practice of involving patients in RCA.

Duty of Candour

- In relation to Duty of Candour and the principles of being open and transparent with people who use services, we noted from the minutes of an anaesthetic clinical governance meeting that this had been discussed. It was made clear that patient harm of a moderate or severe nature would give rise to a duty of candour, and would be a notifiable safety incident and that patients should be informed of the incident.

Safety thermometer

- The NHS Safety Thermometer was a local improvement tool for measuring, monitoring, and analysing patient harms and 'harm free' care. The NHS Safety Thermometer recorded the presence or absence of four harms: pressure ulcers, falls, urinary tract infections (UTIs) in patients with a catheter and new venous thromboembolisms (VTEs).
- The clinical nurse lead stated that safety data was fed in to the Safety Thermometer process and results were discussed at the monthly anaesthetic clinical governance group. We reviewed three sets of minutes for the group including April, May and July 2014 where Safety Thermometer data had been discussed. There were no concerns raised in relation to safety thermometer data.
- We did observe that no Safety Thermometer data was publically displayed. We raised this with staff and this was rectified before the end of the inspection.

Environment and equipment

- The unit and its environment was clean and tidy. Appropriate cleaning took place across the unit, and the store rooms and all other clinical areas were clean.
- There was sufficient storage space and intravenous fluids were stored appropriately.
- Stock was appropriately labelled including identifying stock soon to be out of date, which could be replaced easily.
- No concerns were raised with us regarding availability of equipment. There were assessment processes in place to ensure staff were competent to use the equipment.
- Additional equipment was purchased when required, for example a hoist had recently been purchased for use with bariatric patients.
- However the trusts own gap analysis identified that the unit was not compliant with Health Building Note HBN 04-02 as it did not have enough floor space for clinical areas, clinical support or storage.

Critical care

Cleanliness, infection control and hygiene

- Some infection control data formed part of the quality indicator and outcome data presented within the ICNARC (Intensive Care National Audit and Research Centre) report. The report was for the period April – September 2014.
- Trends in unit acquired infections, for MRSA and Clostridium difficile (C. difficile), for 2014 were within expected limits.
- The units own infection control audit data indicated that compliance with infection control audits were 100% from December 2014 through to April 2015.

Medicines

- The service had identified that there was only an irregular pharmacy service on the unit, and that the National Core Standards for Intensive Care Units (2013) which sets out recommendations for pharmacy cover in relation to the number of Level 3 beds was not being met.
- There were two drug fridges and both had their temperatures effectively monitored. We observed temperature recordings and they were within acceptable ranges.
- Controlled drugs were stored in a locked cupboard. Audits were carried out periodically and compliance was achieved.
- Pharmacy assistants attended the unit twice weekly to stock up medication and check expiry dates. We observed some medication and all were within expiry dates.
- We also reviewed drug charts and found they were accurately and clearly completed.

Records

- We reviewed a number of care records and observation charts. We also reviewed supporting documentation including risk assessments and daily records. The nursing documentation we reviewed was clear to follow and accurately completed.
- Other key information was also present including assessments of fluid state, review of in-dwelling lines, pressure area assessments and nutritional status.
- There was a department of critical care nursing care pathway that contained 12 sections including safety, communication, clinical assessments and care evaluation. Sun headings within the pathway included, but were not limited to, respiratory, nutrition, mobility and psychological/social.
- We reviewed medical records, information was easy to locate and logically set out. However we did not see any records that recording delirium or sedation scores for patients.
- There was a specific 'department of critical care handbook' which was 121 pages and split in to 17 sections. There was information within the handbook that provided guidance on the main documents used and supporting information to promote accurate completion.

Safeguarding

- Expectations for training included basic awareness training (level 1), this was appropriate for staff who did not have regular, day-to-day contact with patients or members and learning was achieved through induction, awareness leaflet and e-learning programme.
- Awareness training (level 2) was appropriate for all clinical staff and those who regularly worked within in-patient care areas / departments; training was achieved by using a safeguarding adult's workbook and by a two hour training session or a three hour session where level 2 safeguarding children was also covered.
- Level 3 safeguarding training was targeted at managers and was appropriate for those staff who undertook a managerial, supervisory or leadership role. The training enabled managers to take on the lead role of safeguarding manager within individual safeguarding cases.
- Staff were reported to have received safeguarding education at corporate induction and via mandatory training sessions throughout the year. However data provided indicated that for administrative and clerical staff in the critical care unit 0% of staff had received training at the time of the inspection against a target of 85%. For nursing staff the data demonstrated that 43% of staff had received with adults or children's safeguarding training at the time of the inspection.
- However the trusts 2014 safeguarding report indicated the lack of confidence staff had in the trusts reporting systems. In 2014 the trust reported that 94% of staff had accessed children's safeguarding and 66% adults safeguarding in quarter four (2013-2014).

- Staff we spoke with knew how to access the safeguarding team and raise any concerns they had in relation to the safety and welfare of people on the unit including patients, visitors and staff.

Mandatory training

- The unit had a designated clinical nurse educator and mandatory training, for critical care staff, was run by critical care; this ensured the training was specific to critical care.
- The clinical nurse educator held a training database which monitored training compliance with the mandatory subjects such as safeguarding, equality and diversity, infection prevention and control and fire and security.
- Data received during the inspection indicated a wide variation in the numbers of staff who had completed training. For fire safety 87% of nursing and midwifery staff had received training against a target of 85%. However, only 63% had received health and safety training, 60% moving and handling training and 3% infection prevention training.

Assessing and responding to patient risk

- Wards and departments across the trust used an early warning score (EWS) process to monitor patients and support staff in recognising the deteriorating patient and flag any concerns. The critical care nurse consultant stated that ward staff, raised appropriate concerns about deteriorating patients by either liaising with medical staff and/or the critical care outreach team.
- The outreach team provided support to the critical care unit. Two members of staff were based at Bassetlaw and there were cross-site working arrangements in place. The nurse consultant who led the outreach team worked across both sites.
- The outreach team also provided support to staff in developing skills and confidence in managing complex patients.

Nursing staffing

- The staff we spoke with did not raise any specific concerns regarding the levels of staff.
- At the time of the inspection there were 30 registered nursing staff employed on the unit with three new nurses who had recently started. Staffing levels were such that the appropriate levels of care could be provided to patients irrespective of their level of care needs on the critical care unit.
- Sickness levels amongst staff on the unit were between 4 – 4.5%, this was in line with the trusts average.
- In terms of agency and bank nurse use, usage was low for both. Permanent staff were able to manage any staffing short-falls between them.
- On occasion, staff would be asked to support the critical care unit at Doncaster Royal Infirmary. Some staff did raise this as a frustration, and the day we were inspecting a member of the night staff had to cover at Doncaster Royal Infirmary.
- If agency nurses were required, all agency staff were required to undergo a short induction to the unit before commencing a shift.

Medical staffing

- Medical staff that we spoke with indicated that there were 8 consultants and all were part of the rota. The consultants worked an 8 week cycle, 6 weeks in anaesthetics and two weeks in intensive care.
- None of the consultants were intensivists or had undergone specialist intensive care training through the Faculty of Intensive Care Medicine (FICM).
- Out-of-hours cover was covered by a resident middle grade doctor though they were responsible for the whole hospital. Consultant anaesthetic staff were on call, and would attend the hospital if required.
- The rota in place was not dedicated to the critical care unit out of hours, and the covering medical staff also had to cover obstetric services.

Major incident awareness and training

- Clear and accessible information was provided about major incident and business continuity plans within the department of critical care handbook.
- The handbook described how the unit had a number of emergency action plans designed to ensure a smooth and effective response to major events. Staff were expected to thoroughly familiarise themselves with the emergency plans.
- The department had clear guidelines and action cards for a MAJAX (major incident) and a copy of the policy was available in the Post Room in the anaesthetic department and also on the critical care unit.

Critical care

Are critical care services effective?

Good

Critical care services were judged as good. Staff had access to appropriate evidenced based policies, and access to specialist training as required. Pain relief was appropriately stored and administered. However the unit did not have access to enough dietetic support, the amount on offer did not meet national guidelines.

Patient outcomes were in line with national averages, with some exceptions, and multi-disciplinary team working was good, though could further improve with the involvement of other key staff groups during ward rounds. Patients were positive regarding the availability of information, and staff were clear with regard to consent including for those who lacked capacity. Seven day working, whilst available from most services remained via on-call processes for other professional groups.

Evidence-based care and treatment

- The department of critical care handbook provided accessible evidence based guidance to all staff and covered many aspects of care and treatment including, but not limited to, care standards, prescribing, pain management, biochemistry and guidelines for specific conditions.
- We reviewed several aspects of care being delivered from both a nursing and medical perspective. Many aspects of nursing care provided were based on the use of care bundles, for example, ventilator care bundle and skin care bundle. Such bundles were evidence-based and aligned to best-practice guidance.
- Policies we reviewed were based on best practice guidelines and were up-to-date and easily accessible via the intranet.
- There was a designated critical care clinical nurse educator and a key aspect of their role was to support staff in developing critical care competencies based on the latest evidence base.
- Staff on the unit actively participated in clinical audits, particularly nurses who were studying for their critical care qualification.
- The audit forward plan we were provided for 2015/2016 included three other audits, these were audit of the handover procedure, case-note audit and venous thromboembolism (VTE) audit.
- Local audits had been completed to check on clinical care including catheter insertion, maintenance and catheter line management. The compliance rates were over 90% and the majority at 100%.
- High impact intervention (HII) audits also completed, such audits are aimed at ensuring high quality care and they provided a way of measuring procedures/practice against key policies.
- The HII audits regularly completed included central venous catheters (CVC), peripheral venous catheter (PVC) and urinary catheter and showed 100% compliance for September, October, November and December 2014.

Pain relief

- There was a hospital-wide pain team and the team provided support and advice to staff across all wards and departments; this included critical care.
- Staff within the unit managed patients, including surgical patients, with pain control and pain assessments; this included patients with epidurals and patient controlled analgesia (PCA) pumps. Support was also provided from outreach nurses.
- We reviewed patient records and observed the appropriate use of pain scores and support for patients requiring pain relief.
- All pain relief medication was stored and managed appropriately by staff.

Nutrition and hydration

- Dietetic services were only available during the week and not at weekends, and did not meet the British Dietetic Association recommendations that there should be 0.05 – 0.1 wte dietician per one bed within critical care.
- Dietetic support was mainly provided Monday – Friday during usual working hours. There were processes in place, in the form of a standing feeding protocol, to initiate nutritional support out-of-hours.
- Appropriate monitoring of patients fluid and hydration levels were in place.

Patient outcomes

Critical care

- We reviewed the ICNARC (Intensive Care National Audit and Research Centre) data for April 2014 – September 2014. The majority of data was within average ranges, though there were some differences.
- Unit mortality data for ventilated admissions had been running above average as compared to other similar units but had reduced to within expected ranges during quarter three of 2014. Average length of stay for ventilated admissions had been consistently above average as compared to other similar units for the previous two years, though again this had reduced to average levels recently.
- Unit mortality for admissions with severe sepsis was similar to that of other similar units as was the average length of stay.
- The other unit mortality outcome measures including elective surgical admissions, emergency surgical admissions and admissions with trauma, perforation or rupture were all within normal ranges, though there were peaks and troughs in the data range, particularly for unit mortality for patients admitted with trauma, perforation or rupture.
- For other quality and patient outcome data, including early readmissions, early deaths, late deaths and late readmissions, these were all within expected ranges as compared to other similar sized units.

Competent staff

- We spoke with the clinical educator about several aspects of staff competency; over 60% of registered nursing staff had completed their post registration award in critical care nursing. All nursing staff were encouraged to apply for the course after completing their competency based induction programme.
- All staff working on the unit had access, at all times, with staff that had completed the post registration award in critical care nursing.
- At the time of the inspection, around 83% of nursing appraisals were in date of which around 8% were due within the following 30 days.
- We were informed centrally from the trust that the appraisal rates for medical staff were 100%. This differed slightly from the view of medical staff who considered that 80% of medical staff had been appraised.
- The appraisal process for medical staff was robust and all went through the appraisal committee.
- Two consultant doctors we spoke with stated that revalidation processes were suitable and relevant medical staff were up-to-date in maintaining portfolios and the overall revalidation process.
- New staff starting on the unit attended the trust wide corporate induction programme and induction on to the unit; this included a four week supernumerary period.
- Staff we spoke with felt well supported in terms of learning and development and the opportunities provided to develop knowledge and skills.
- Newly appointed consultants also received a formal induction including a formal departmental induction with a walk-around and familiarisation with common practices; there was also explanation as to the regular practice in relation to how the department ran.
- New medical starters were not placed on-call for their initial until they were fully prepared and familiar with the unit and processes.

Multidisciplinary working

- Nursing staff we spoke with felt the different specialities on the unit worked together well and there was positive team work.
- We observed ward rounds which included staff working together and we observed the treatment decisions made for some patients.
- Pharmacists and dieticians were not, in the vast majority of occasions, involved with ward rounds. However, they were available on the unit for support and advice if required.
- The MDT approach enabled care to be delivered in a coordinated way and services such a pharmacy, physiotherapy, pain management and dietetics worked well with the nursing and medical team.
- There was some cross site working between the Doncaster and Bassetlaw hospitals' critical care units and there were joint management and governance meetings.
- We recognised that aspects of care between the two critical care units, Doncaster and Bassetlaw, differed to varying degrees and the support provided to the team at Bassetlaw to ensure exacting standards of care was limited.

Seven-day services

Critical care

- We spoke with the clinical nurse lead about the accessibility of services during a seven day week. The majority of support services for example x-ray, and scanning and imaging services were available 7 days a week.
- Pharmacy, physiotherapy and occupational therapy services were only available on an on-call basis out of core working hours, Monday to Friday.

Access to information

- Information was available to relatives of patients being cared for on the critical care units.
- The most recent patient survey from 2013 demonstrated that 83% of patients or relatives felt they received enough information and 81% stated they understood the information being given to them.
- All policies and procedures we easily accessible via the intranet.
- The department of critical care handbook was easily accessible in both electronic and paper versions.
- Nursing staff we spoke with felt that information they required was straightforward to access.
- Documents were easy to locate including all care pathways, care bundles and infection control paperwork.

Consent and Mental Capacity Act

- There was a trust wide policy on consent and related policies including guidance around mental capacity and deprivation of liberty safeguards.
- Staff on the unit knew about the trust wide policies for consent, mental capacity and deprivation of liberty.
- We spoke with nursing staff about consent to treatment and it was recognised how this was a challenge in the critical care environment due to the acute nature of the care provided.
- Of the nurses we spoke, they described how consent was gained, where possible, from patients prior to certain procedures. For example, some patients required additional sedation and this was something that was discussed with patients beforehand and documented.
- We observed a situation where staff gained verbal consent from patients before proceeding with a medical intervention and information was suitably delivered and documented by the staff.
- In relation to mental capacity and deprivation of liberty safeguards, staff provided examples of situations where certain safeguards were required with patients. The examples included where best interest decisions needed to be made which required the involvement of the MDT, safeguarding lead and family or friends were involved.
- Training around mental capacity and deprivation of liberty was provided as part of mandatory training programme.

Are critical care services caring?

Good

The care on the critical care unit was judged as good. Patients were well supported, and their privacy and dignity was maintained. Both patients and their relatives felt involved in and informed about their care being provided. We did note that there were some occasions when alarms were not attended to promptly.

Compassionate care

- Overall, medical and nursing staff provided good care and patients felt well cared for; a patient described being 'looked after very well'.
- The relatives we spoke with felt staff were responsive to their needs and had no significant concerns.
- We observed nursing and medical staff interact with patients and with relatives. Staff were compassionate and caring in their approach and manner.
- The nurse consultant we spoke with stated that the unit did participate in the Friends and Family test and they had also conducted surveys involving patients and also visitors; they said that overall feedback was positive. Results from the patient survey (2013) indicated that 94% of patients believed they were treated with dignity during their stay. These results were from responses across the two units.
- If there were areas of concern highlighted changes were implemented where necessary. For example, some people had commented about the restrictions for visiting; the unit was trialling different visiting times to be more flexible.

Understanding and involvement of patients and those close to them

- Both of the patients we spoke with described feeling involved with their care and staff explained the intended treatment plan and medical interventions in suitable detail.
- We observed how during ward rounds medical staff, where possible, explained patient's planned care and treatment.
- We also reviewed care records, both nursing and medical, and there was in the majority of cases suitable documentation around discussions with patients and / or relatives.
- The relatives we spoke with felt they were kept informed about their relative's care, but not necessarily well supported as relatives, where they relied on each other for support.
- We observed a number of interactions between patients and staff and there were positive examples of where staff ensured patients understood their intended treatment and offered choices where possible.

Emotional support

- There was a chaplaincy service available and this was provided 24 hours a day seven days a week.
- Psychiatry support was also available and there was a referral process for this.
- No specific counselling services were available and this needed organising patients' GP.
- In relation to anxiety and depression, there was a specific section in the nursing daily care plan that prompted the nurses to continually assess this and recognise potential areas of concern.
- The medical and nursing team were seen as instrumental in providing ongoing emotional support on a day-to-day basis during someone's hospital admission.
- It is recognised that some patients can be emotionally affected after having been a patient on a critical care unit and follow-up clinics are recognised as a way of providing support and an opportunity for patients to discuss their experiences.
- Follow-up clinics were provided and these were nurse led. However, it was recognised that the clinics were under resourced and, ideally, have more medical input.

Are critical care services responsive?

Good

We judged the responsiveness of services to be good. Flow of patients was appropriate and length of stay and discharges were all within national limits.

Patients' needs were met. Staff were aware of the complaints process, but the unit had not received any complaints in the last 12 months. Staff were not however able to articulate learning from complaints that had occurred in other areas of the hospital that may have had relevance to their unit.

Service planning and delivery to meet the needs of local people

- The unit's average occupancy rate was around 70%; we did not identify any particular concerns regarding planning for patient services, or an inability to meet the needs of the local population.
- There were questions concerning the future of the Bassetlaw unit. Key questions were around whether or not to expand the medical workforce at Bassetlaw that ensured separate intensivist led cover and whether to stop critical care services at Bassetlaw and expanding the unit at Doncaster. It was recognised that the unit at Doncaster, in its current form, would not be able to absorb the patients from the Bassetlaw unit if it closed; an expansion of the unit would be required.
- The challenges were recognised by the senior directorate team and there was sensitivity around wanting to provide a high quality service but, at the same time, taking in to account the views of the local population; this was particularly the case at Bassetlaw.
- Discussions with local clinical commissioning groups (CCGs) and NHS England were imminent and service planning and provision across the two sites was a key focus.

Meeting people's individual needs

- From our observations, from speaking with staff and from speaking with patients and family / friends, care was centred on meeting people's individual needs. These needs were, in the main, acute medical needs but other patient needs were addressed, for example, emotional needs.

Critical care

- The unit had experienced caring for and supporting patients with complex health needs and staff described the importance of MDT working and care planning.
- People with complex health needs, in many cases, received close support from family members or carers; staff on the unit worked closely with family members / carers in such instances.
- The trust had a learning disability support nurse and they were available to provide support to staff, patients and relatives if required.
- In certain circumstances, visiting hours were flexible and this helped support families who had additional support needs.
- The trust did not report any breaches of mixed sex accommodation during June 2015.
- We did note during the inspection that there were times when alarms were not dealt with in a timely fashion, to silence the alarm and deal with any clinical need that was as a consequence of the alarm sounding.
- There was suitable access to translation services and this was usually provided via telephone.
- The unit did not manage a significant number of patients with dementia but the clinical nurse lead described how staff were competent to manage such patients and, again, it was often important to involve family members and / carers in providing aspects of the care and support required.

Access and flow

- We reviewed the ICNARC (Intensive Care National Audit and Research Centre) data for April –– September 2014. All data was in line with or better than that of similar units.
- There were no concerns with delayed discharges.
- There were no specific concerns with regard to length of stay, which was in line with units of a similar size.

Learning from complaints and concerns

- We spoke with the various members of staff about the complaints process and there was some uncertainty; it was thought that complaints were managed by the matron.
- The clinical nurse lead stated that, from their understanding, complaints were low and they had not been asked for a considerable period to investigate a complaint.
- We asked about any specific examples where learning had been applied after having resolved a complaint and no specific examples were provided.

Are critical care services well-led?

Good

Overall the services were well led and we judged this as good. The care group was relatively new, but had appropriate systems and processes in place. Clinical leadership was good and clinicians were engaged in the governance of the care group. There was a lack of clarity regarding the future use of the critical care service, though discussions were being held with the local commissioners.

Vision and strategy for this service

- We spoke with the general manager (surgical), head of nursing (surgical), matron and medical critical care lead about vision and strategy for the critical care service, including both the Doncaster and Bassetlaw locations.
- The general manager stated that the care group was working on a site review programme which included a site control plan; the budget available was in the region of 100 million pounds.
- In terms of progress, we were informed there was a committed external partner who would be involved with the build plan for the forthcoming 3-5 years, some further discussions were required with the clinical commissioning groups.
- We reviewed senior management team meeting minutes and corporate investment committee meeting including a number of business case summaries. We also reviewed the draft capital investment plan for 2015/ 2016.
- The main schemes listed in the draft capital investment plan were development at the Montagu hospital, Bassetlaw, endoscopy, operating tables and site development schemes. Site development included the clinical decision units, Mallard and Kestrel ward refurbishments and Medical Admissions Unit (MAU) development. For critical care, work included isolation facilities at the Bassetlaw unit.

Governance, risk management and quality measurement

Critical care

- There were appropriate governance structures in place within the care group. The critical care quality and governance group met regularly (monthly), and this reported to the care group quality and governance meeting. The care group structure linked to the trust wide quality and governance committee as well as the senior management team.
- In addition to quality and governance meetings, there were regular business meetings which reported to trust wide senior management meetings and onward to the board.
- The care group structure was relatively new and had formed in August 2014. Staff considered that the new structure was developing well and there were good support mechanisms in place.
- Records from other meetings for example mortality and morbidity also fed in through the quality and governance structure so the care group was sighted on issues across the sector.
- The care group reported a range of care indicators, including catheter line insertion and care, urinary catheter care.
- There was a risk register for the care group, which contains 10 risks associated with critical care. The majority (7) of these were in relation to the use of equipment.

Leadership of service

- At unit level, there were changes occurring in terms of leadership and the critical care nurse was closely involved in developing the proposed nursing team structure and leadership arrangements. Plans were in place and this included increasing administration support and the responsibilities taken on by the senior nurses.
- Leadership within the unit clinically was good, staff felt engaged and there were plans for medical and nursing staff development.

Culture within the service

- Staff reported an open and supportive culture. They were supported to report incidents, and to develop as individuals professionally.
- Over 60% of staff had undertaken the critical care course and were encouraged to develop whilst working on the unit.
- Staff were engaged in the care group as a whole and participated in the development of the unit.

Public engagement

- The unit undertook patient surveys, both as part of the family and friends test and locally.
- The results of the family and friends tests for January – March 2015 were all positive in their comments, though the return rates were low, due in the main to the nature of the service, and were not differentiated between the two units.
- The trusts own patient survey dated 2013 had a 47% response rate, and was overall positive in the feedback from patients and their relatives. The results were based on responses from both units, but did not differentiate between the two.

Staff engagement

- Staff stated that they felt involved in the service and were engaged with senior staff, and informed of developments that took place. The staff survey, whilst not specific to the unit, identified that staff felt they made a difference at work to patients care, and were supported by their line manager. There were some areas of concern, especially in relation to appraisal rates, however data from the critical care unit indicated that the majority of staff had received an appraisal.

Maternity and gynaecology

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

Information about the service

Bassetlaw General Hospital offered a full range of maternity and gynaecology services for women and families provided in both hospital and community setting. There was midwifery led care including home births, and consultant led hospital care provided to high risk women who needed more specialist care.

Antenatal and postnatal care took place on ward A2 which had 18 beds in bays plus three single side rooms. Two of the side rooms had en suite facilities. There were offices on the corridor for the specialist midwives to use. There was a seminar room used for teaching sessions and as a base for community midwifery equipment.

There was a delivery suite at the end of A2. In between A2 and the delivery suite was an area which could be used flexibly as a clinic, or triage / assessment area. The gynaecology ward, B6 was also used as a 31 bed mixed sex surgical ward, where men and women with urological or general surgical problems were cared for. At the end of B6 was the Early Pregnancy Assessment Unit (EPAU) and a counselling room.

The maternity service at Bassetlaw hospital delivered 1,142 babies between April and December 2014.

We visited the antenatal and postnatal ward, the delivery suite, obstetric theatre, the EPAU and gynaecology ward.

We spoke with five women and two patients in the gynaecology ward and 10 staff including midwives, midwifery support workers, health care assistants, the chaplain, nurses and doctors. We also spoke with the Local Supervisory Authority Midwifery Officer (LSAMO) for the region. We observed care and treatment and looked at eight sets of care records. We also reviewed the hospital's performance data.

Maternity and gynaecology

Summary of findings

Overall, maternity and gynaecology services required improvement. There had been two clusters of stillbirths from January 2014 to January 2015. A still birth review had taken place and each case was assessed against the National Patient Safety Agency Stillbirth Toolkit. The action plan was due for completion shortly after our visit.

There was no dedicated emergency obstetric theatre team at Bassetlaw during the mornings on weekdays. An emergency team was available at all other times.High rates of sickness were evident on the gynaecology ward. Mandatory training participation for medical staff was poor.

There was a range of specialist midwives in post, however neither the teenage pregnancy special midwife nor the substance- misuse specialist midwife had input into vulnerable women at Bassetlaw hospital. There was no specialist diabetes midwife in post.

There was limited awareness of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

On the labour ward there was no documentation evidence of wastage of controlled drugs used in epidural procedures.

Since 2010 there had been a high percentage of non-elective neonatal readmissions within 28 days of birth. An action plan was in place and was being monitored. There were no designated scanning facilities in the EPAU at Bassetlaw; women had to go to the Ultrasound department with other 'general' users of the service.

We found there was disconnection between ward staff and the board. Most staff were unaware of the vision for the service.

Systems were in place for reporting, investigating and acting on adverse events. Midwifery staffing ratios were in line with the national recommended ratio of 1:28. Consultant cover at Bassetlaw maternity unit was 40 hours per week in line with the number of babies delivered on the unit per year.

Completion of mandatory training was at a good level for midwives, midwifery support workers and health care assistants. Good evidence of safeguarding vulnerable women was evident.

Maternity and nursing staff were caring. Patients and women spoke positively about their treatment by clinical staff and the standard of care they had received. There was good evidence of individualised maternity care. Hypnobirthing was available on delivery suite.

We observed strong team working with medical staff, nurses and midwives working cooperatively and with respect for each other's roles. They told us that Bassetlaw was a 'good place to work'. Most staff we spoke with were positive and enthusiastic.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

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. The information and findings were shared with the Local Supervising Authority Midwifery Officer for the region. 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).

Staffing ratios in maternity were in line with the national recommended ratio of 1:28; this meant one midwife to 28 births. The ratio of one to one care in labour averaged at 89.8 % between April 2014 to October 2014. Some months it was recorded as over 94%.

The gynaecology ward planned for staffing to be at the Royal College of Nursing (RCN) recommended nurse to patient ratio of 1:8 (RCN 2012). This meant one registered nurse for eight patients. Nurses told us eight staff had been either sick or absent from the ward over recent months which took the actual ratio to 1:11 or higher at times. The hospital risk register for the end of 2014 included details of vacancies for registered nurses on the gynaecology ward. Closed beds were opened on a weekend and used for medical or care of the elderly outlier patients. Plans to mitigate this included ongoing recruitment, additional / overtime shifts to cover shortfalls by staff, the use of agency staff and nurses from the day surgery unit and over recruitment of health care support workers to bridge the gap. It had been acknowledged by senior managers that measures had not always been effective. The risk was recognised as amber on the register.

The maternity and gynaecology ward areas were visibly clean and equipment was in date and in working order. The recording of equipment checks was not consistent in all areas. Some equipment was stored in the corridor outside the ward manager's office on the ante/post-natal ward. We were told that storage space is limited.

Completion of mandatory training was at a good level for midwives, midwifery support workers and health care assistants at Bassetlaw Hospital. The percentage of medical staff who had received mandatory training was low. Only 14% of medical staff had attended adult resuscitation training, none had attended neonatal or paediatric resuscitation training.

Medicines were stored safely and managed appropriately, apart from the recording of disposed epidural drugs on labour ward. Disposed amounts were not recorded in the controlled drugs register.

Arrangements were in place to safeguard adults and babies from abuse and reflected safeguarding legislation and local policy. However the hospital domestic abuse policy did not contain the NICE recommendation that women needed to be asked as part of routine care, whether they were experiencing abuse, that they were asked more than once (as most women will not disclose abuse the first time they are asked); to be asked about abuse only when they are alone (or with a professional interpreter) and that they should be seen alone at least once during the pregnancy, even if normally accompanied by partner or family member.

Effective systems were in place for reporting, investigating and acting on adverse events. There was a dedicated safety and risk team for the maternity and gynaecology department. This team was shared with Doncaster Royal Infirmary.

Serious incidents were monitored and action taken when things went wrong. There had been one never event in February 2015 at Doncaster which involved a retained vaginal pack following a clinical procedure. Learning from this event had been shared with Bassetlaw.

Appropriate plans were in place to respond to emergencies and major incidents. There was no dedicated emergency obstetric theatre team at Bassetlaw during the mornings on weekdays. An emergency team was available at all other times.

Incidents

- Serious incidents were monitored and action taken when things went wrong. The process for reporting incidents, near misses and adverse events was embedded in maternity and gynaecology.
- All staff we spoke with said they felt confident to report incidents and were aware of the process to do so. Incidents were reported on an electronic system. Staff told us they received feedback about incidents they had

reported and outcomes of investigations were shared in a variety of ways, including a risk newsletter and safety brief at ward handovers. We observed copies of the safety briefs on the ante/postnatal ward which had been filed in an accessible folder for staff to read.

- There had been no never events at Bassetlaw Hospital. Learning from a never event within maternity services at Doncaster Royal Infirmary had been shared with staff at Bassetlaw. The trust had taken appropriate steps to minimise the risk of this event in the future. There had been two clusters of stillborn babies between January 2014 and the end of January 2015 between Doncaster and Bassetlaw Hospitals. Seven stillbirths occurred at Bassetlaw. The information and findings were shared with the Local Supervising Authority Midwifery Officer for the region. 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. The review of the clinical care identified that in 4 cases, different management may have changed the outcome. Also the review found that in 6 other cases although the management of care was not optimal in certain areas, the reviewing clinicians did not believe that this contributed to the stillbirths.
- There were some concerns over the recurrent theme of staff not following clinical guidelines. There were incidences of a lack of documentation, cardiotocography (CTG) being discontinued against guidelines, and failure to escalate concerns. One RCA described staff being unfamiliar with resuscitation techniques of a new-born baby. The review identified a number of actions which included an updated scanning policy to be implemented, all midwives and medical staff to undertake further growth assessment protocol (GAP) training and specific training for staff who deviate from guidelines. The guidelines were also to be reviewed and cascaded to all staff. The action plan was due for completion shortly after our visit.
- Further information received after our inspection from Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) report on 10th June 2015 showed the stillbirth rate had reduced to 4.64 per 1000 births. This was marginally lower than the England average.
- We looked at Serious Incident reports and RCA's of still births and a Serious Incident report from the never event. An action plan had been put in place which included specific training for staff that deviated from guidelines.
- We saw the patient safety bulletin clearly displayed on notice boards. The safety team were responsible for carrying out audits if triggered by a root cause analysis (RCA).

Safety thermometer

- The NHS Patient Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. This enabled measurement of the proportion of patients that were kept 'harm free' from pressure ulcers, falls, and urine infections (in patients with a catheter) and venous thromboembolism.
- We observed safety thermometer findings and action plans were openly displayed on notice boards in ward areas. We saw that the ante/post-natal ward had achieved 100% harm free care over several months.
- There had been four pressure ulcer incidents reported on the gynaecology ward in March 2015. Investigation of these found they had not originated on the gynaecology ward.

Cleanliness, infection control and hygiene

- All the areas we visited at Bassetlaw looked visibly clean and tidy. The clinical areas were very organised. There were cleaning checklists or books in each area, which were monitored for completion. The ante/postnatal ward had received an Infection Prevention and Control (IPC) accreditation for 2015. The average environmental audit score was 98.5 %. In some areas 100% had been achieved.
- The gynaecology ward used a bedside cleanliness checklist to ensure each patient's bedside area including the bed, locker, table and chair was clean.
- We saw that staff complied with 'bare below the elbows' best practice. They used appropriate personal protective clothing, such as gloves and aprons. Staff complied with the standard dress code.
- Women were screened for MRSA before undergoing elective caesarean sections.

- There were disposable bedside curtains in use in some clinical areas. Disposable curtains have a fresh, clean appearance; can provide effective infection control and an improved patient environment.
- There were no alcohol gel hand dispensers outside any of the wards we visited, including gynaecology wards, nor in the ward corridors. These had been removed intentionally due to slip accidents from the gel and the COSSH risk assessment of use in an environment where small children were likely to be visiting.
- Staff carried personal use hand gel dispensers and there were wash basins in each bay and patient room.

Environment and equipment

- Throughout the maternity and gynaecology department, clinical equipment appeared clean; it was noted there were different ways to indicate when it had last been cleaned.
- We found there was plentiful equipment in the maternity areas and all service schedules were up to date including all the infant resuscitaires (new-born life support) on the labour ward.
- There was a robust system for checking resuscitaires on central delivery suite.
- The emergency and resuscitation equipment we saw during our inspection was in date and in working order. However, some equipment that needed to be checked on every shift did not have a complete record to indicate that this had been done. For example, the adult defibrillator and resuscitation trolley on the ante/postnatal ward had four missed checks since January 1st 2015.
- There was sufficient numbers of monitoring equipment. There were Cardiotocography (CTG) machines to monitor baby's heartbeat in every room on central delivery suite.
- Use of the birthing pool for water births had fallen from 5% in June 2014 to 3.4 % in December 2014 although this was still higher than average use.
- 'Productive ward' was in use at Bassetlaw Hospital. This focused on improving ward processes and environments to help staff spend more time on patient care thereby improving safety and efficiency. Staff told us a monthly audit was performed and reviewed in order to address any concerns. As a result of audits, the staff office on the ante/post-natal ward was moved to be nearer to women. This meant staff were more accessible to women and that confidential information boards were not in public view.
- An annual Patient Led Assessment of the Care Environment (known as PLACE) had been carried out on the ante/postnatal ward in March 2015. As a result, the ward had been redecorated. A PLACE visit is when local teams go into hospitals to assess how the environment supports patient's privacy and dignity, and general building maintenance. It focuses entirely on the care environment.
- Staff told us there had been recent fire assessments of the clinical areas at Bassetlaw Hospital and these had been found to be satisfactory.
- Records showed monthly waste audits were all up to date and satisfactory.
- Some equipment was stored in the corridor outside the ward manager's office on the ante/postnatal ward. We were told that storage space is limited.
- There were appropriate security measures in place. Wards were accessed by locked doors, which needed to be opened by staff from the inside.

Medicines

- Medicines were safely stored in locked cupboards and trolleys in all of the clinical areas and wards.
- Records showed the administration of controlled drugs (CD) were subject to a second check. After administration, the stock balance of an individual preparation was confirmed to be correct and the balance recorded.
- We were shown medicines audit results and an action plan on ward A2. The results were between 98% and 100%.The action plan was written after a minor handwriting issue. Staff told us they almost always achieved 100% and wanted to ensure they carried on at this level, hence the action plan was developed and followed.
- The drugs fridges we checked all had up to date temperature checks and the medicines inside were in date. This meant staff knew the medication had been stored within the correct temperature range in between the checks and, therefore, the medication remained safe to use.

- We found pre prepared take home medications on the postnatal ward. This meant that women and their partners did not need to wait for medicines to be dispensed from pharmacy.
- On the labour ward there was no documentation evidence of wastage of controlled drugs used in epidural procedures. The wasted amounts should have been clearly documented in the Controlled Drugs (CD) register.

Records

- The hospital had recently launched an electronic system on which to record maternity information. All ward areas had access to the system; however both paper records and electronic records were in use in some areas. Observations such as temperature and blood pressure were currently recorded on paper and were intended to continue until completion of implementation of all modules had been completed, which was anticipated to be in October 2015.
- Staff told us the software company came to clinical areas regularly and worked with staff to ensure the system functioned according to the needs of the area.
- On the whole staff were quite positive about the electronic system; most staff we spoke with told us it saved time and freed them up to give more direct care. They said they had received training to use the system and felt confident in its use. One or two midwives told us they didn't like using it as they preferred paper records.
- Community midwives were not always able to access the electronic system due to not having strong Wi-Fi connections in the children's centres, GP surgeries and women's homes. This meant that community midwives often had to come into the hospital in order to complete their electronic records.
- Women could access their own records with their own Wi-Fi network.
- There was good evidence of care planning, ongoing assessment of care needs and evaluation.
- We checked two sets of paper records; they were for 'out of area' women. Both sets had loose sheets in, and some other sheets held in by paper clips. Good record keeping standards indicate all paper sheets should be securely filed in the notes folder.

Safeguarding

- There was an up to date safeguarding policy in use and staff we spoke with told us they were aware of the policy and where to find it. They told us how they would escalate issues of concern during the day and outside of working hours.
- There was a senior staff member acting as safeguarding midwife in post who was responsible for managing the protection of vulnerable women and new-born babies, although the person in post had other duties in a substantive role. This person had been acting as the maternity safeguarding lead for some time in addition to her substantive post. Staff told us this post had recently been recruited to as a separate role for another person.
- We saw copies of the safeguarding newsletter on display on notice boards.
- There was a safeguarding database which was used to record issues of concern about women and their families. Midwives recorded information which could be shared in high risk situations with other relevant professionals such as social workers, the police or other health workers. They were able to do this within the law in order to prevent a crime or protect a life.
- There was an up to date domestic abuse policy in use at the hospital. However, the hospital policy did not contain the NICE recommendation that women needed to be asked as part of routine care, whether they were experiencing abuse, that they were asked more than once (as most women will not disclose abuse the first time they are asked), to be asked about abuse only when they are alone (or with a professional interpreter); and that they should be seen alone at least once during the pregnancy, even if normally accompanied by partner or family member. Staff told us they sometimes asked about domestic abuse in front of women's partners or family members.
- There was an up to date policy relating to abduction or suspected abduction of an infant or child. This policy instructed staff on how to respond in the event of an infant or child abduction or suspected abduction. There were appropriate security measures in place. Wards were accessed by locked doors, which needed to be opened by staff from the inside.
- Good evidence of safeguarding vulnerable women was evident. We were told about good practice which took place when a 'Schedule 1' offender was visiting someone on the ante/postnatal ward. (Schedule 1 Offences are set out in Schedule 1 of the Children and

Young Persons Act 1993. The types of offences against children or young person's up to the age of 18 years include; all forms of child abuse; any form of sexual assault; all other forms of maltreatment including murder, manslaughter, infanticide, incest, violence, neglect or cruelty).

- The ward had worked closely with the safeguarding team and other public organisations to risk manage the situation and keep women and babies safe.
- Staff told us body mapping of new-borns took place following delivery. This meant that any bruising or other injury related to the birth process could be observed and documented. The body map provided a baseline for subsequent checks of the infant.

Mandatory training

- Staff told us that mandatory training was moving to a three day programme which would include emergency drills, adult and neonatal resuscitation, fire safety training and other mandatory topics.
- There was some variety in the percentage of mandatory training which had been achieved, however between 82% and 88% of registered nurses and midwives had been on mandatory training in the last year, and 94.7% of health care assistants and midwifery support workers had attended their training. The trust target was 85%.
- Compliance with mandatory training for medical staff was poor. Only 14% of doctors had received mandatory training in adult resuscitation, 29% had completed infection prevention and control training; 11% and 17% respectively had done children and adult safeguarding. None had completed neonatal and paediatric resuscitation.

Assessing and responding to patient risk

- Midwifery staff used an early warning assessment tool to assess the health and wellbeing of women who were identified as being at risk. This assessment tool enabled staff to identify and respond with additional medical support if required. The records we reviewed contained completed tools for women who had been identified as being at risk.
- There were arrangements in place to ensure checks were made prior to, during and after surgical procedures in accordance with best practice principles. This included completion of the World Health Organization's 'Five Steps to Safer Surgery' guidelines. We looked at two checklists which showed all the stages were completed correctly.
- We were shown an action plan which had resulted in additional security measures at night time; doors which had been previously open and allowed public access during the night were now locked.
- If women had a large post-partum haemorrhage (extensive bleeding) they were stabilised at Bassetlaw and subsequently transferred to Doncaster Royal Infirmary. Staff told us this was because the neonatal intensive care facilities were better equipped to deal with the needs of acutely ill new-borns. (A major haemorrhage which triggers the 'Massive Obstetric Haemorrhage' protocol is defined as blood loss that is 'uncontrolled' and 'ongoing' with a rate of blood loss of 150mls or more per minute or blood loss of over 2 litres).
- There was no dedicated emergency obstetric theatre team at Bassetlaw during the mornings on weekdays. This meant in the event of an emergency, an anaesthetist from a gynaecology surgical team had to be used. Medical staff told us this could result in cancellation of elective gynaecology surgery although they were unable to tell us when this had happened. An emergency team was available at all other times. The trust managers advised there was approximately one emergency section per month. The trust managers were aware of the situation, had arrangements in place to manage the risk and were exploring additional resource to improve this.

Midwifery and Nurse staffing.

- Planned and actual staffing numbers for the next 24 hours were displayed on notice boards in every ward area.
- The midwife to births ratio was 1:28. This meant one midwife to 28 births; it had been recorded as this since April 2014. These standards meet the recommendation by the Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (Royal College of Obstetricians and Gynaecologist 2007). The ratio of one to one care in labour averaged at 89.8 % between April 2014 to October 2014. Some months it was recorded as over 94%.
- A recent Birthrate Plus® assessment had been carried out at the trust and the recommendations were due to

be presented to the trust board after our inspection. The use of Birthrate Plus® (a midwifery workforce planning tool) had been recommended in recent Department of Health maternity policy; endorsed by the Royal College of Midwives and incorporated within standards issued by the NHS Litigation Authority.

- In order to achieve safe staffing levels across both hospital sites, staff were moved between wards and between Doncaster and Bassetlaw hospitals.
- Staff we spoke with said they felt very anxious about moving to Doncaster Royal Infirmary. Some of them had to go during a night shift in their own car in the early hours which they said felt unsafe. It could take 30-45 minutes to get from one hospital to the other. Staff travelled on the hospital shuttle in the day time, but this stopped running at 6pm. They told us that a taxi could be ordered at the manager's discretion.
- Staff told us there were not as many staff to draw on at Bassetlaw, it was a smaller maternity unit than the one at Doncaster. They told us they understood they had to go where the demand for staff was greater, but they sometimes felt they were there to support the bigger hospital.
- Midwives told us some colleagues had left their jobs because they didn't want to be moved on a regular basis.
- We observed copies of duty rosters from October 2014 to early December 2014. Over a time period of 8 weeks one or two staff were moved each week from the ante/postnatal ward to cover Doncaster. Midwives told us this left their own areas short staffed. Community midwives could be called in to fill gaps in staffing in the hospital. This meant they were not able to work the next day, so visits were cancelled and pressure was placed on their colleagues to meet the needs of women.
- We observed the sickness and absence rates for the gynaecology ward on the notice board. The sickness levels had increased month on month from 10.7% in September to almost 17% in December 2014. This had reduced gradually to 8.3% in March. Nurses told us they had been through a very difficult and stressful six months as a result of poor staffing levels.
- They told us they had escalated concerns to senior managers, but little could be done at the time. Staff told us there were eight colleagues off at one time which had a negative impact on the remaining staff on the ward. They told us they pulled together as a team and supported each other through the crisis.
- We observed comprehensive safe patient handovers of information between staff of all grades. Information was concise and relevant.
- Nurses and midwifery staff were very flexible and worked hard to support each other. They all had a strong commitment to their jobs and displayed loyalty to senior staff.

Medical staffing

- At the time of our inspection the consultant cover at Bassetlaw maternity unit was 40 hours per week in line with the number of babies delivered on the unit per year. This cover was provided from 8am to 5pm on Monday to Friday and five hours of cover provided on each weekend day. Consultants were on call outside the hours when they were present on the unit.
- At the time of our inspection, there were medical staffing vacancies. Doctors told us this could impact on their workload. Senior managers told us there had been a problem with recruitment in the region; however they had recently been successful in the appointment of a new consultant.
- Junior doctors told us that support from senior colleagues was readily available.
- There was a consultant run elective caesarean section theatre list twice a week. There was a dedicated team for this group of women.
- There was 24 hour availability of an anaesthetist for epidurals, but this was not part of a designated obstetric service, due to the low demand.
- The middle grade doctor on duty covered obstetrics, intensive care and outreach patients.
- Doctors told us that only Hospital 'CEPOD level 1' surgical patients could go to theatre out of hours. (Confidential Enquiry into Patient Outcome and Death). This was a national tool which supported the decision to when someone required surgery. Level 1 was the immediate lifesaving need to go to theatre.
- It was not clear whether the absence of an emergency obstetric team or dedicated anaesthetist impacted on the risks to women at Bassetlaw. Action taken included the use of an anaesthetist from a surgical team.
- The Royal College of Obstetricians and Gynaecologists (RCOG) recommended that staffing levels needed to

recognise that emergencies happened frequently and often rapidly, with a requirement to respond quickly in order to save mothers' or babies' lives. This meant that in all but the smallest units the duty anaesthetist for obstetrics should not, in addition, be responsible for the intensive care unit or other anaesthetic duties. RCOG also recommend that as well as timely response to emergencies, anaesthetic services also needed to respond to elective operating such that it is not normally interrupted by emergencies.

- The medical staffing at Bassetlaw hospital did not fulfil the above recommendations. We were shown minutes from the trusts labour ward forum and maternity and gynaecology clinical governance group (MCGGG) which indicated this had been discussed several times in 2014 and was an ongoing issue.

Major incident awareness and training

- Midwives told us continuity plans for maternity were in place. These included the risks specific to each clinical area and the actions and resources required to support the service in the event of a major incident.
- We were shown the 'battle box' cards and major incident action plans. The contents of the box included torches, batteries and action cards describing what to do under specific circumstances. We were told staff knew what to do in the event of a major incident.

Are maternity and gynaecology services effective?

Requires improvement

Some staff had not had a performance appraisal in the preceding 12 months. The Supervisor of Midwives role had been used instead of an appraisal or performance review. This practice had recently changed and some staff had appraisals booked in the coming months.

Normal births were promoted; although the rates of induction of labour were high at over at over 34%, the hospital considered a rate of over 28% to be 'red' on their red, amber, green (RAG) rating. Non-elective caesareans was higher than average at over 17% for the last three months of 2014 which accounted for a high number of births. The hospital considered a rate of over 13.9 % to be a red RAG rating.

Three out of five National Neonatal audit Programme (NNAP) questions were below the national standard for Bassetlaw. (The audit took place in 2013 and was published in September 2014).

There was no designated 24 hour anaesthetic obstetric service at Bassetlaw; anaesthetists had to be called in from other teams for situations which occurred out of hours.

The maternity and gynaecology services used national evidence based guidelines to establish and deliver the care and treatment they provided.

The staff participated in national and local audits. Staff told us that outcomes from audits had helped to make improvements in care.

There was a multidisciplinary approach to care and treatment, which involved a range of staff in order to enable services to respond to the needs of women. Consent was appropriately obtained and women were supported to make decisions about their care and treatment. There was a general lack of awareness of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS).

The hospital had recently achieved level 3 of the UNICEF Baby Friendly Initiative. This was the highest level which could be awarded.

Evidence-based care and treatment

- The delivery of care and treatment was based on guidance issued by professional and expert bodies such as National Institute for Health and Care Excellence (NICE). Maternity used a combination of NICE and Royal College of Obstetrics and Gynaecology Safer Childbirth (RCOG) guidelines, and the RCOG minimum standards for the organisation and delivery of care in labour to determine the treatment they provided.
- Staff participated in national and local audits and showed us an audit plan which included the management of 3rd and 4th degree tears, the national diabetes in pregnancy audit, caesarean sections, medical staff handover, the management of miscarriage and the use of chaperones. Staff told us that outcomes from audits had helped to make improvements in care. For example the rate of 3rd and 4th degree tears had reduced from 8.23% in April 2014 to 0.84% in December 2014; this was then below the England average of 2.56%.

- The hospital worked closely with Doncaster Royal Infirmary in the research and development programme and had joined with the clinical commissioning group in order to improve healthcare. Maternity services had been involved in a range of research studies conducted across the multi-disciplinary team.
- A ward quality assurance tool (WQAT) was in use in the maternity areas. This audit was carried out by the deputy director of nursing and a matron as part of a 'board to ward' review. They systematically reviewed evidence of essential care delivered to women to ensure that care was safe, effective, positively experienced and delivered to a consistently high standard.

Pain relief

- Various forms of pain relief were available to women; these ranged from drug free methods, such as the birthing pool or relaxation techniques, to Entonox gas, opioids or epidurals.
- The women we spoke with said they were "more than happy" with the pain relief they had received during labour.
- A patient who spoke with us on the gynaecology ward said the nurses had been "really good" in treating her pain.

Nutrition and hydration

- Women and patients told us they had a choice of meals and these took account of their individual preferences. The gynaecology ward used menus with colourful pictures of food. Patients told us this helped them decide what to have and one person said it made her look forward to her meals; we observed nursing staff help someone to fill in a menu.
- There was a specialist infant feeding coordinator who worked closely with the midwifery staff to provide advice and support for women who chose to breastfeed. The hospital had recently achieved level 3 of the UNICEF Baby Friendly Initiative. This is a worldwide initiative which encourages hospitals to promote breastfeeding. The rates of breastfeeding initiated in the hospital were lower than the target of above 81%; the figures had been an average of 65% for the last six months of 2014.

Patient outcomes

- From April to December 2014 there had been 1,142 deliveries at Bassetlaw Hospital.
- One to one care during labour was good, around 91% had been reported over the last three months of 2014.
- The proportion of delivery methods were mostly in line with national expectations.
- Normal births were promoted; the rate of normal unassisted births averaged at over 68% from July to December 2014, and was over 69% in December. The rates of induction of labour were higher than average at over 34%. The hospital considered a rate of over 28% to be 'red' on their red, amber, green (RAG) rating.
- The rate of non-elective caesareans however was high, and averaged over 17% for the last three months of 2014 which accounted for a high number of births. The hospital considered a rate of over 13.9 % to be 'red' RAG rating.
- The number of home births was very low. The rates had fallen from 3.8% in August 2014, to none in December 2014. We were not aware of any actions to improve on this.
- Three of the five National Neonatal Audit Programme (NNAP) questions were below the national standard for Bassetlaw. (The audit took place in 2013 and was published in September 2014).
- Two of the five NNAP audit questions had good results. The hospital received 91% for women being given antenatal steroids before delivering a premature baby, and 100% for babies who had their temperature taken within an hour of being born.
- Since 2010 there had been a high percentage of non-elective neonatal readmissions within 28 days of birth. An action plan was in place and was being monitored. It had been identified there were recurring issues which were related to neonates who were losing weight or who were jaundiced or had hypoglycaemia (low blood sugar). We found the trust had implemented changes, such as monthly review of incidents of neonatal readmission and revised coding. The hospital currently used a threshold of around 10% weight loss as criteria for readmission or review; this was below the threshold of 12% used at other trusts.
- There was a 'Guideline For Infant Feeding Policy' which was up to date. The breast feeding midwife had also proposed a new policy which included a management plan according to the amount of neonatal weight loss. This had yet to be considered by senior managers.

Competent staff

Maternity and gynaecology

- Newly qualified midwives undertook an 18 month preceptorship programme. During this time they had access to extra training and support. .
- Appraisal rates were very low or non-existent for maternity staff, nurses and health care assistants. Managers were aware of this and had recently changed the appraisal process. A manger had to have their appraisal done first in order to be able to appraise others. Doctors told us their appraisal system worked well and were completed in line with the revalidation process.
- Some staff we spoke with had not had a performance appraisal in the preceding 12 months. One person told us they hadn't had an appraisal in three years.
- 100% of the EPAU staff had received an appraisal in the previous year.
- The Supervisor of Midwives (SOM) ratio to midwives was 1:16; this was slightly higher than the national recommendation, which was 1:15.
- The SOM role had been used instead of an appraisal or performance review for about two years. This practice had recently changed and all maternity staff had appraisals scheduled before the end of July 2015.
- Supervision was a statutory responsibility that provided a way for midwives to get support and guidance, it was not meant to incorporate performance management.
- We spoke with the Local Supervisory Authority Midwifery Officer (LSAMO) for the region, who told us this practice had recently changed since the interim head of midwifery had been in post.
- Midwives told us they had good access to the SOM, they were usually able to contact them across the whole 24 hours.
- SOM's have two days a week protected time to meet with midwives.
- Junior doctors told us they had good access to ward based teaching sessions, they felt supported by the senior doctors and could approach them at any time if they had concerns.
- Newly qualified midwives told us they had a good preceptorship package in place. They felt very encouraged by an 18 month programme of support and were allowed to develop their skills at an individual rate.
- The link lecturer from the university visited the maternity areas three times a month to support the student midwives.
- We were told that the specialist midwives also worked alongside clinical staff. This kept their skills up to date and gave them credibility in their role.
- Staff told us they were able to request extra training opportunities at times. Two midwifery support workers had been encouraged to study to midwife training and were due to leave to start university in September.
- The gynaecology ward had a comprehensive information file for the use of nurses and HCA's to support their learning needs.
- Bassetlaw had a learning environment manager (LEM) in post. The LEM was an expert within the clinical setting and responsible for ensuring that the practice area was a learning environment that was productive for students and staff in the clinical setting.

Multidisciplinary working

- Effective integrated working was evident between the hospital and community midwives. Community midwives had a rota for covering the hospital in the event of staffing problems. This meant they could keep up to date with knowledge and skills required for hospital working.
- The gynaecology ward worked with a full multidisciplinary team (MDT) including therapists, social workers, doctors and other professionals.
- Midwives we spoke with told us they felt able to challenge medical decisions in a constructive way and they were listened to by the doctors.
- Doctors told us they respected the experience and skills of the midwives and they worked well together.
- Some doctors told us that Bassetlaw maternity unit was more midwifery led, that that they drove the service forward.
- We observed effective multidisciplinary team (MDT) handover and communication between midwives and doctors. Midwives told us about how they handed over care to health visitors. Handover to health visitors was in verbal or written format, as health visitors did not have access to the electronic maternity record.
- Midwives and nurses told us the midwifery support workers and health care assistants were "invaluable" and worked hard in breastfeeding support and parent education.

Seven-day services

- Junior and middle grade doctors were available seven days a week on both maternity and gynaecology.

- Doctors we spoke with told us the consultants provided five days of cover. Consultants were also available on call outside daytime hours and at weekends.
- There was 24 hour availability of an anaesthetist for epidurals, but this was not part of a designated obstetric service
- GP's or community midwives could refer women to the assessment area on the ante/ postnatal ward 24 hours a day.
- There was a theatre list on Saturdays and Wednesdays for termination of pregnancy.
- The EPAU opened until 2pm four days a week. On a Tuesday, the nurses ran an EPAU service at Retford Hospital.
- The manager of EPAU told us she would like to extend the hours. Outside of EPAU hours, women could be seen and assessed in the emergency department or the gynaecology ward if they were under 17 weeks gestation.

Access to information

- We observed good communication between teams. This was either verbal, written or in the form of an electronic print out.
- Ward and MDT handovers used the SBAR communication tool (Situation, Background, Assessment, Recommendation).
- There were 'live' electronic patient flow boards on the wards; these could be updated by any member of staff who had access; the boards were used at ward handover.
- Some ward areas had the board away from public view for confidentiality reasons.
- Pregnant women could access their own maternity records with their own Wi-Fi network at home.
- There was relevant clinical information displayed in the clinical and ward areas for women and their partners to read.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Records we looked at in both maternity and gynaecology showed that women were consented appropriately and correctly for surgical procedures.
- Women who required a termination of pregnancy were consented on a standard form, as expected in national consent practice. The trust was able to demonstrate full compliance with HSA1 form completion by two doctors and notifications required. A monitoring process was in place, led by the lead clinicians on the termination services, who confirmed 100% compliance with the HSA1 form completion. If a girl under 16 years of age required a termination, the consent form was signed by two doctors. The consent form in use included Gillick competence guidance which could be used for pregnant teenagers. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. For example, if a child under the age of 16 had sufficient understanding and intelligence to enable her to consent fully what is proposed, then she will be competent to give consent for herself. Young people aged 16 and 17, and legally 'competent' younger girls, could therefore sign a consent form themselves. Parents could countersign the form if young girls wished them to do so.
- There was a consent form for disposal of products of conception.
- Midwives on the ante/postnatal ward described a situation when a woman with learning disabilities and limited capacity to make some decisions had been due to give birth. An individual plan of care was designed with her input, and the support of her mum and keyworker.
- There was limited awareness of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) especially on the gynaecology ward. Staff told us they would usually find out from pre assessment clinic if a patient coming for an elective procedure didn't have capacity.
- Staff said they would refer to the safeguarding team or a mental health liaison service between Monday to Friday but were not aware of how to seek authorisation for deprivation of liberty, how to make a best interest decision for someone, or the difference between lawful and unlawful restraint.
- The gynaecology ward frequently took a number of medical outlier patients, including older people with acute delirium or living with dementia. Some of these patients lacked capacity to make decisions about their care or treatment.

Maternity and gynaecology

Are maternity and gynaecology services caring?

Good

Maternity and nursing staff were caring. Patients and women spoke positively about their treatment by clinical staff and the standard of care they had received.

A patient on the gynaecology ward said nurses "went the extra mile" and had "been fantastic" when giving care. We observed staff interacting with women and their partners in a respectful compassionate way.

Women were involved in their birth plans and had a named midwife for their pregnancy.

Compassionate care

- In the CQC Maternity Services Survey 2013, the results showed that the majority of questions relating to labour and birth, staff during labour and birth, and care in hospital after birth were rated 'about the same as' other trusts.
- The NHS Friends and Family test (FFT) was asked four times in maternity services; during the antenatal period, birth, on a postnatal ward, and in post-natal community situations. The results for Bassetlaw from December 2013 to December 2014 showed that between 87% and 100% of women would recommend the service to someone else. There were instances where 100% recommendation had been attained.
- Women told us they had a named midwife. They felt well supported and cared for by staff, and their care was delivered in a professional way.
- Labour ward had fold up beds which could be used by a woman's partner if they wished to stay overnight.
- Midwives told us in the event of a stillbirth, the woman did not have to be moved from her single room on labour ward if she didn't want to.
- There was a purpose designed counselling room near to the EPAU. Nurses used the room to break bad news, or if the woman was distressed after a scan.
- There were 'care in progress' signs on the curtains on ward B6 and in the examination room on EPAU. This protected women's dignity and privacy when the curtains were closed.
- Staff who spoke with us said they were proud of the care they gave; they felt like a family team.
- Whilst most women we spoke with felt they were treated compassionately, one pregnant woman in the assessment area on the ante/postnatal ward had not had an explanation of her care or been provided with a drink.

Understanding and involvement of patients and those close to them

- All the ward areas had informative boards either just outside the ward or in the ward clerk area. The boards contained information and photographs of staff and descriptions of uniforms for different roles.
- There were a range of information leaflets available in ward and clinic areas.
- The women we spoke with told us they were involved in developing their birth plans and had received sufficient information to enable them to make choices about their care and treatment during labour.
- Patients on the gynaecology ward told us they felt well informed and able to ask staff if they were not sure about something.
- Staff on the delivery suite told us there was no restriction on the number of birth partners a woman could have with her if she wanted.
- There were tea and coffee making facilities in all rooms on delivery suite.
- There was a large waiting area on the gynaecology ward. A female patient told us she felt "uncomfortable" sitting with male patients when waiting for a bed.

Emotional support

- Staff held an 'afterthoughts' service where debriefing and resolution meetings were held with women to discuss any concerns relating to their care and treatment and referrals were made to counselling or other specialist services, where required.
- There was a specialist bereavement midwife in post to support parents in cases of stillbirth or neonatal death. The midwife worked across both hospital sites.
- The bereavement midwife did home visits and offered counselling to women and their partners. She would also accompany women to outpatient appointments if they needed that level of emotional support.

Maternity and gynaecology

- There were no dedicated bereavement facilities within the unit. Some medical staff told us they thought the service could be improved by having am area designed for bereavement.
- We were shown a 'notification of pregnancy loss' form which, in the event of a pregnancy loss was sent to a woman's GP, the community midwife, and scanning department. This was sent to ensure relevant staff were aware of the pregnancy loss. Staff in the EPAU told us they would also ring the community midwife with this information.
- We spoke with one of the chaplaincy team and were shown a remembrance book for stillbirths or late miscarriages. The chaplaincy team were on call 24 hours and would come in to meet with women, their families and patients if required.

Are maternity and gynaecology services responsive?

Requires improvement

The gynaecology ward took a high number of outlier patients from other specialities.

The trust target for 18 week Referral to Treatment Times (RTT) for gynaecology patients was 90%. At Bassetlaw this had fallen from 84.6% in January 2015 to 68.5 % in March 2015.

On the gynaecology/ surgical ward the bays were open areas, without doors, and male patients had to walk past the open female area on the way to the toilet.

Bassetlaw had a higher than average number of women with gestational diabetes, however there was no specialist diabetes midwife in post. The teenage pregnancy midwife and substance misuse specialist midwife did not provide input into Bassetlaw hospital.

There were no designated obstetric scanning facilities at Bassetlaw Hospital. Women who were at risk of losing the pregnancy were scanned in a general ultrasound department. There was a high rate of induction of labour (over 34%, the England average is 22.5%) which meant women were on the delivery suite for long periods of time.

Senior staff members who spoke with us were aware of the increasing demands of the local and wider community, and the impact this had on maternity and gynaecology services.

The percentage of women booking in before 13 weeks of pregnancy was a good rate, at around 90% for the last three months of 2014. Bassetlaw maternity services had a low rate of women booking in late in pregnancy.

The hospital had an up to date 'Complaints, Concerns, Comments and Compliments: Resolution and Learning' policy in place. Staff told us they had the opportunity to learn from complaints or concerns. We observed a lot of thank you cards and complimentary letters in the maternity and gynaecology areas.

Service planning and delivery to meet the needs of local people

- Community midwives were locality based. This meant they could be more responsive to women in their own area as care was given at home or in the children's centres and GP surgeries.
- Maternity and gynaecology services worked with the local commissioners of services, the local authority, other providers, GP's and women who used the service to coordinate and combine pathways of care. For example, community midwives were able to use local authority children's centres to see women in the community rather than bringing them back to hospital.
- Bassetlaw was an area with high levels of deprivation and health problems such as obesity. Women who were obese are more likely to have diabetes that develops during pregnancy (gestational diabetes) than women who have a 'normal' weight. However, there was no specialist diabetes midwife in post at the trust as recommend in NICE guidelines.
- Women could be seen by a diabetes specialist nurse at the unit.
- The percentage of pregnant women who smoked at the time of booking had fallen from 24% in July 2014 to just over 12% in December 2014.
- The percentage of women who were smokers at the time of delivery had also fallen from over 26% in September 2014 to around 12% in December 2014.
- There was no smoking cessation midwife in post; however the healthy lifestyle specialist midwife had involvement with women who were smokers.

- Midwives told us they triaged maternity care over the phone. If there was any doubt about the care of a woman they advised her to come to hospital.
- There were no designated scanning facilities in the EPAU at Bassetlaw; women had to go to the ultrasound department with other 'general' users of the service. Women could refer themselves to the EPAU, or be referred by their GP or community midwife.

Access and flow

- The gynaecology ward took a high number of outlier patients from other specialities. The trust target for 18 week Referral to Treatment Times (RTT) for gynaecology patients was 90%. At Bassetlaw this had fallen from 84.6% in January 2015 to 68.5 % in March 2015. The trust explained this was agreed as part of an agreed national plan.
- Bed occupancy rates in maternity services during 2014 were between 40% and 43%. This was significantly lower than the England average of 59%. Staff who spoke with us told us the low bed occupancy rates were as a result of a successful telephone triage system.
- Women could self-refer, or be referred by their GP or midwife for a range of problems for example, bleeding, a change in their baby's movements, abdominal pains, or for advice. The midwives assessed women and gave appropriate advice on whether a woman needed to be admitted, stay at home or be seen by their GP or community midwife. There was a specialist registrar and consultant on call.
- The maternity unit closed on eight occasions between July 2013 and December 2014. This ranged from four hours to a maximum of 18 hours. During this time diversion to the Doncaster site was activated and access to trust maternity services was maintained as part of the escalations plans.
- Midwives told us the high rate of induction of labour in the unit (over 34% of births, the England average is 22.5%) meant that rooms on the labour suite were occupied for longer periods of time, thus reducing capacity and flow through the unit. Staff told us this was being reviewed. There was a possibility that induction of labour may be moved to the antenatal ward.
- The gynaecology ward had 31 beds. At the time of our inspection there were six medical patients and one orthopaedic outlier patient. Nurses told us outlier patients usually were transferred to the ward for a weekend just before their planned discharge date; they also told us since Easter 2015 a number of elective gynaecology patients had to have their surgery cancelled due to there not being a bed for them.
- There were five consultant surgeons who had patients on the gynaecology ward. Ward rounds also took place for the outlier patients on this ward. Staff told us there was a good system in place to make sure outliers were reviewed by the correct team and that communication took place during and after the ward rounds despite ward rounds overlapping at times.

Meeting people's individual needs

- The percentage of women booking in before 13 weeks of pregnancy was a good rate, at around 90% for the last three months of 2014. Bassetlaw maternity services had a low rate of women booking in late in pregnancy.
- We observed individual centred care on the delivery suite.
- We saw a midwife give information in a sensitive way to a woman whose baby needed to go to special care for some tests.
- The maternity service responded to the needs of vulnerable women. There were a number of specialist midwives who provided support in areas such as bereavement, patient safety, healthy lifestyle, breast feeding and safeguarding.
- The specialist midwives were 'shared' with Doncaster Royal Infirmary, however the trusts substance misuse specialist midwife and the teenage pregnancy midwife had input into vulnerable women at Bassetlaw.
- We checked the notes of two teenagers who had recently delivered babies. Neither had been referred to the teenage pregnancy specialist midwife. The teenagers had instead been referred to a family nurse practitioner in their locality.
- When we spoke with the safeguarding midwife later, she was unaware of the presence of the two teenagers. This gave us some concern about communication of safeguarding issues from one hospital to the other.
- Women could access their personal electronic maternity records at home.
- Access to translation and interpreter services was apparent. Staff told us they used telephone interpreters for 'basic' needs, but booked face to face interpreters for complex discussions or to break bad news.
- Women were given the name and mobile number of their midwife so they had it to hand if needed

Maternity and gynaecology

- Women who spoke with us in the maternity unit told us they were very happy with their care and that their individual needs had been well met.
- Hypnobirthing was available on delivery suite. Hypnobirthing is self-hypnosis, relaxation and breathing techniques used for pain relief during labour and childbirth.
- Delivery suite offered tours of the unit to pregnant women at less busy times. They also held parent craft and water birth sessions.
- We learned of individual maternity care being planned and given to a woman with learning disabilities. She had been encouraged to visit the ante/post-natal ward and delivery suite before giving birth. Maternity staff worked closely with her key worker and her mum had been able to remain with her throughout her admission.
- Nurses on the gynaecology ward told us planned termination of pregnancy (TOP) took place on a Wednesday and Saturday. Bassetlaw Hospital carried out 137 medical TOP's and 154 surgical TOP's between April 2013 and March 2014. It was not clear if women who had a TOP could choose whether they were admitted to the gynaecology ward or another general surgery ward.
- Staff told us they didn't have enough time to spend with women who had miscarried or had a TOP due to other work pressures.

Learning from complaints and concerns

- The hospital had an up to date 'Complaints, Concerns, Comments and Compliments: Resolution and Learning' policy in place. Staff told us they had the opportunity to learn from complaints or concerns.
- Learning from complaints was shared with staff through newsletters and staff briefings. Actions taken following complaints included a programme of work with Human Resources, improvements in communication, documentation and staff attitude.
- Complaints and concerns were reported to the matron and head of midwifery and were included on the agenda for monitoring at the governance meetings. When complaints were received, staff offered to meet the complainant, in order to try achieve early resolution to the complaint. Any meeting was followed up in writing, along with the outcome.
- Senior staff told us the main two themes of complaints were attitude of staff and communication breakdown.

Are maternity and gynaecology services well-led?

Good

There were risk, quality and governance structures in place. There was a women's, maternity and genito-urinary risk register, and a women's and maternity risk management report was published on a monthly basis. Maternity services had its own dedicated risk and safety team; they were involved in analysing audit data, publishing reports and producing a safety bulletin.

Staff described leadership and support from ward level and above up to the head of midwifery as good; we were told managers up to the level of head of midwifery were visible and approachable.

The staff we spoke with told us they were proud of the care they provided and spoke of positive team working between professionals and across disciplines. Strong team working was evident, with medical staff, midwives and midwifery support workers working cooperatively and with respect for each other's roles. There was evidence of positive working at a local ward level to make service improvements.

There was a 'Children and Families Care Group Operational Plan' in place for 2015-2017 but ward teams were not familiar with this document or its key objectives. Staff sickness was lower than average at less than 3.5 % in the maternity areas. It had been considerably higher than this on the gynaecology ward where it was almost 17% at the end of 2014; sickness had reduced to over 8% in March 2015

Compliance with mandatory training was good for midwifery staff. Compliance with mandatory training for medical staff was poor. The hospital data indicated none had completed neonatal and paediatric resuscitation.

We found there was disconnection between ward staff and the board. Most staff were unaware of the vision for the service. Senior managers were not clear on their strategy for Bassetlaw.

Vision and strategy for this service

- There was a 'Children and Families Care Group Operational Plan' in place for 2015-2017, however ward staff were not familiar with this document or its key objectives.
- The ward managers were able to describe the service they wanted to deliver, which was to have more high risk deliveries and induction of labour at Doncaster, but these plans depended on the senior team.

Governance, risk management and quality measurement

- A maternity risk register was in use and monitored on a monthly basis. There were processes in place for escalating risks to the trust board where required.
- The service used a quality dashboard that was reviewed on a monthly basis by the governance groups. This used a red/amber/green flagging system to highlight areas of concern.
- We were told how obstetric incidents were reviewed by the risk and safety team and their role in root cause analysis.
- Clinical governance meetings took place on a monthly basis and were held alternately at Doncaster and Bassetlaw. On labour ward we observed a folder and notice board which showed evidence reflecting the CQC domains. We were told this had been prepared for our visit, but had helped focus the team to future planning to ensure good outcomes in care and treatment for women.

Leadership of service

- The leadership structure in women's services was a care group director, a clinical governance lead, head of nursing and midwifery, a matron and a general manager. The care group director was accountable for the service.
- The leadership team were committed and enthusiastic.
- During discussions with the senior management team we found that they worked collaboratively with a mutual interest of improving services.
- The care group told us their challenges included staffing, including the medical workforce. A consultant had been recently recruited and locum doctors had been in post. The hospital made the decision to over recruit nurses and midwives to take account of any new recruits who did not take up their post.
- The head of midwifery told us she met with the director of nursing on a regular basis. There were bi-monthly head of nursing and midwifery meetings with the deputy director of nursing. The care group leaders also met together.
- When we spoke to front line staff about leadership they told us they felt supported, that their immediate leader was visible and credible but we found some disengagement between the trust board and the wards.
- The gynaecology ward had been supported over recent months by a matron from another area as their own was off sick. We were told the matron had other areas of responsibility and her availability for the gynaecology ward was compromised as a result of this.
- There were some barriers to staff giving optimum care such as staffing resources, particularly in relation to demands placed on the gynaecology ward.
- All midwives had a named supervisor of midwives (SOM) with whom they had an annual review; however the SOM's had been used in a performance management role which was at odds with the role of a SOM. The rate of SOM to midwives ought to be 1:15; that is one supervisor to 15 midwives; but we were told it was slightly higher than this at 1:16.
- SOM's were meant to use two days a month to carry out their supervisory role, they told us it could be a challenge to do this due to other demands on their time.
- The ante/postnatal ward manager at Bassetlaw shared peer leadership with the ward manager of the antenatal ward at Doncaster. They worked on each other's wards at least once a month to provide a 'fresh eyes' approach.
- Senior midwifery meetings took place on a quarterly basis. There were also monthly ward manager meetings.
- Doctors told us that midwifery leadership was good at ward level.
- There was a senior midwifery forum whose membership included the interim head of midwifery, specialist midwives, matrons, ward managers, a midwifery lecturer and patient safety leads. The purpose of the forum was to discuss mentorship for students, vacancy and recruitment of staff, demonstrate learning, provide links for the specialist midwives and embed the public health pathway needs of the community.
- We were told the medical director was involved with governance decisions at the hospital.
- It was generally felt that maternity leadership and morale had improved in recent months at Bassetlaw.

Maternity and gynaecology

Culture within the service

- We observed strong team working with medical staff and midwives working cooperatively and with respect for each other's roles. They told us that Bassetlaw was a 'good place to work'. Most staff we spoke with were positive and enthusiastic.
- Staff told us managers performed some hands-on care which made them credible and accessible. Staff viewed them as helpful and knowledgeable. Most staff felt confident their concerns would be listened to.
- Some midwives spoke of a 'them and us' culture between Doncaster and Bassetlaw. They felt they were used as a staffing resource for the bigger hospital.
- We were told staff sickness was lower than average at less than 3.5 % in the maternity areas. It had been considerably higher than this on the gynaecology ward where it was almost 17% at the end of 2014 and had reduced to over 8% in March 2015. We were told that human resources supported ward managers on managing sickness and absence.
- We saw a clear commitment to care and that teams worked constructively together to deliver good quality care. Nurses and midwifery staff were very flexible and worked hard to support each other. They all had a strong commitment to their jobs and displayed loyalty to senior staff.
- There was a transparent philosophy of reporting incidents when things went wrong.

Public and staff engagement

- The service had a Maternity Services Liaison Committee where women who used the service, parents to be, grandparents from the local area and midwifery staff came together to influence maternity services in the Doncaster area. The committee met on a monthly basis.
- Previous Friend and Family test results had been used to encompass suggestions from women and their families who had used the service, for example being able to have more visitors on delivery suite.

Innovation, improvement and sustainability

- We were told that other maternity services planned to visit the hospital to see the new electronic care record system and to share learning opportunities.
- The midwifery team were part of a regional forum which met on a monthly basis to share good practice.

Services for children and young people

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

Information about the service

The children's and families care group at Doncaster and Bassetlaw NHS Foundation Trust was responsible for services for babies, children and young people. The services at both Doncaster Royal Infirmary and Bassetlaw District General Hospital (BDGH) were managed by the same management team; documentation and policies and procedures were generally the same.

Bassetlaw District General Hospital site was 16 miles from Doncaster Royal Infirmary; some staff worked at both sites and others only worked at BDGH. There were two inpatient wards at BDGH; a special care baby unit (SCBU) with eight Level 1 cots used for babies from 32 weeks gestation and a children's ward (ward A3).

We found the children's ward had 22 beds and 14 were open for use at the time of the inspection; this could be increased to 18 if necessary. There was also a child development centre (CDC) where outpatient clinics were held. Children were also seen in the adult outpatients department. A small number of minor elective children's surgery cases were performed, with input from nurses and play specialists from the children's service.

There were 2183 children's admissions to BDGH between July 2013 and June 2014, 99% of which were emergencies, and 1% elective with no day cases. There were 2599 outpatient admissions during 2014 (Jan-Dec 2014).

During our inspection we visited all clinical areas where children were either admitted or attended on an outpatient basis, including the children's ward, SCBU, outpatients department and theatre suite. We did not visit the CDC as it was closed on the day of our visit. We talked with six medical staff, six nursing staff, a theatre co-ordinator, two support workers and the lead nurse. We also examined five sets of medical nursing records and spoke with nine parents, family members and children/young people.

Services for children and young people

Summary of findings

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

The service followed evidenced-based best practice guidance and participated in appropriate national and local audits. Children and young people had access to appropriate pain relief. Staff were competent to carry out their roles and received appropriate professional development. There was good multidisciplinary working within and between teams and children and families were provided with appropriate information. Consent procedures were in place and were followed.

Children, young people and family members told us they received supportive care and staff kept them informed and involved in decisions about their care and treatment. The service was responsive to the individual needs of the children and young people who used it. The service was planned and delivered to meet the needs of the children and young people who lived locally.

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 in order to try and ensure the needs of the children and young people using the service were met. Nurse staffing levels on the children's ward did not meet current national guidelines; staffing levels on the SCBU complied with current requirements.

The service did not have all of the necessary risk assessments in place for assessing children and young people prior to their admission and stay. For example, we found there were no nutritional risk assessments and no moving and handling risk assessments.

However, the management team were committed and feedback from staff was generally positive. There were systems and processes in place to assess and monitor the quality of service children and young people received. There were systems and processes in place to manage risk.

Are services for children and young people safe?

Requires improvement

The levels of nursing staff on the children's ward did not meet nationally recognised guidelines; staffing levels on the special care baby unit (SCBU) complied with current requirements for units in hospitals providing neonatal care. There were significant gaps in the medical staffing establishment, which meant medical locum staff were being used on a regular basis. Medical and nursing staff were under significant pressure to meet the demands required of their individual roles.

The service had systems in place to assess and respond to risk. However, not all of the expected individual risk assessments were in place to allow staff to make informed judgements about the care and treatment required for children and young people using the service.

We found all clinical areas were visibly clean and there were some systems and processes in place to reduce the risk and spread of infection. The environment and equipment used by the service was fit for purpose and well-maintained. Medicines were stored and administered correctly and medical records were stored securely and handled appropriately.

Staff knew how to report incidents and these were followed up by the senior nursing team, with lessons learned being shared and preventive measures put in place where possible. Staff of all grades confirmed they received appropriate mandatory training to enable them to carry out their roles effectively and safely and training included awareness of safeguarding procedures. Clinical educators attached to the service played a key role in the design and delivery of standard and bespoke training packages for all grades of staff and staff had been trained to deal with major incidents.

Incidents

- All staff on the children's ward had access to the trust's electronic incident reporting system. We were told that support workers reported incidents with assistance and medical staff also reported incidents. There had been 35 incidents reported at the Bassetlaw site since May 2014. Staff on the children's ward told us they felt confident

and competent in reporting incidents on electronic incident reporting system and they always received feedback. Staff on the SCBU told us the number of incidents reported there was low.

- Most incidents were categorised as 'no harm' or near misses. The service's last serious incident was in March 2013. Managers said Bassetlaw reported fewer incidents and they were not sure why. They said Bassetlaw saw approximately a third as many patients as Doncaster. They also said staff working for the service were good at reporting incidents. Managers were aware that Bassetlaw outpatients submitted incident forms mostly about systems and processes rather than clinical harm. They said staff also completed incident forms about staffing issues at Bassetlaw.
- When we looked at the information provided, we found there had been 56 incidents reported by the children's service from September to December 2014. We saw these were all for incidents occurring at the Doncaster site; none were for the Bassetlaw site. This meant we were unable to confirm whether incidents at the Bassetlaw site were being investigated and followed up appropriately or not.
- We attended part of the monthly clinical governance meeting for children's services at the Doncaster site during the inspection; we heard incidents reported by the service were discussed and lessons learned shared. Minutes confirmed this was a regular agenda item.
- Data submitted by the trust showed there was no evidence of an increased risk of paediatric and congenital disorders and perinatal mortality.

Cleanliness, infection control and hygiene

- All of the areas we visited were visibly clean, including the communal areas, toilets and bathrooms. We saw there were wall mounted alcohol gel dispensers at the entrance to the children's ward areas; these were also available throughout the wards. We saw nurses also had alcohol gel dispensers on their belts; the medical staff we observed did not carry personal alcohol gel dispensers.
- When we visited the SCBU staff explained that one of the nurseries was designated as an isolation nursery and babies were kept in this nursery until their (MRSA) swab results came back.
- We saw 12 completed 'Your experience counts' forms from 2014 displayed on the notice board in the senior sister's office. One said, "The ward was very clean." Some of the families we spoke with also commented on the cleanliness of the ward environment.
- Senior staff on the children's ward told us staff had a hand hygiene assessment annually and every month there was an observation of staff carrying out hand washing and use of alcohol gel. They said the infection prevention and control team worked across both sites. Nursing staff also told us the infection control link nurse was responsible for carrying out annual hand washing audits.
- Records provided by the trust prior to the inspection suggested that a significant proportion of staff on the inpatient wards had hand hygiene observations outstanding. Data seen during the inspection showed hand hygiene observations were outstanding for 20 out of 30 staff on the children's ward. Mandatory training records provided by the trust showed that only 6% of nursing staff on the children's ward, 7% of nursing staff on the SCBU and 17% of medical staff had completed their mandatory training in infection prevention and control, compared with the trust target of 85%.
- Senior staff on the children's ward told us the ward had an infection prevention and control link nurse. They said the ward environment was audited three times a year. However records submitted by the trust showed the last environmental audit on the children's ward was on 20 July 2014 and there were no dates listed for environmental audits on the SCBU. This meant there was no information to confirm whether the environment of the two inpatient wards had been audited over the past eight months.
- Data showed there had been no cases of MRSA between April 2013 and November 2014 within children's services. Trust data showed C. difficile rates at the trust were lower than the England average.

Environment and equipment

- We visited most of the areas where children and young people were cared for in the trust; this included the children's ward, the SCBU, the theatre suite and the adult's outpatient department where a children's clinic was being held. We did not visit the child development centre as this was closed on the day of the inspection.
- The special care baby unit (SCBU) had eight cots. There were four cots in each nursery and one was designated

as 'special care.' We found the SCBU had good facilities for babies and parents including a parent's room and a double bedroom for resident parents with adjacent shower and toilet. There was also a kitchen where parents and staff could make hot drinks and snacks, such as tea and toast. Parents we spoke with gave positive feedback about the facilities.

- We saw the clinical room, where medications were stored, staff room, sluice room, linen store, milk kitchen, cleaner's room and staff changing room were all fit for purpose and well-maintained.
- Senior staff on the children's ward (A3) told us it had been open for 18 years. They explained that it was a 22 bed unit originally but the ward currently had only 14 beds available. Senior staff explained they could 'flex up' to 18 beds if needed. The ward had eight individual cubicles, two of which had en-suite facilities. There was no separate assessment unit for children.
- We saw the facilities on the children's ward were suitably designed and well-maintained with child friendly décor, providing good facilities for children, young people and their parents. We looked around the ward, which included a treatment room, drugs room, clean utility, parent's room and kitchen. The only negative comment from staff about the ward environment was regarding the inability to open the windows. This had been reported but staff said they had been waiting over three years. Senior staff on the children's ward explained that building work had been due to start during April 2015. They showed us ward areas that had been cleared in anticipation of this. Work had started in the administration areas.
- On the inpatient wards we saw equipment storage was organised, clean and tidy. There was a secure resuscitation trolley on the children's ward and records showed other equipment, such as the oxygen suction, defibrillator and fridge temperatures were checked daily.
- There was a paediatric resuscitation trolley available in the adult outpatients department (OPD) at Bassetlaw. Staff in the children's OPD on the day we visited told us used the blood pressure machine from the CDC (child development centre) and there were not enough ophthalmoscopes and oroscopes in the adult OPD.

Medicines

- Appropriate arrangements were in place in relation to obtaining, recording and handling of medicines. Medicines were stored, prescribed and given to children and young people appropriately.
- We reviewed paper based treatment records on the children's ward and SCBU. Controlled drugs were checked and signed for daily.
- We looked at incidents reported by the service for the four month period from September to December 2014; no medication errors had been reported at the Bassetlaw site.
- At the time of the inspection the service's protocol was for two nurses checking medications prior to administration. It had been agreed in a governance meeting on 18 February 2015 that the service would move to single nurse checking of medications. This was intended to reduce the number of medication errors as this would remove the risk of involuntary automaticity. Involuntary automaticity means the second person doing the medication check automatically assumes that it will be correct.
- The senior sisters on the children's wards told us there were established procedures to follow to support staff when a medication error had occurred. There were also plans in place to roll out the service's staff support system to other parts of the trust.
- We were told the service had plans to introduce electronic prescribing and the clinical lead also told us the service also had plans to introduce a paediatric prescribing tool. This aimed to improve the safety of prescribing medication for children.

Records

- Children's and young people's medical records were accurate, fit for purpose and stored securely. We did not see any unattended notes during our inspection.
- We found the service used paper based care records with combined medical and nursing input and results were available to staff via the trust's Integrated Clinical Environment (ICE) system.
- We looked at five sets of care records and saw they were accurate and child and family centred. We saw care records included the risk assessments and care plans needed to ensure children's care, treatment and support needs were being met. We also saw that records which required completion by staff were all up to date and filled in correctly.

- Senior staff on the children's ward told us all of the policies and procedures and paperwork used at BDGH were the same as that used at the Doncaster site.
- All care records viewed on the children's wards and SCBU contained patient safety check sheets or stickers. These were used to ensure children and young people's care was monitored regularly. Information recorded on the patient safety check included whether the patient had a wristband, and equipment and alarm checks.
- The WHO surgical safety checklist was used for all patients undergoing surgery.

Safeguarding

- We found safeguarding for adults and children was a high priority within children's services and was well embedded. We found there were on-going safeguarding training, supervision and awareness sessions for all staff.
- Staff received safeguarding supervision sessions every three months and all senior sisters, matrons and clinical educators were trained as safeguarding supervisors. The service had a range of self-directed learning tools for staff, which had been in use for the previous 3-4 years.
- Staff on SCBU told us they received safeguarding supervisions every four months and there was a named nurse for safeguarding. Staff on SCBU told us the BDGH did not make as many safeguarding referrals as the Doncaster site.
- Senior staff told us the service carried out audits of staff safeguarding awareness, for example to assess staff knowledge of child sexual exploitation.
- Staff said they were well-supported by the trust's safeguarding team and had good links with other services as and when required. Within the trust there were two safeguarding nurses who were paediatric trained. The children's and family care group operational plan document for 2015-2017 showed that Bassetlaw historic sexual abuse cases would be managed by Sheffield Children's Hospital from January 2015 and the care group would follow up on care for all sexual abuse cases.

Mandatory training

- Staff told us they received appropriate training and professional development on a regular basis which enabled them to carry out their roles safely and effectively.
- The majority of staff told us they were up to date with their mandatory training; we did not view any training records at the Bassetlaw site to confirm this.
- However, trust data showed low percentages of completed training. For example, on the children's ward trust mandatory training records showed 22% of nursing staff had completed equality and diversity training, 50% had completed fire safety training and 59% had completed paediatric resuscitation, compared to the trust target of 85%. Trust records also showed 21% of nursing staff on the SCBU had completed equality and diversity training, 79% had completed fire safety training, 64% had completed paediatric resuscitation and 0% had completed neonatal resuscitation. However, data provided following the inspection showed staff compliance in all clinical areas is above 90% attendance for mandatory training
- Senior nursing staff told us they were aware that trust records for mandatory training were not accurate; this was the reason the service kept local records. Data provided following the inspection showed 93% of staff on the SCBU had completed basic neonatal resuscitation and advanced neonatal life support (NALS). The target was for more than 90% of staff to have received training.
- Staff on the SCBU told us there was a good uptake for mandatory training and all dates for training required were booked going forward. The clinical educators confirmed training dates were booked for the following 12 months. This showed the service planned training to ensure all staff were kept up to date.
- Senior nursing staff told us the trust had recently taken a subscription to a national nursing journal which meant staff could access its e-learning packages. The senior sisters on the children's wards told us this training included record keeping, drug calculations and conflict resolution.
- The clinical educators had worked with the senior nursing staff to produce a workforce training plan for nurses for 2015-2016. The management team told us this would provide good evidence for staff when they were due for revalidation with the Nursing and Midwifery Council (NMC). The clinical educators told us the development and training staff at the Bassetlaw site was the same as for staff working at the Doncaster site.

Assessing and responding to patient risk

- Staff carried out a basic assessment of the activities of daily living for each child and individual risk assessment tools were used when needs were identified. For example, we found the service was using a traffic light system to assess skin integrity for pressure sore risk assessment.
- Senior staff told us the service did not currently use a specific moving and handling tool or nutritional screening tool where risks had been identified. They told us patients who needed nutritional support would be referred to a dietician. This meant there was a risk that children and young people who required additional support with nutrition and hydration may not have their nutritional risks adequately assessed and followed up.
- The children's ward used the paediatric advanced warning score (PAWS) early warning assessment / clinical observation tool. This included a clinical observation chart which was used to identify any deterioration in the child's condition. When we checked PAWS assessments during our review of care records and found these were completed appropriately.
- In the SCBU care records we examined we saw there was a visiting list (signed by parents), which documented the names of people who were allowed to visit the baby when the parents were not on the ward.
- The hospital was part of the EMBRACE network. This is a specialist transport service for critically ill children and neonates in the Yorkshire and the Humber region. Staff we spoke with told us they accessed this service for advice and transfer of critically ill children and neonates to other hospitals.

Nursing staffing

- The SCBU had eight cots and when we visited morning of our inspection day we found it was staffed by a sister and a staff nurse plus a housekeeper (shared with ward A3). There were no ward clerks or healthcare assistants on the ward; the staff nurse told us nursing staff and doctors did all their own paperwork. There were two qualified registered nurses on each shift, early late and night. This basic staffing was compliant with BAPM (British Association of Perinatal Medicine) staffing standards.
- Staff on the SCBU told us they covered for sickness or other absence within the team; they said there were 14 staff in total. Otherwise they would try and get staff from the Doncaster site. One staff nurse explained that they were "on long term loan" from Doncaster Royal Infirmary.
- We found handovers were attended by medical and nursing staff and the senior sister on the children's ward was in medical handover when we arrived on the ward.
- The children's ward had 14 beds open and four additional beds which could be used when required. The senior sister told us staffing on the ward should be two (registered nurses) plus two (support workers) for day time shifts (early and late) and two (registered nurses) plus one (support workers) for night time duties. They said a new staff nurse had started in post the week prior to our visit.
- These staffing numbers gave a ratio of one registered nurse to seven patients during the day and night. The recommended minimum staffing levels for children's wards, as advised by the Royal College of Nursing (RCN) staffing guidance, is one RN to three children (under two years of age) and one RN to four children (over two years of age). The current staffing on the children's ward fell below this expected minimum.
- Senior staff explained that the ward currently had a 36 hour per week vacancy for a support worker and another support worker was off sick. They said this meant that on some days the daytime staffing was two (registered nurses) plus one (support worker). They said the ward had 10.74 whole time equivalent registered nurses and approximately seven healthcare assistants (support workers).
- The service very rarely used agency staff as part time staff were willing to do extra shifts as and when required and registered nurses were available through NHS Professionals. They said the service utilised staff across both sites in order to meet the demands of the service. This confirmed what senior staff told us regarding nursing staffing was being "tight" and the need to move staff around to make it safe. Staff confirmed they were frequently moved between wards and sites to cover for staff shortages; most accepted this was to meet the needs of the service.
- Senior nursing staff told us the children's ward told us the children's service had recently invested in the 'PANDA' (paediatric acuity and nurse dependency assessment) staffing acuity tool. The children's ward had been using it for 12 days and 12 nights when we visited. PANDA is a tool which assesses the nursing dependency

needs for children and calculates safe nurse staffing requirements. The management team explained to us that the results of this tool would be used to inform the nurse staffing establishment for the inpatient wards in the future.

- Senior staff said they were currently recruiting to various nurse positions. Sickness levels and staff turnover within the children's service were low.
- Several staff told us they had concerns that medical staffing numbers were a potential risk. They felt staffing pressures could affect the ability of the service to respond to emergency situations, such as those involving critically ill children and young people. They said these patients could have asthma, need intravenous medication or be a severe epileptic. There was no evidence to show that any patients using the service at Bassetlaw hospital had come to any harm.
- Medical staff we spoke with at Bassetlaw told us there were significant pressures on nurse staffing within the children's service; they said nurses were 'stretched' at times. Ward staff confirmed that there were staffing issues on the children's ward and said there had been occasions when there was only one nurse on duty. Staff also raised concerns about the time it took to travel between sites and not being able to take sufficient breaks due to the high workload. Some staff told us they regularly worked 12 hour shifts without a break. They also said 'ward attenders,' (where patients come to the children's ward for procedures such as blood tests), added to the pressure of the workload.
- Staff on the children's ward told us that critically ill children were sometimes transferred to the ward following paediatric resuscitation in the emergency department and there could be no high dependency cubicle available and no nurse for one to one care. They explained this left the other children and families on the ward without appropriate attention.
- We looked at copies of staff rotas from 2 to 29 March and we saw there were two late shifts during this four week period when there was only one registered nurse on duty for the 14 beds. We also saw that between 2 and 8 March 2015 for 10 of the 55 shifts allocated in the week staff (registered nurses and support workers) had written on the rota 'no break' and between the 9 and 15 March 2015 15 of the 63 shifts allocated in the week were annotated as 'no break.'
- Families we spoke with said they had not noticed any issues with staffing. Some parents told us that the ward was short staffed recently but felt it had not affected care.

Medical staffing

- At Bassetlaw we spoke with medical staff of all grades, including a consultant paediatrician, locum registrar and trainee doctors. They told there was a high use of locum medical staff and this was confirmed when we looked at the cross site on call rotas for January 2015. The service had a 'consultant of the week' system which covered both the Doncaster and Bassetlaw sites. These rotas showed that locum consultants had been used on the paediatric 'consultant of the week' daytime rota for two weeks out of four between 4 January 15 and 1 February 2015. Data submitted by the trust also demonstrated that medical agency locum use within the children's service at the Bassetlaw site was high, for example it was 51% in November 2014.
- Consultant staff told us they were concerned about the high use of medical locum staff, as this did not provide safety and continuity. Medical staff also raised concerns with us about the adequacy of senior house officer (SHO) and registrar cover for paediatrics at the Bassetlaw site. For example, if a SHO was at Bassetlaw on GP training they would cover paediatrics, gynaecology and obstetrics; this meant these staff may not be available for the children's service when needed and senior consultants often had to cover junior duties. The trust managers reported no incidents had been reported as a result.
- One consultant told us they had stayed at the hospital the weekend prior to our visit as there was no SHO on duty. They added that there was a national shortage of SHOs and registrars. They said some of the consultants lived an hour or more away from the Bassetlaw site and when they were on call they got called in.
- They said specialty trainees, SHOs or GP trainees (junior doctors) covered the SHO rota at Bassetlaw. They said this meant there were potential risks for patient safety at Bassetlaw due to the lack of experience of the medical staff on the SHO rota.
- Consultants told us they also had concerns regarding the recruitment processes and lack of checks made on agency medical staff. For example, we were told the clinical practice of locum medical staff was not monitored.

- Consultant staff told us they currently covered 'consultant of the week' at a frequency of one week in six. When this figure was adjusted for annual leave, it resulted in covering one week in 5.5. At the time of our visit there were nine consultant staff participating in the on call rota. Consultant staff told us they felt this placed them under increased pressure.
- Staff at the clinical governance meeting we attended at the Doncaster site said there were significant shortages in medical staffing. There was a 0.4 whole time equivalent (WTE) at tier 1 (foundation trainee) and 1.4 whole time equivalent (WTE) vacancy at tier 2 (specialty trainee). Managers told us they were advertising for two fixed term locum medical staff.

Major incident awareness and training

- We were told by senior staff that staff had been trained to deal with major incidents. They said laminated emergency evacuation action cards had recently been updated and were readily available at the nurse's stations; these covered different major incident scenarios. Awareness of these action cards and how to use them was checked as part of the assurance rounds carried out by senior nursing staff.
- When we visited the SCBU we saw these emergency evacuation cards were available in the ward office, these included:-
  - Business continuity action card
  - Risk assessment action card
  - Control of substances hazardous to health (COSHH) action card
  - Major incident action card

Are services for children and young people effective?

Good

The service had systems and processes in place to review and implement National Institute for Health and Care Excellence (NICE) guidance and other evidenced-based best practice guidance. The children's service participated in appropriate national audits relating to patient outcomes and carried out local audits according to the departmental audit plan.

Children and young people had access to appropriate pain relief and the service used an evidence based pain scoring tool to assess the impact of pain. Nutrition and hydration was identified as a potential issue, as the service did not use a nutritional screening tool. This meant children and young people with nutritional needs may not be appropriately supported.

Staff were competent to carry out their roles and received appropriate professional development, including an annual appraisal. There was evidence of multidisciplinary working within and between teams and children and families using the service were provided with appropriate information. Consent procedures were in place and were followed.

Evidence-based care and treatment

- The trust had systems and processes in place to review and implement National Institute for Health and Care Excellence (NICE) guidance and other evidenced-based best practice guidance, such as clinical outcome reviews. We saw in the minutes, and heard discussions during the meeting, that this was an agenda item at the monthly clinical governance meetings.
- We found the service was working towards achieving the Royal College of Paediatrics and Child Health (RCPCH) service standards.
- We saw that the service at the Bassetlaw site was involved in various local and national research and innovation development projects. These included:-
  - Feverish illness in children <5 years – based on NICE (August 2014)
  - PAWS audit carried out by the nurse educators (October 2014)
  - Paediatric discharge documentation (October 2014)
  - Childhood nocturnal enuresis (October 2014)
- The childhood nocturnal enuresis audit looked at new referrals to Bassetlaw for children with primary nocturnal enuresis (bedwetting), based on a NICE audit tool.
- At the time of our inspection the service was in the process of reviewing, updating, and re- publishing existing policies and producing new policies/guidelines. A senior manager told us the service had between 150 and 180 policies and 35 of these still needed to be

reviewed and updated. They told us these documents were currently stored electronically, but the service had plans to make these available on the intranet in the near future.
- During the discussions at the clinical governance meeting it was identified that policies were still needed for child protection clinics and signing off results from the ICE system, including destruction of the paper copies.
- The senior sister on the children's ward told us policies, procedures and other documentation in use at the Bassetlaw site was the same as at the Doncaster site.
- The children's service held audit meetings, such as the paediatric audit meeting and attended audit meetings within the trust, such as the medical audit meeting. Relevant audits were also carried out looking at the safety, efficiency and appropriateness of the service. For example, an audit of handover practice had been carried out in September 2014 and the results were to be included in the trust's handover policy.

Pain relief

- We found children and young people had access to appropriate pain relief as and when this was required.
- Senior staff told us that inadequate pain relief was not a recurrent theme within incidents and complaints relating to the service. They also said that completed patient experience forms confirmed that pain relief was not an issue.
- When we looked at the PAWS (paediatric advanced warning score) documentation in care records on the children's ward we found these had all been completed as required. The PAWS assessment includes an assessment of pain level.
- Families and patients we spoke with told us they had been given appropriate pain relief during their patient journey. This included pain relief in the emergency department, on the ward, prior to surgery and to take home.

Nutrition and hydration

- Families and patients we spoke with on the children's ward and the SCBU did not raise any issues with us about the quality of the food, or access and availability of food and drink. Parents on the children's ward and SCBU had access to kitchen areas where they could make hot drinks and snacks.
- Breastfeeding was promoted on the SCBU and breast pump kits were available in the milk kitchen; this was accessible to parents at all times. While we were on the SCBU we observed a baby having a nasogastric feed administered by one of the nurses.
- We found the service did not use a nutritional risk screening tool. When we asked senior staff about this they explained that adult nutritional assessment tools were not suitable for use in children. The service used dieticians to support children and young people with nutrition, however there needed to be a reliable system in place to identify those children and young people who need this additional support.

Patient outcomes

- Senior staff explained the service had looked like a national outlier for neonatal readmission rates for jaundice. They had done work around this and now the service had much lower readmission rates for jaundice; this showed the service was assessing patients correctly prior to discharge.
- The paediatric readmission rates for Doncaster and Bassetlaw overall were better than the England average. The rate of multiple emergency readmissions within 12 months for asthma patients was 16.5%, which was similar to the England average of 16.8%. However the rate of multiple emergency readmissions within 12 months for epilepsy patients was 38.1%, which was worse than the England average of 28.1%.
- The service participated in national audits such as diabetes and paediatric asthma. The latest available national paediatric diabetes audit was from 2012/2013 and showed results were similar to the England and Wales average. For example, the median HbA1c (average blood sugar) at Bassetlaw Hospital was 68 mmol/mol, compared with an England and Wales average of 69 mmol/mol.
- We saw that the children's service's 'audit forward plan for 2014-2015' listed 27 audits, nine of which were listed as completed, seven as ongoing, three as incomplete, one as a re-audit and one as 'not applicable.' We saw the remaining four audits listed did not have completion dates or registration dates; these included the epilepsy 12 national audit and NICE neonatal jaundice audit.

Competent staff

- Staff told us they were supported to develop their skills and knowledge. They said they received all the training

they needed to carry out their role safely and competently. The service's clinical educators told us all staff working in the service were given the same opportunities for training and personal development. The clinical educators ran a staff development day which was linked to patient safety.

- The clinical educators told us the service ran bespoke induction programmes, as there was nothing available nationally. They said these included workshops which covered different skills, such as nasogastric tube feeding. After six months in post nurses were trained in the administration of intravenous medications. They said the service also ran 'student (nurse) induction days.'
- The service had also developed a range of bespoke clinical skills packages for staff. One of the clinical educators told us these were updated to incorporate any changes to practice within the service, such as neonatal blood spots. They had also developed revalidation packages for nursing staff.
- Senior staff told us staff had regular supervision sessions, either individually or in groups. This was confirmed by the clinical educators and staff we spoke with.
- The service had an appraisal system for staff and we were told compliance rates were above the trust target. We looked at the professional development and appraisal (PDA) learning tools used by the service and saw these were very comprehensive. Staff on the SCBU told us the format was the same as at Doncaster but had been 'tweaked' to meet the different needs of the staff working at the Bassetlaw site. They said their appraisals were "all completed." However, data submitted by the trust showed none of the nursing staff on the children's ward or SCBU had an appraisal between April and December 2014. The trust target was 90%. Data for the previous 12 month period (April 2013-March 2014) showed 78% of the staff on the children's ward and 0% of staff on the SCBU had an appraisal that year. This suggested nursing staff appraisal rates were not meeting trust targets.
- We spoke with five medical staff on the children's ward at Bassetlaw who told us the training and clinical supervision they received was good and they felt well-supported by their clinical supervisors, consultants and the nursing team. One said the consultants at Bassetlaw were "amazing" and always came in to support them when needed. They said medical trainees got much more input from the consultant staff at Bassetlaw. They felt this was because Doncaster was much busier with 'lots of patients.'
- Junior medical staff we spoke with on the children's ward told us their revalidation was all up to date. Clinical staff told us the consultant appraisal and revalidation rates were "almost 100%." Trust data confirmed this and showed that 100% of children's medical staff had an appraisal between April and December 2014.

Multidisciplinary working

- The management team gave us good examples of multidisciplinary working, both within the service, with other hospital departments and outside agencies. For example, we were told sisters attended medical handovers and the medical audit meetings and the consultants attended the monthly clinical governance meeting.
- The neonatal lead consultant, lead nurse and sister from the neonatal unit at the Doncaster site represented the trust at the Yorkshire and Humber paediatric operational delivery meeting. One consultant told us representatives from the children's service attended a monthly meeting with Sheffield Children's Hospital.
- The clinical lead told us the service had good transition services for children in most areas, especially those with diabetes. For example, young people with cystic fibrosis began their transition to adult services at age 14 and young people with respiratory problems, such as asthma, began their transition from age 13. They said they had checked their practices with Asthma UK and the British Thoracic Society and they were in line with current recommendations.
- Staff recognised that transition services for young people with mental health problems and complex needs were not well-established.
- The management team told us the service did not have any problems with accessing child and adolescent mental health services (CAMHS) in a timely manner. They said the service dealt with a significant number of patients with eating disorders and self-harm. They said the CAMHS team usually came the following day when a referral had been made. Staff gave an example of how the children's service and CAMHS had worked well together to achieve the required outcome for a patient.

Services for children and young people

Seven-day services

- The service was working towards seven day working in paediatrics.
- Senior staff told us there were consultant ward rounds at the weekend and patients were discharged from the inpatient wards seven days a week. They said the play team did not work at the weekends and this was confirmed by staff and play leaders we spoke with.
- Senior staff told us they were hoping to improve nurse staffing for out-of-hours cover at the weekends once the new staff had been appointed. They said site managers were available to support nursing staff working out of hours and at the weekends.
- There was an out of hour's rota for consultants, which covered both the Doncaster and Bassetlaw sites.
- Staff we spoke with did not raise any issues relating to access of diagnostic services out of hours.

Access to information

- Staff and families we spoke with told us the service provided information which was timely and accessible, this promoted effective patient care.
- We saw the inpatient areas we visited had noticeboards displaying current and relevant information. We also found a suitable range of information leaflets were readily available for families and children; these were easily accessible.
- The senior sister on the children's ward told us the ward was awaiting the delivery of a new 'electronic ward board.'

Consent

- Senior staff told us consent documentation was audited by nursing staff every six months. They said the results of these audits did not raise any concerns about the consent processes within the children's service.
- They explained that consent forms were not only used for elective surgery. They said consent forms would also be used for other procedures, such as a patient who needed a blood transfusion. They explained that the service used implied consent for the majority of procedures carried out, as these would generally be classified as emergencies.
- In one of the SCBU care records we examined we saw that verbal consent had been obtained from a baby's mother for destruction of their baby's admission spot test.
- We spoke with parents of a child who was undergoing surgery and found they were very happy with the consent procedures. They told us everything had been clearly explained to the family, and their child had been included in the discussions. They also told us, and we saw, that they had signed a consent form for their child's surgery.
- Senior nursing staff told us that each patient's written consent was also checked against the details on the computer system (Bluesphier).
- Staff we spoke with showed they understood the Gillick competency standard surrounding consent. Staff told us young people were encouraged to be involved in decisions about their care and treatment.

Are services for children and young people caring?

Good

We spoke with nine parents, family members and children/young people during our visits to the different areas of the hospital where children and young people were seen. They all told us they had received supportive care. Children, young people and family members we spoke with all told us staff kept them informed and involved them in making decisions about their care and treatment. They said the staff were kind and had provided them with compassionate care and emotional support which had met their individual needs.

Feedback from surveys carried out internally by the service was positive. Systems used for gaining feedback from children and young people were being developed, as the service had recognised that the numbers of patients who been asked for their opinions in the past was low.

Compassionate care

- All of the families we interviewed on the children's ward and the SCBU were very pleased with the facilities and happy with the care they had received at Bassetlaw District General Hospital. We did not interview any families in the outpatients department. Families all said their care had been very good and staff were caring and supportive.
- Staff felt they provided a good service for children, young people and their families.

- Concerns were raised by staff about continuity of care for the patients that attended the outpatients department. We found there were plans in place to relocate all of the children's outpatient clinics to the CDC once the building works had been completed.
- Senior staff on the children's ward told us the ward had recently changed the patient feedback forms that were in use. They said the play team printed these off and handed them out to families for completion. We saw these were age specific For example, there were separate forms for completion by:
  - Parent / guardian
  - Young people aged 12 to 16
  - Young children aged 7 to 11
- Senior staff explained that up until three months ago they would only hand out feedback forms on one day a month, on the same say as the adult 'patient safety thermometer.' They now handed out eight a month to each age group. We saw a selection of comments were displayed on the notice board on the ward.
- We saw 12 completed 'Your experience counts' forms were on display on the notice board in the senior sister's office which dated back to 15 October 2014. We saw that the comments were all positive.

Understanding and involvement of patients and those close to them

- We observed members of staff talking with children and young people. We heard staff using language appropriate to their patient's age and level of understanding.
- Families we spoke with told us they were always kept informed and that the information was clear and concise. Staff introduced themselves and parent's knew who was their the named nurse.
- We looked at the Picker institute national children's inpatient and day case survey 2014 for Doncaster and Bassetlaw hospitals NHS foundation trust executive summary. We saw the trust was significantly worse than other trusts for the following questions (lower scores are better):
  - Hospital did not fully tell parents what would happen to their child in hospital, trust score 44%, average score for other trusts 26%.
  - Staff did not always provide clear information to parent about their child's care and treatment, trust score 31%, average score for other trusts 17%.

Emotional support

- Parents and children we spoke with on the children's ward and SCBU told us they had been well supported during their visits or stays. Parents we talked with gave examples of how the service overall and staff supported their children and themselves.
- The children's service at the Bassetlaw site had three play leaders who worked Monday to Friday. They provided distraction techniques when children were upset of frightened, for example when they were going to theatre or having blood samples taken. They also played with the children and if they were confined to bed they would take toys or games to their bedside. Parents we spoke with confirmed this.
- Staff on the children's ward told us there was good teamwork and support within the team and from the senior staff on site.

Are services for children and young people responsive?

Good

The children's service was responsive to the individual needs of the children and young people who used it. The service was planned and delivered to meet the needs of the children and young people who lived locally.

Children shared the OPD waiting area with adult patients. There was a lack of availability in new appointments in outpatients

Comments and feedback people made were responded to appropriately. The service kept records of the numbers of complaints received and when and where they occurred. Complaints were not always responded to within the trust response time.

Service planning and delivery to meet the needs of local people

- We found that the children's service had good links within the trust, commissioners, the local authority and other providers. These helped to ensure that services were planned and delivered in order to meet the needs of the local population.

- Senior managers told us the service had good relationships with local commissioners of services and that a representative had attended a consultant's meeting six weeks prior to our visit.
- Senior managers were aware that the local population had a high level of comorbidities. These are medical conditions that are present simultaneously in a patient. They said the children's service provided local care and was the second largest unit in the area.
- Child protection clinics were held in the outpatient's department; the matron told us play leaders from the service chaperoned children and young people at these clinics.
- The care group was in discussions with the clinical commissioning group and other agencies to establish an appropriate local infrastructure to support care for local sexual abuse cases.

Access and flow

- Access and flow was well-established within children's services at Bassetlaw District General Hospital. The 14 bedded children's ward was immediately adjacent to both the SCBU and CDC. The adult outpatient's clinic area, where children's clinics were being held on the day of our visit, was located some distance from the children's ward area; however there were plans in place to relocate this service once the building work was completed.
- There were eight patients on the children's ward on the day of our visit. Senior staff on the children's ward explained that the number of beds open on the ward had been reduced, from 22 to 14, following a clinical service review which had shown bed occupancy on the ward was 52-54% across the year. There were four additional beds available, which could be used as and when they were needed.
- Senior staff explained that the children's ward dealt with a small number of minor elective surgery cases, such as children needing circumcisions, hernia repairs and day case general surgery. On one day a week there was eye surgery for problems like squints and there was a dental list on one day twice a month. They told us there had been two orthopaedic surgery cases on the ward the day before our visit. They said the only emergency surgery carried out on site would be for orthopaedic cases, such as broken wrists. We found here was no formal pre-assessment carried out prior to surgery; pre-assessment was done in the outpatient's clinic. Staff told us patients also attended the ward in the afternoons for procedures such as taking blood.
- The children's ward provided care for children and young people with a predicted stay of more than 24 hours. Senior staff told us the ward did not have a designated stabilisation room for high dependency patients. They said most patients with asthma and epilepsy would come to the ward via the accident and emergency department. There was an open door policy for long term patients on the children's ward. Staff told us ambulances brought patients directly to the ward especially at night.
- Staff used a comprehensive paediatric advanced warning score (PAWS) monitoring chart to help them identify whether children and young people required transfer to a tertiary centre, such as Sheffield.
- The senior sister on the SCBU told us the bed occupancy on the unit varied, on the day of our visit there were two babies. Staff on the SCBU told us they used the EMBRACE service when transfers to other centres were needed.
- When we visited the children's clinic in the adults outpatient department (OPD) we found there was one staff nurse on duty and one general paediatric clinic was running. We were told one staff nurse would be on duty for either one or two clinics and in the Bassetlaw adults OPD. Staff were concerned about appointment timings for the children's clinics in the adults (OPD) clinic as these were sometimes booked for a time after the clinic was due to close.
- We were told that children's outpatient clinics were also held in the Bassetlaw CDC (child development centre) and at Mexborough hospital on a Wednesday.
- There was no sample collection service in adult OPD at Bassetlaw; this meant staff running the children's clinic(s) had to take sample to the laboratories, leaving patients and families unsupervised.
- We observed children and adults were sharing the OPD waiting area with adult patients. This meant care was not being provided in an appropriate location or in an environment that was well-suited to the age of the child or young person, as required by the National Service Framework for Children standard for hospital services.
- We were informed that when consultants were on call as 'consultant of the week' their outpatient appointments had to be cancelled. Outpatient cancellations affected

all specialties and included both new and follow up appointments. Results of the childhood nocturnal enuresis audit carried out at the Bassetlaw site between October 2013 and October 2014 also showed there was a shortage of outpatient clinic appointments for review at four weeks.

- We looked at the children's and families care group operational plan document for 2015-2017.This documented a lack of availability in new appointments in outpatients (OP). For example, the demand for new OP appointments was 5708 per year and the capacity was 4505. There appeared to be overcapacity in OP follow ups, with a demand of 9133 and a capacity 10,556. However we found the available appointments were not always in the correct clinic. For example paediatric cardiology, respiratory and neurodevelopment suffered from a lack of capacity, while general paediatrics and paediatric diabetes had sufficient capacity to meet demand. The trust recognised this and planned to recruit to vacancies to increase capacity.

Meeting people's individual needs

- Results of the 2014 national children's inpatient and day case Picker survey for Doncaster and Bassetlaw hospitals showed that overnight facilities for parents and carers were rated as fair or poor in 59% of responses. These results were significantly worse that the national average of 33%. As a result of this feedback all of the parents' beds on the inpatient wards were due to be replaced at both sites.
- Several of the staff we spoke with told us the trust was buying new parent beds. The service had been getting feedback from parents about the new beds before deciding which to purchase.
- Staff on the children's ward told us there were two nurses trained in phlebotomy (taking blood samples) and two more were due to be trained. On the afternoon of the inspection we found patients were waiting for blood tests on the children's ward and there was only one member of nursing staff on duty who could take blood.
- Staff told us the outside play area on the children's ward had been closed for a while, but had recently re-opened. It had been closed because the artificial surface had been identified as a hazard and had now been replaced.
- Staff we spoke with told us play leaders on the children's ward worked Monday to Friday and one also worked late in the emergency department until 6.30pm. Play leaders carried a bleep so other areas of the hospital, such as the accident and emergency department or adults OPD, could call them to attend and provide distraction for children in that area.
- The children's ward had a well-equipped play area and we were told it also had photo story books which the play leaders used when they took children to theatre. There were also 'tablets' for children and young people to play games on and access the internet. Staff said they could get new and replacement toys easily.
- The reception area in theatres was a shared area, with adults and children waiting in the same area before their operations. Theatre staff told us the theatre team ensured that children were not called to theatre from the wards until the team were ready to start the operation. This meant that children did not usually have to wait in the shared area.
- Staff told us there were no problems accessing translation services for black and minority ethnic (BME) families that required them. Senior nursing staff told us the service did not use family members to translate; a mixture of interpreters and a telephone interpretation service were used. They said the service's information leaflets could also be translated as and when required.

Learning from complaints and concerns

- Data showed children's services had received 28 complaints in the 12 months to April 2014 to March 2015 across both sites. We asked for details of complaints received, including investigation and follow up, during the inspection.
- Complaints data for paediatrics was submitted after the visit; however this recorded the location and month when the 28 complaints had occurred. This meant we were unable to assess whether the service was investigating and responding to complaints appropriately.
- In the children's clinical governance group minutes dated 18 February 2015 we saw that the number of 'learning from complaints and patient experience which needed to be shared with individuals/all staff' was recorded as 'none.'

- These minutes also identified that complaints were not always responded to within the trust response time. The management team told us some of the delays were due to waiting for responses from families about how they would prefer to proceed.
- Documents submitted by the trust after the inspection showed there had been seven complaints received by the children's and family services care group in December 2014, of which only 33% had been resolved within the trust time limit. We saw that three of these seven complaints were for paediatrics.

Are services for children and young people well-led?

Good

Overall we rated well-led as good. The management team were committed to the vision and strategy for the children's service and feedback from staff about the culture within the service, teamwork, staff support and morale was generally positive. There were systems and processes in place to regularly assess and monitor the quality of service that children and young people received, and we saw evidence which demonstrated evidence that feedback was acted upon to improve people's experience of using the service.

There were systems and processes in place to manage risk. There were issues relating to nursing and medical staffing identified over the last three years, which were on the risk register and remained under regular review.

Vision and strategy for this service

- The children's and families care group had an operational plan for 2015-2017; this included a review of children's and maternity services across Yorkshire and Humber. This was part of the working together programme and the strategic clinical networks programme.
- The operational plan also identified that the local clinical commissioning groups had been supportive in implementing plans which included investment in consultant staffing. The plan stated that this would free up resources for a better provision of emergency general paediatric support in the hospital's emergency department and children's observation unit.
- We found that the service was working towards seven day working in paediatrics as part of its quality plans; this is required as part of the Keogh recommendations. This would also improve ability to cope with the service's increasing demand, especially in the evenings.

Governance, risk management and quality measurement

- There were identified issues around nursing and medical staffing and recruitment of staff. Plans were in place to recruit more nursing staff, including a head of nursing for paediatrics.
- The operational plan, which was written in December 2014, identified the inability to recruit paediatric nurses and during our inspection we found there had been no significant increase in nurse staffing numbers since that time. This meant the service was unable to meet current best practice guidelines for staffing in paediatrics.
- When we met with the management team they told us the trust board had been supportive of the children's service in relation to the use of agency staff, overtime and closing children's beds. They told us the service had never been fully recruited to full establishment. This meant the service always had vacancies.
- The management team were unable to tell us what the full establishment of staff should be, for example they could not say what the expected numbers of nursing staff on the inpatient wards should be. They explained that the results of using the PANDA staffing acuity tool would help them establish what the required staffing levels should be and identify the gap between the required staffing and the current staffing.
- The management team told us the service's consultant staff worked across both sites and the nursing cohorts were site based. They told us nurse staffing at the Bassetlaw site was "tight." They said when more nursing staff were appointed and in post then band 6 staff would rotate across sites.
- Senior staff on the children's ward confirmed this and told us the new band 6 staff would rotate to Bassetlaw one week in six and the band 7s would do one in four Saturdays. There were no plans for support workers and band 5 nurses to rotate between sites.
- We saw the risk register had first identified pressures on nursing staffing and medical staffing in April 2012. The control measures identified staff recruitment as being in progress, however no other actions had been identified to manage and reduce the risk rating.

- We saw seven out of the ten risks on the risk register had been added to the register between April 2012 and September 2013 There were issues relating to nursing and medical staffing identified over the last three years, which were on the risk register and remained under regular review.The service had introduced management databases to monitor sickness, performance appraisal, patient safety and safeguarding supervisions. The wards also had quality assurance tools and a patient safety dashboard; these were used to provide assurance that the care provided for children and young people was safe.
- There was a lack of evidence to demonstrate how people's complaints were listened and responded to and used to improve the quality of care.

Leadership of service

- During our interview with the management team, we found they were well aware of the challenges the service faced and what measures they needed to put in place to deal with these. They confirmed the main issues as nursing and medical staffing.
- The general manager had been in post since September 2014 and several staff commented that things had improved significantly since they took up their position.
- We saw from the minutes, and were told, that the monthly clinical governance meeting was always held at the Doncaster site. We attended part of one of these meetings during our visit and found it was well-attended by nursing and medical staff, including the clinical educators and the service's patient safety lead.
- The lead nurse told us they visited the Bassetlaw site once a month. Staff we spoke with confirmed this and indicated they would prefer to see more of senior managers.
- Medical staff told us they felt listened to by the leadership team. They told us Bassetlaw was a good hospital for training and they enjoyed working in their speciality within the children's service. However several commented on the on-call frequency, saying this affected their ability to devote enough time to their chosen areas of interest.
- Some medical staff told us they felt they couldn't influence change within the trust and that when concerns were raised they didn't feel listened to.
- We found children did not have representation at the trust's board level and this was confirmed to us by the management team and clinicians we talked with. We found there was an executive board lead for safeguarding children. However, we were told there was no formal board-level director to promote children's rights and views as required by the National Service Framework (NSF) for Children standard for hospital services.

Culture within the service

- Staff we spoke with felt the service provided for families at the Bassetlaw site was good. They said there was good teamwork; staff worked well together and supported each other.
- Staff told us they felt well-supported by their line managers. Several staff commented on the quality and value of the training provided.
- The majority of the staff we spoke with were very happy working within the children's service at the Bassetlaw site, even though all of them told us it was very busy. They said it was a stable group of staff with a low turnover.
- Some staff told us that morale trust-wide and in the children's service could be better.

Public and staff engagement

- Local and national feedback surveys had been carried out by the service and we saw evidence that improvements had been made as a result. The service was working towards obtaining larger sample sizes which would give more robust data.
- Senior staff on the children's ward told us the service held staff meetings and that staff often attended these on their days off. Staff we spoke with confirmed this and said that information from the senior management team was shared at these meetings.
- We were told the SCBU at Bassetlaw used to run a parent's support group; however the attendance had waned so this group was no longer meeting.
- Staff told us they were kept informed about changes within the service and that they felt well-supported by their line managers.

Innovation, improvement and sustainability

- The management team us they were improving clinical coding. They explained that this would have a beneficial effect on the results of audits carried out by the service.
- The appointment of nursing staff to the clinical educator role was innovative and well thought of by staff, senior

nurses and the management team. The clinical educators worked alongside staff when checking staff competency and also worked clinically. The training programme was individually tailored and extensive. The service did not have an electronic medicines management system, but they planned to introduce one and were in discussion with two other hospitals that already had systems in place.

End of life care

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

Information about the service

Bassetlaw District General Hospital forms part of the Doncaster and Bassetlaw Hospitals NHS Foundation Trust and provides end of life care services on site and in partnership with Doncaster Royal Infirmary, community and hospice services. The hospital did not have any wards that specifically provided end of life care. Patients requiring end of life care were identified and cared for in ward areas throughout the hospital with support from the end of life care lead nurse and specialist palliative care team. Specialist palliative care was provided as part of an integrated service across both Bassetlaw and Doncaster hospitals. A WTE (whole time equivalent) end of life care coordinator was based on site at Doncaster Royal Infirmary but would provide support to staff at Bassetlaw. Across the trust there were three WTE specialist palliative care consultant posts (one post was vacant at the time of our inspection) and there were 4.3 WTE specialist palliative care CNS (clinical nurse specialists). One specialist palliative care nurse was based at Bassetlaw District General Hospital. We saw that referrals to the integrated service from April to December 2014 totalled 906, 82% of whom were patients with cancer and 232 referrals were for patients at Bassetlaw. Between April 2014 and March 2015 the end of life care coordinator had seen a total of 608 patients.

During our inspection we spoke with a palliative care consultant, the lead nurse for end of life care, the end of life care coordinator, the chief operating officer, director of nursing, specialist palliative care nurses, mortuary staff, chaplaincy staff, service staff, medical staff, ward managers, nursing staff, allied healthcare professionals and discharge facilitators. In total we spoke with 24 staff. We visited a number of wards and clinical areas across the hospital including general medicine, general surgery, cardiology, respiratory medicine, gastroenterology, and the Intensive Therapy Unit. We also visited the bereavement office, the chapel and the mortuary. We reviewed the records of two patients at the end of life and reviewed nine Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders. We spoke with one patient and two relatives and we reviewed audits, reports and strategy documents specific to end of life care.

End of life care

Summary of findings

We saw that end of life care services were safe, caring, responsive and well led. However, we saw that improvements were required in order for services to be effective. Mental capacity assessments were not being carried out on patients who were considered to be lacking capacity to be involved in discussions about DNACPR decisions. The trust needed to have a more systematic approach to recording mental capacity assessments in relation to DNACPR decisions where patients were unable to be involved in these discussions.

We observed specialist nurses and medical staff providing specialist support in a timely way that was aimed at developing the skills of non-specialist staff and ensuring the quality of end of life care. Specialist palliative care nurses provided a five day face to face assessment service which was different to the seven day face to face service available at Doncaster. While staff told us the Doncaster on-call nurse could see patients in Bassetlaw if required, this was not widely known by staff at Bassetlaw. There was an agreement by the trust board to recruit to a further two end of life care coordinator posts that would include an improved service for patients at Bassetlaw District General Hospital. We were told that staff were caring and compassionate and we saw the service was responsive to patients' needs. There were prompt referral responses from the specialist palliative care team and a good focus on preferred place of care and fast track discharge for patients at the end of life wishing to be at home.

Action had been taken against the issues identified in audits including the National Care of the Dying Audit. The implementation of the last days of life individual plan of care (IPOC) had been closely monitored by the end of life care coordinator with continuous reviews and feedback in place to develop this."A business case had been developed to increase the capacity of the end of life care service and the trust board had committed investment in improving the service as a result. The trust had a clear vision and strategy for end of life care services and participated in regional discussions and collaboration in relation to strategic planning and delivery of services to improve end of life care in the region.

End of life care

Are end of life care services safe?

Good

There were effective procedures in place to support safe care for patients at the end of life and staff demonstrated a good understanding of reporting procedures. There was evidence of learning from incidents and we saw that this was discussed as part of end of life care steering/ governance meeting Medicines were provided in line with national guidance and we saw good practice in prescribing anticipatory medicines for patient's at the end of life. We saw that specialist palliative care nurses worked closely with medical staff to ensure appropriate prescribing for patients at the end of life, including the use of local guidance for alternative prescribing for patients with renal impairment.

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms were generally completed consistently, with 78% of those we viewed being completed correctly. A risk register showed specific risks relating to end of life care and we saw that the trust had addressed these to improve patient safety. Attendance at mandatory training by specialist palliative care nurses was inconsistent and needed to improve in order to meet the 85% attendance target, particularly around infection prevention and control and safeguarding.

Incidents

- There had been no never events or serious incidents relating to end of life care reported in the twelve months prior to our inspection.
- Staff were aware of how to report incidents on the electronic incident reporting system and we saw evidence of this relating to end of life care.
- We were told that all end of life care incidents would be reported to the end of life care lead nurse who was responsible for ensuring incidents were investigated.
- There were eight incidents relating to end of life care recorded between December 2014 and January 2015 across the trust. For example we saw that when staff had not entered a patient onto the end of life care dashboard when started on the last hours/days of life individual plan of care (IPOC), this was reported. Action included the end of life care coordinator contacting the ward manager to remind them of the requirement to enter patient's details onto the dashboard.
- Managers and senior staff we spoke with had a good understanding of Duty of Candour and had attended relevant training about their responsibilities in disclosing to patients when an incident has occurred that could cause harm.

Environment and Equipment

- We viewed mortuary protocols and spoke with mortuary and services staff about the transfer of the deceased. We viewed manual handling training records that showed staff had been appropriately trained in the use of manual handling equipment.
- There was no specialist bariatric concealment trolley available for transferring deceased bariatric patients and no bariatric mortuary fridge at Bassetlaw. 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.
- Staff told us that there were generally no issues with obtaining relevant equipment for the care of patients at the end of life and that equipment was stored centrally and easily accessible to ward staff from an equipment library.
- We were told that McKinley syringe drivers were used on the wards and that nursing staff had been trained in the use of the pumps. We viewed a syringe driver monitoring chart, with 4 hourly safety checks of the administration of medicines via the pumps required.

Medicines

- We saw that the trust used the British National Formulary and the trust's own formulary guidelines for Palliative Care as guidance in prescribing medicines at the end of life. Guidelines were based on NICE (National Institute for Clinical Excellence) guidance and were recorded as algorithms as part of the Individual Plan of Care (IPOC) for the last hours/days of life.
- Guidance included treatment protocols for pain, respiratory tract secretions, nausea and vomiting, terminal restlessness and agitation, and breathlessness. There was also guidance available for the treatment of patients with renal failure.

End of life care

- Guidance was also available also available to staff electronically via a medicines management system on the intranet which would prompt prescribers in line with the protocols.
- A number of nurses within the specialist palliative care team were nurse prescribers and would support and guide junior medical staff in prescribing medicines at the end of life.
- We saw that the specialist palliative care nurses worked closely with medical staff on the wards to support the prescription of anticipatory medicines (medication that patients may need to make them more comfortable). The guidance the specialist nurses provided was in line with the end of life care guidelines and was delivered in a way that focused on developing practice and confidence in junior doctors around prescribing anticipatory medicines.
- There was a syringe driver chart as part of the last days of life IPOC that included guidance on setting up the machine and included prompts for assessing the patient 30 minutes after commencing a syringe driver and then every four hours. The assessment included checking the site of the infusion, the volume, rate and time remaining.
- We reviewed two medication record charts of patients who were considered to be at the end of life and in all cases we saw that anticipatory medicines were prescribed appropriately and in line with the guidance.
- We saw that controlled drugs were stored, administered and recorded in line with controlled drug guidance and that medicines for anticipatory prescribing for key symptoms were available and accessible.

Records

- We saw that all patients on admission were assessed and that these assessments were recorded including patient details, medical and nursing assessments and risk assessments, and care plans.
- Patients identified as being in the last days of life were cared for using an individual plan of care that had been developed by the specialist palliative care consultant and end of life care coordinator. The last days of life care plan included daily reviews and regular assessments of the patient's condition.
- Specific guidance was in place around diabetic management and pressure ulcer prevention in the last few days of life.
- We viewed the records of two patients who were at the end of life; one was being cared for using the IPOC for the last days of life. We saw that initial assessments were completed appropriately and accurately by nursing and medical staff with four hourly nursing entries generally recorded.
- The end of life care coordinator told us they were aware of issues relating to the IPOC not always being completed consistently and was in the process of implementing an audit to identify what the issues were.
- As part of the electronic record system an alert was triggered when a patient at the end of life was admitted or identified. This meant that through a process of record management, specialist staff were alerted to patients who may require specialist input.
- We reviewed nine Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms. The majority of these were completed accurately. In all cases we saw that decisions were dated and kept at the front of the patient's file. Two DNACPR decisions had not been approved by a consultant and one included 'frailty' as a reason for decision making.
- Discussions about DNACPR with patients and relatives were recorded in sufficient detail within the patient's notes.
- Syringe driver monitoring was generally completed and recorded every four hours for patients receiving medicines in via a continuous subcutaneous infusion.

Safeguarding

- We viewed mandatory training records and saw that four out of five (80%) staff members were within date of their safeguarding training.
- Staff we spoke with demonstrated a good understanding of their responsibilities in reporting safeguarding concerns.
- Staff told us the safeguarding team were accessible for advice and support.

Mandatory training

- Mandatory training for specialist palliative care nurses included conflict resolution, equality and diversity, health and safety, infection control and safeguarding children and adults. While all specialist palliative care nurses had attended health and safety training, attendance at infection control training was zero. Safeguarding children training stood at 45% and safeguarding adults at 55%. Fire safety training stood at

91% and manual and patient handling at 82%. Targets for all mandatory training were 85%. This meant that specialist palliative care nurse mandatory training had achieved this target in fire safety and health and safety only.
- Training for foundation year 1 (F1) doctors included end of life care, the use of the last days of life IPOC and rapid discharge.
- Training for nursing staff includes the use of the last days of life IPOC, syringe driver training and breaking bad news/communication and end of life care issues.

Assessing and responding to patient risk

- We observed the use of general risk assessments on the wards, including those relating to the risk of falls, and nutrition and hydration risks.
- The last days of life IPOC included specific assessments of risk relating to pressure area care and prescribing of medicines for patients who were diabetic or those who had renal failure.
- Early warning tools were in use throughout the hospital, with regular assessments guiding staff in identifying patients whose condition was deteriorating.
- We did not see specific areas of risk identified on the trust's risk register relating to end of life care.

Nursing staffing

- There were 4.3 WTE specialist palliative care nurses working across the trust with one part time CNS based at Bassetlaw. We saw that specialist palliative care nurses would rotate to ensure there was always cover at Bassetlaw from Monday to Friday. The specialist palliative care nursing team were managed by a lead nurse who also covered cancer, chemotherapy and acute oncology services.
- The end of life care coordinator had successfully developed a business case to increase the numbers of specialist palliative care/end of life care nurses by two across the trust. We were told these posts were due to be recruited to imminently and that there would be an end of life care coordinator based at Bassetlaw.
- Specialist palliative care nurses were available from 8.30 – 4.30 five days a week and they were able to conduct face to face assessments during this time. At the weekend, telephone cover was available from the specialist palliative care nurse based at Doncaster and we were told that if necessary a face to face assessment could be carried out at Bassetlaw.
- Nursing staff on the wards told us they generally felt they had sufficient staffing to prioritise good quality end of life care when needed and that they had processes in place to escalate staffing concerns should they arise.

Medical staffing

- There were two whole time equivalent palliative care consultants across the trust at the time of our inspection, with a third due to commence in post in September. The consultants worked across acute, community and hospice settings.
- We spoke with one junior doctor who told us they felt confident in dealing with end of life care issues and confirmed they had attended an end of life care training session as part of their induction into the trust. They were aware of how to refer patients to the specialist palliative care team and told us they had good access to the team during the week.
- The SPC Consultants provide an out of hour's on-call rota covering Doncaster and Bassetlaw, as well as other localities within the region. The Consultants provided specialist palliative medicine phone advice to health care professionals of patients being cared for by the employing trusts, whatever the patient's place of care. On-call advice was provided between 5pm at night and 9 am the following morning and at weekends.

Major incident awareness and training

- We viewed mortuary protocols where Doncaster & Bassetlaw Hospitals NHS Foundation Trust participated in the Mass fatality coordination group (MFCG) and health transfer planning meetings for South Yorkshire and Bassetlaw area. It stated that mortuaries at all sites could be considered for use.

Are end of life care services effective?

Requires improvement

We saw that end of life and specialist palliative care staff had a good level of competence to provide quality end of life care. We saw that where patients were identified by staff as lacking the mental capacity to be involved in DNACPR decisions, that family members were consulted and decisions taken in patients' best interests in three out of five cases, however we did not see records of discussions with family members in the other two cases. Mental

capacity assessments were not recorded in relation to DNACPR decisions where a patient was considered to be lacking the mental capacity to be involved in discussions about the decisions.

We saw that the trust had an action plan in place to address areas identified as part of the National Care of the Dying Audit (NCDAH), and that a number of areas had been addressed at the time of our inspection. The trust had taken action to plan and develop services in line with national guidance, with the implementation of last hours/ days of life individual plan of care for the assessment and coordination of care and symptom management of patients at the end of life. We saw that the Liverpool Care Pathway was no longer in use since the national phase out date of July 2014.

Evidence-based care and treatment

- The Liverpool Care Pathway (LCP) had been phased out nationally by July 2014 and staff we spoke with at Bassetlaw District General Hospital told us it had not been used since this time.
- We saw that end of life care documentation had included national guidance from sources such as the Leadership Alliance for the Care of Dying People, the Department of Health End of Life care Strategy, the National Institute of Clinical Excellence (NICE).
- An individualised plan of care (IPOC) for patients in the last hours/days of life was in use. The IPOC included guidance around the recognition of dying, preferred priorities of care and advanced care planning. There were plans in place to review and audit the IPOC alongside the 2015 National Care of the Dying Audit (NCDAH).
- The end of life care coordinator had trained a number of consultants and nurses within the trust in the use of the AMBER care bundle. (a tool used to help identify people in the last months of life so that they may be involved in open discussion and care planning about their future care) and were preparing to roll out the tool across the trust.
- Advance Care Planning (ACP) was an issue being addressed across the region due to inappropriate admissions from care homes of patients at the end of life, where not enough was known about the patient's wishes. Members of the SPC attended locality meetings with the CCG and other organisations where ACP was discussed within the context.
- We viewed plans to pilot the Gold Standards Framework (GSF) on 4 wards across the trust in 2015, including one ward at Bassetlaw District General Hospital. We spoke with the ward manager who told us they were taking part in the GSF pilot.

Pain relief

- Staff told us that there were generally adequate stocks of appropriate medicines for end of life care available including controlled drugs and these were stored and managed appropriately in line with national guidance and legislation. However, we saw one situation where a patient had to be prescribed an alternative medicine due to stock not being available. The patient's pain was well managed.
- We saw that patients' pain was assessed regularly as part of the last days of life IPOC and we saw that one patient we reviewed who was in the last days of life had received regular assessments of their pain. We also saw that medicines were titrated to manage their pain appropriately.
- A pain assessment tool using a 0 – 10 pain assessment score and a pain assessment care plan was available but we did not see this in use for the patients we reviewed.
- We saw that pain was assessed as part of an early warning score when monitoring patients' physiological parameters and we saw that patients' pain was assessed regularly as part of the last days of life IPOC.
- Alternative pain assessment tools that prompted staff to make a full assessment of a patient's pain incorporating the assessment of body language or facial expressions when patients were unable to score their pain were not seen although staff on a ward caring for people with dementia told us they had used them in the past.
- Regular comfort rounds were carried out and included asking patients regularly about their level of comfort.

Nutrition and hydration

- A Nutritional Screening and Assessment Tool was in use for all patients on admission to Bassetlaw District General Hospital.
- As part of the end of life care IPOC nutrition and hydration were assessed as an initial joint medical and nursing assessment and also as part of ongoing nursing assessments.
- Incorporated into the end of life care IPOC was guidance around the use of clinically assisted hydration and

nutrition. There were also prompts for this assessment and decision making to involve the multi-disciplinary team, as well as involvement of the patient and their relatives as appropriate.

- Staff we spoke with told us they were led by patient wishes in relation to oral intake of food and fluids and they demonstrated a good understanding of the use of food and hydration as part of maintaining comfort and patient choice at the end of life.
- We saw that staff administered regular mouth care to a patient at the of life and family members told us that staff had listened to them when they had questions about nutrition and hydration for a relative at the end of life. However, another relative told us there had been problems obtaining suitable foods for a patient at the end of life who had difficulties swallowing.

Patient outcomes

- The trust had taken part in the 2013/14 National Care of the Dying Audit (NCDAH) where they had achieved three out of seven organisational key performance indicators. The trust performed well in the use of clinical protocols for the prescription of medications for the five key symptoms at the end of life, care of the dying continuing education, training and audit; and, clinical provision/ protocols promoting patient privacy, dignity and respect, up to and including after the death of the patient .
- Bassetlaw performed higher than the England average in 8 out of 10 clinical key performance indicators, including multi-disciplinary recognition that the patient is dying, communication relating to patient's plan of care for the dying phase and a review of interventions during the dying phase.
- The trust had addressed a number of issues following the audit, including the appointment the chairman of the board as the non-executive director with specific responsibility for care of the dying, and the development of bereavement support training. A business case was developed to increase the nursing establishment at Bassetlaw hospital in line with the caseload. We viewed examples of internal audit programmes. One example included an audit of the patient alert system. An alert system was introduced to alert the end of life coordinator of any patients that had been commenced on the end of life IPOC. The aim of the audit was to establish current practice and identify areas for improvement. The results demonstrated an improvement in practice and the end of life care coordinator identified areas of training and feedback to specific clinical areas.

Competent staff

- There were 4.3 whole time equivalent specialist palliative care nurses across the trust with a further two new posts being recruited to. An end of life care coordinator was based at Doncaster Royal Infirmary and we viewed plans to develop additional end of life care roles to include Bassetlaw District General Hospital.
- We saw that the specialist nurses visited the wards on a daily basis to review patients at the end of life and to support ward based medical and nursing staff in planning and delivering care to patients.
- The end of life care coordinator and specialist palliative care nurses were alerted of all patients at the end of life via an electronic alert system. Staff also told us that specialist palliative care nurses would also visit the wards regularly to ask if they had patient's with end of life care issues.
- The specialist palliative care team and end of life care coordinator provided training for ward based staff including breaking significant news, communication at the end of life, end of life link nurse study days and syringe driver update training.
- Ward staff we spoke with told us it was sometimes difficult to access training due to staffing issues; however the end of life care team were able to attend the wards and deliver specific training relevant to the needs at the time. For example one member of the nursing staff told us they had received training in the use of the last hours/days of life IPOC on the ward. Staff told us that the palliative and end of life care specialist team were flexible in their approach for support and would spend time on the ward teaching staff and addressing specific end of life care issues.
- The end of life care coordinator maintained records of staff who had attended end of life care training. For example, we saw that 391 clinical staff across the trust had attended training in the end of life care IPOC.
- The end of life care coordinator told us they invited staff with an interest in end of life care to shadow them. Part of the agreement was that the staff member would have set goals relevant to their work area with agreed objectives to ensure their learning influenced care.

End of life care

Multidisciplinary working

- Members of the specialist palliative care team participated in multidisciplinary team (MDT) meetings, working with other specialists to support good quality end of life care across clinical specialities.
- A weekly specialist palliative care MDT meeting was held at Doncaster Royal Infirmary with teleconference access at Bassetlaw District General Hospital to ensure joint discussions and involvement across both hospital sites.
- Criteria for discussion at the MDT included all new patients referred to the specialist palliative care team, patients of particular concern, patients where a team member seeks support/advice of the rest of the team, patients who required the skills of the MDT to remain in their preferred place of care and patients who had died or been discharged from the service.
- Membership of the specialist palliative care MDT included the SPC consultant and nurses, the end of life care coordinator, the pain consultant, chaplain, social worker, dietician, pharmacist, physiotherapist and occupational therapist.
- Members of the team also attended specialist cancer, lung and upper gastrointestinal MDT meetings.
- All patients who were commenced on the individualised plan of care for the last hours/days of life were entered onto the nursing metrics dashboard for end of life care. An email alert was then sent to the End of Life Care Coordinator, Chaplaincy and Specialist Palliative Care Team to identify that a patient has been commenced on the care plan. Patients at Bassetlaw were seen by a specialist palliative care nurse with input if necessary from the end of life care coordinator who was based at Doncaster Royal Infirmary.

Seven-day services

- The specialist palliative care team provide a 5 day 8.30 – 4.30 face to face service at Bassetlaw District General Hospital where patients would be assessed in relation to their palliative and end of life care needs.
- At weekends a specialist palliative care nurse would be based at Doncaster Royal Infirmary and was available for telephone advice. We were told the specialist palliative care nurse would also be able to assess patients at Bassetlaw District General Hospital if required. However nursing staff we spoke with on the wards at Bassetlaw District General Hospital were not all aware of how to access weekend support from specialist nurses, although they were aware of the specialist palliative care consultant on call rota.
- The trust participated in a regional out of hours SPC consultant on call service where professionals caring for patients at the end of life could access advice. Staff we spoke with on the wards were aware of the availability of specialist advice out of hours.
- In addition, the trust SPC team were working with a local hospice to re-establish an out of hour's advice via a publicly available advice line.
- The chaplaincy service provided multi-faith pastoral and spiritual support, including out of hours cover via an internal on call system.

Access to information

- We saw that risk assessments and care plans were in place for patients at the end of life. Patients were cared for using relevant plans of care to meet their individual needs.
- Once a patient had been identified as being in the last days of life medical staff would use the individual plan of care for patients in the last days/hours of life. The guidance incorporated prompts for staff to assess patient symptoms, identify advance decisions and discuss wishes, feelings, beliefs and values with relatives or carers to ensure they were delivering care in a way that best meets the needs of the individual.
- We viewed records that included detailed information about the management of symptoms, discussions and interventions. We also saw that when patients were seen by the specialist palliative care team information and advice was clearly recorded so that staff could easily access the guidance given.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust's 'do not attempt cardio pulmonary resuscitation policy' provided guidance for completing a DNACPR form for an individual who does not have capacity, stating that when a specific care decision was to be made the Best Interests process under the Mental Capacity Act 2005 (MCA) must be followed.
- Of the nine DNACPR forms we viewed across a variety of wards and clinical areas in the hospital we saw that one included confirmation that the decision had been discussed directly with the patient. Of the other eight we

saw that three patients had DNACPR decisions made in the community prior to admission. For the other five patients we saw recorded that they were not able to be involved in discussions for a variety of reasons, including reduced consciousness (1), dementia (2), and confusion (1) and frailty(1). We did not see formal mental capacity assessments being undertaken in relation to DNACPR decisions.

- In two of five cases where a patient was not involved in discussions there was no record of the DNACPR decision being discussed with the patient's family.
- We viewed a quality and effectiveness audit report of DNACPR records and saw that actions had been identified to address the issues identified and improve quality. This included reinforcement of the requirement to involve patients with mental capacity in DNACPR decisions.
- Members of the specialist palliative care team demonstrated an awareness of the issues around mental capacity and best interest decision making, although they had not all attended mental capacity training. Staff told us the trust was addressing mental capacity awareness training for all staff.

Are end of life care services caring?

Good

End of life care services were seen to be caring. Patients and relatives told us they were generally happy with the quality of care they received and that staff were kind, caring and compassionate in their approach. We observed staff caring for patients in a way that supported them with compassion and respected their dignity.

We saw that patients and their relatives were involved in care and we viewed plans to develop advance care planning systems to ensure that patient's wishes and views were central to the care they received. Specialist palliative care and end of life care specialists had a good level of communication skills training. We viewed training programmes and evaluation records relating to breaking significant news and communication at the end of life and saw that these were areas in which the trust had prioritised and invested.

Compassionate care

- During our inspection we saw that patients were treated with compassion, dignity and respect.
- We observed staff caring for patients in a way that respected their individual choices and beliefs.
- Relatives we spoke with told us they were generally happy with the quality of care and they felt that the patients were well looked after. One relative we spoke with told us they couldn't fault the care and that they felt patient care was prioritised.
- A relative also told us that there was good communication and they were involved in decision making and kept informed at all times.
- A bereavement support service was available for people living in the Bassetlaw area. This provided one to one counselling support from qualified volunteers. The service was based at Bassetlaw hospital but could provide services in the community during the day, evenings and weekends.
- Support was available Monday to Friday from bereavement officers and volunteers in relation to issuing cause of death certificates and providing advice around procedures for registering the death and arranging a funeral.
- We saw that care after death honoured people's spiritual and cultural wishes. Staff told us they were able to source expertise from the local community around different cultures and faiths. We viewed an information folder on one of the wards that included advice for staff about different faiths.
- A bereavement support leaflet was available for relatives offering guidance on how to register a death and make funeral arrangements. There was also a list of advice and support organisations and how to contact them as well as information about bereavement and the emotional impact of this.
- Where possible patients at the end of life would be cared for in a side room. There were 2 palliative care rooms within the hospital, these rooms were designed to enable families to stay and provide a peaceful environment for patient's at the end of life. When the palliative care rooms or side rooms weren't available staff did their best to ensure privacy and dignity with the use of curtains and positioning of beds.

Understanding and involvement of patients and those close to them

End of life care

- Family members we spoke with told us they felt involved in the care delivered and we saw that where possible patients were involved in planning their care and their choices and preferences were taken into account.
- We saw that staff discussed care issues with patients and relatives where possible and these conversations were clearly documented in patient's notes. We observed the specialist palliative care nurses asking patients about their wishes and choices, for example about where they preferred to be cared for and any priorities in terms of their wishes.
- One relative we spoke with told us they felt involved in the patient's care and were asked about their preferences in terms of their care.
- We saw that the five priorities of care for dying people (LACD) were embedded into last days of life care guidance and the individual plan of care for patients at the end of life. For example we saw prompts in the guidance to remind staff to involve patients and those identified as important to them.
- Guidance literature was available for patients and their relatives. This included a booklet about the end of life and what they might expect to happen.
- Patient experience surveys were given to relatives of patients who had died at the hospital. Staff told us the return rate was generally poor but that they had been able to make changes as a result of the feedback they'd been given by relatives. One example of this was that free parking for relatives of patients at the end of life had been reinstated.
- The specialist palliative care team were involved in regional plans to develop a common advance care planning (ACP) document. We were told there was a plan to have an electronic ACP document to be shared across primary and secondary care where information such as DNACPR decisions and preferred place of care could be recorded, including specific information about the patient's wishes.
- Staff told us of plans they had to record relatives experience in the form of a diary to capture feedback at the end of life to encourage engagement with relatives and open communication.

Emotional support

- The specialist palliative care nurses had all successfully completed the National Advanced Communication Skills Training Programme (ACST).
- Training for general medical and nursing staff included breaking significant news and communication and end of life care issues. Breaking significant news training included the use of actors and role play. Training evaluations were positive with staff stating it had improved their confidence and reminded them to allow patients and relatives to have the time to express what they wanted to say.
- Staff we spoke with on the wards told us they had attended training on how to communicate with people at the end of life and the issues that should be considered in terms of supporting people emotionally at the end of life

- We saw that visiting times were flexible for family and friends when patients were at the end of life and we saw that relatives were able to stay with patients at the end of life if they wished.
- Concessionary car parking was available to relatives of patients at the end of life.
- Where possible, patients at the end of life were given the option to move to a palliative care room or side room to ensure their privacy and dignity and time with relatives. One ward manager we spoke with told us they would ring around to find a side room for patient's at the end of life.
- There was a chapel and multi-faith room available for patients, staff and visitors. The chaplaincy services within the trust were geared towards providing support for patients and their relatives irrespective of their individual faith or if they did not follow a faith.
- The chaplain was informed via the electronic alert system when a patient was identified as being in the last days/hours of life and would make contact with the patient and family to offer support if they should need or want it. One ward manager gave us an example of a patient who had died on the ward a few days before, telling us how the chaplain had attended and stayed with the family to provide support after death.

Are end of life care services responsive?

Good

All patients requiring end of life care had access to the specialist palliative care team and there was an end of life care coordinator based at Doncaster Royal infirmary who

would work with the specialist palliative care nurses to ensure a responsive service. We saw that referrals to the specialist palliative care team had totalled 232 at Bassetlaw District General Hospital in 2014/15. Specialist palliative care referrals were mostly for support with pain and symptom management, with additional support provided for patients and family members for people with complex end of life care needs. An electronic referral/alert system was in place for ward staff to alert the end of life care coordinator/specialist palliative care team when a patient was commenced on the last hours/days of life IPOC.

Staff, patients and relatives told us that end of life care services were responsive and we saw evidence of this during our inspection. We observed the specialist palliative care nurses seeing patients when required. However, there was not a 7 day face to face service available at Bassetlaw District General Hospital and there was no end of life care coordinator post based there. However, we saw that this was being addressed with the investment of additional resources in the service. Preferred place of care was recorded by the specialist palliative care team and via the last hours/days of life IPOC. Fast track discharge was prioritised for patients at the end of life and we viewed plans in place to further develop the service and improve access for patients who wanted to die at home.

Service planning and delivery to meet the needs of local people

- Preferred place of care at the end of life was recorded by the specialist palliative care team and as part of the IPOC in last hours/days of life.
- The trust has developed its own end of life care strategy, identifying key priorities relating to meeting the needs of people in the region. Six strategic priorities had been identified, including raising awareness of death and dying, providing high standards of end of life care through a skilled, confident and compassionate workforce and improving quality and governance.
- The end of life care strategy took account of the local demographic and identified issues such as deprivation, a reduced life expectancy, an ageing population and increasing levels of dementia. However it was not entirely clear how the trust were addressing these issues, particularly around end of life care for patients with a non-cancer diagnosis.
- The majority of patient's accessing the service were those with a diagnosis of cancer, however from the end of life care strategy we could see that there were increasing numbers of patients with other conditions within the population such as patients with dementia or those with disease relating to alcohol consumption.
- As part of the strategy there was an emphasis on rapid discharge home as national data demonstrated that home was the preferred place of death for 81% of people, whereas in Bassetlaw the percentage of people dying at home was 20%.

Meeting people's individual needs

- Staff on the wards told us that all patients with who had been started on the last hours/days of life IPOC would be referred to the end of life care team via the electronic alert system. They also told us that patients with complex needs would be referred to the specialist palliative care team for additional support, particularly when there were issues around managing their symptoms effectively.
- We observed specialist palliative care nurses assessing and monitoring patient's needs as part of their daily work.
- Staff told us that nurses from other specialities would be involved in care as necessary and that because end of life and palliative care services were incorporated into the specialist service directorate it meant there were clear pathways for working across different specialities to meet the needs of patients.
- We saw that patient care was individualised and we observed discussions around care and treatment decisions that demonstrated this.
- Mortuary, chaplaincy and ward staff told us they had access to information about different cultural, religious and spiritual needs and beliefs and that they were able to respond to the individual needs of patients and their relatives.
- Staff told us that interpreting services were available for patients who didn't speak English and for those who had other communication difficulties. We saw a hospital communication book available to staff with information on communicating with people with a learning disability. This included the use of pictures and symbols as well as advice and tips on the use of gestures, body language and tone of voice.
- We saw that advance care planning had been identified as one of the trust's priorities in terms of developing end of life care services. We did not view specific ACP

documentation in use on the wards but specialist palliative care staff told us this was an area they were working on. We saw that as part of the end of life care strategy, ACP had been identified as a key tool to raising awareness about end of life care issues among patients, relatives and staff.

Access and flow

- The patients whose records we viewed had gone through a process of assessment and risk assessment from both medical and nursing perspectives on admission.
- Ward staff we spoke with told us they knew how to access the specialist palliative care team during the week and that the team were responsive to the needs of patients. However, one staff member who had worked at Doncaster Royal Infirmary told us they felt there was less specialist support for end of life care issues at Bassetlaw District General Hospital. A doctor we spoke with told us there were limitations to the specialist palliative care service at Bassetlaw due to no cover at the weekend. A relative of a patient told us they felt there was poor inconsistency of specialist nursing input. We were told a part time specialist palliative nurse was based at Bassetlaw District General Hospital and that other specialist nurses would cover from Doncaster Royal Infirmary during other times.
- The end of life care coordinator and other staff within the specialist palliative care team acknowledged that there were less resources available within Bassetlaw f District General Hospital or specialist input but that this had been addressed within a recent business case to increase the service. As a result the trust board had committed to investing resources and increasing the end of life care team by 2 band 6 nurses and that this would include additional input for Bassetlaw District General Hospital.
- Staff we spoke with on the wards told us the specialist palliative care nurses would respond very quickly to concerns. One ward manager told us the specialist nurses would often be involved with patients before they were started on the last hours/days of life IPOC. The manager told us this was because the nurses would often visit the ward or call and ask if there was any patient's approaching the end of life.
- We saw that the specialist palliative nurse visited patient's at the end of life and provided specialist advice and support to ward staff, patients and relatives.
- The chaplaincy service was accessible 7 days a week via an on call system.
- We viewed an end of life care policy that incorporated a structure and guidance for rapid discharge at end of life. An integrated discharge team (IDT) was in place and guidance included the use of collaborative case conferences that involved the end of life care coordinator/specialist palliative care nurse, the IDT social worker and OT (occupational therapist) and the patient or their relative.
- Staff told us that generally rapid discharge could be organised within 4 hours although that could be affected by the availability of care packages in the community. Anticipatory medicines, equipment and transport could be organised in a few hours. One member of the discharge team told us that there could be some delays accessing equipment and transport but that generally they would be able to get patient's home within a few hours.
- Across the region work had been undertaken to develop a palliative care service in the community providing hospice at home services. They told us that once the service was established they would provide immediate support to patients being discharge where they were considered to be in the last hours/days of life.
- We did not see specific data relating to rapid discharge; however we saw an audit plan that included rapid discharge to commence in April 2015.

Learning from complaints and concerns

- While the lead end of life care nurse would be alerted to incidents relating to end of life care, the system to capture specific end of life care complaints was being developed to ensure appropriate involvements of the specialist team in the evaluation and learning from complaints.
- We were told that the specialist palliative care team and lead end of life care nurse were planning a 'time out day' to look at complaints with the complaints team and identify appropriate procedures for specialist support in relation to this.
- The lead nurse told us that at the time of our inspection because all complaints relating to specialist services would go to the head of nursing for the care group, then the lead end of life nurse would be alerted to relevant complaints as they arose.
- We saw that 'complaints and concerns' was a standing agenda item for the end of life care steering group

meetings. Minutes showed that the process for capturing end of life care complaints and details of specific issues and learning were discussed and acted upon as part of these meetings.

- One ward manager told us they had recently dealt with a complaint that involved a relative who had concerns about the care a patient received out of hours. The manager told us they had investigated the complaint and that learning identified the need for raising awareness about out of hour's access to specialist palliative care.

Are end of life care services well-led?

Good

The trust had a clear vision and strategy for end of life care services and had applied resources appropriately to develop end of life care services as a priority, including the appointment of a non-executive director to lead. We saw evidence of good leadership at board level and we saw a good approach to investing in services when a need and business case had been identified.

Gaps identified as part of the NCDAH had been addressed and there was visible, motivated and committed leadership in terms of end of life care at board and service levels and a number of initiatives were in place to develop services. We saw evidence of initiatives having been developed at specialist and ward level, notably the use of an electronic referral/alert system to capture patient's at the end of life and the development of palliative care rooms where patients could be cared for in a suitable space with their relatives with them.

Vision and strategy for this service

- A vision and strategy for end of life care identified key priorities including raising awareness of death and dying, the development of high quality and responsive services, the development of a skilled, compassionate and confident workforce was prioritised as well as collaborative working with other services in the region.
- The chairman of the board had been nominated as the lead Non-Executive director for end of life care within the trust and we saw minutes of meetings they attended where end of life care was discussed. One example of this was a discussion and endorsement by the board for end of life and palliative care nurses to move from 5 to 7 day working, aligned with the trust's objectives to improve end of life care.
- We viewed minutes of end of life care strategy meetings and saw that these meetings were attended by key staff such as the end of life care lead nurse and coordinator, specialist palliative care consultants, the speciality services group head of nursing and a strategy and delivery manager for the local CCG (clinical commissioning group).
- Strategy meetings incorporated issues relating to the development of services within the trust and across the region as a whole. Other issues addressed included education and training, as well as initiatives that were being implemented across the trust.

Governance, risk management and quality measurement

- Specialist palliative care reports within the structure of the speciality services care group.
- We viewed minutes from the end of life steering group where quality and governance issues were discussed and saw that these had been attended by the Director of Nursing. These meetings included discussions on areas of clinical governance including complaints, incidents and policy and guidelines.
- We saw that a speciality services care group quality and governance meeting was held monthly where quality and governance issues and actions were addressed. Areas discussed included learning from monthly Datix reports, infection prevention and control, duty of candour, learning from complaints and patient experience and training and development.
- Specific quality and governance objectives had been set for the speciality services care group, for example, ensuring 100% of clinical staff attended statutory training in the coming year.
- We saw the results of the National Care of the Dying (NCDAH) audit had been used to develop an action plan that was led by the end of life lead nurse and the palliative care consultants. We saw that the action plan had been implemented to address all areas identified from the audit. Key areas that the trust had addressed since the audit included the appointment of a non-executive director to lead end of life care, the

implementation of the last days of life IPOC, the move to seven day face to face service and ensuring end of life care is part of the trust's mandatory training programme for 2015/16.
- The trust had developed an internal audit programme for end of life care for 2015/16. Audits planned included the ongoing review of the IPOC alert system, rapid discharge home to die, patient experience questionnaires, the last hours/days of life IPOC, and end of life care teaching evaluation.
- Monthly mortality reviews were carried out with actions recorded and shared learning cascaded internally and via the CCG.

Leadership of service

- We saw evidence of good local leadership at ward level, with end of life care being seen by ward managers and staff as a priority in terms of quality and meeting patient needs and wishes.
- Staff spoke positively about the leadership of the end of life care and specialist palliative care service and we saw evidence of the specialist palliative care staff providing clinical leadership to ward staff in relation to end of life care.
- Staff we spoke with told us there was good senior level engagement, including the executive board, in improving end of life care. We viewed minutes of meetings where end of life care was discussed at board level and staff told us the director of nursing would often ask specialist staff about the issues they were facing.
- Staff on one ward told us they regularly saw the chairman of the board and members of the executive team on the ward and that there was a culture of openness between the board and staff.
- Staff consistently told us they felt that the trust board had been prioritising end of life care services in the 18 months leading up to our inspection. We saw evidence of review and investment in the service. For example, the end of life care coordinator told us that following a presentation to the board about increasing referrals to the service, agreement had been reached to increase the capacity of the service by two nurses across the trust.
- Senior executive staff we spoke with had a good understanding of the issues relating to end of life care.

Culture within the service

- Staff we spoke with demonstrated a commitment to the delivery of good quality end of life care. Ward staff felt proud of the care they were able to give and there was positive feedback from nursing and care staff as to the level of support they received from the specialist palliative care team.
- Specialist palliative and end of life care services had created a responsive, reflective service where they were easily accessible to ward based staff, thus creating a culture of good quality end of life care being a priority.
- There was evidence that the culture of end of life care was centred on the needs and experience of patients and their relatives. Staff told us they felt able to prioritise the needs of people at the end of life in terms of the delivery of care.
- One ward manager told us they felt there was a good culture of quality of end of life care at Bassetlaw. They told us this was demonstrated through a commitment by senior staff to ensure that end of life care was a priority within the trust.

Public and staff engagement

- Training and education programmes were designed to bring about skills and confidence in the delivery of good quality end of life care. We viewed training evaluations of each course the specialist palliative and end of life care services delivered and saw that this feedback was used to further develop the training to meet the needs of staff delivery the care on the wards.
- Staff we spoke with told us they had been able to feedback to specialist palliative and end of life care staff about the use of the last hours/days of life care IPOC.
- Relatives of patients at the end of life were encouraged to provide feedback via the patient experience questionnaire. Specialist staff also told us of plans to develop a relative diary so that relatives could record their and the patient's experience of care at the end of life so that staff could use this to learn from and develop the service, as well as improve the experience of patients and relatives.
- We viewed a strategy action plan that included the plan to raise public awareness of advance care planning and we saw plans in place to work collaboratively with other services across the region to do this.

Innovation, improvement and sustainability

End of life care

- The specialist palliative care team and end of life care coordinator were focused on continually improving the quality of care and we observed a commitment to this at ward level also.
- The development of the electronic alert system had ensured that patients were being captured by specialist staff at an earlier stage so that ward based staff could benefit from specialist input in relation to the delivery of good quality end of life care. This system had seen an increase in referrals to the service and had resulted in additional funding and resources to meet the growing identified need.
- Members of the executive team and staff working in the integrated discharge team told us of a new innovation in the community which provided a single point of contact for care in the community for patients requiring rapid discharge at the end of life. This was due to commence in May 2015 and we saw that the trust had worked collaboratively with the CCG and other organisations to address the issue of rapid discharge at the end of life.
- We saw evidence of innovation at ward level. For example we saw that two wards had received funding to develop palliative care rooms. One ward manager told us they had received good support from the trust to develop a calm and peaceful space for patients and relatives. They also told us there had been good commitment from staff across a number of departments, including the estates department, to ensure the room met the needs of the people using it.

Outpatients and diagnostic imaging

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

Information about the service

The outpatients and diagnostic imaging services at Bassetlaw District General Hospital covered a wide range of specialities.

For outpatient these included dermatology, trauma and orthopaedics, ophthalmology, respiratory, urology and general surgery. The imaging services included, plain film x-rays, fluoroscopy, mammography, ultrasound, DEXA, Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) and a limited number of interventional radiological procedures.

There were 102,146 outpatient attendances between January and December 2014 at Bassetlaw District General Hospital.

The outpatient services were provided in main outpatients and other specialty departments such as diabetes centre and cardiorespiratory unit. Outpatients and imaging services were managed as part of the Diagnostic and Pharmacy Care Group within the trust. The main outpatient's facilities and staff were managed by this Care Group, however the responsibility for the provision of the outpatient's clinics was held by individual Care Groups. Outpatient clinics ran Monday to Friday with some clinics being held on Saturday mornings.

Radiographer staffing for imaging services covering the hospital sites included a combination of permanent and rotational staff.

During our inspection at Bassetlaw District General Hospital we visited main outpatients including ophthalmology (eye clinic), fracture clinic, cardiorespiratory unit, gynaecology outpatient and the diabetes centre.

We spoke with eight patient and relatives, 12 members of staff and looked at four sets of records.

Outpatients and diagnostic imaging

Summary of findings

There is a legal requirement to protect the public from unnecessary radiation exposure. We saw that there were some doors with no signage that had unrestricted entry to x-ray controlled areas. This was raised with the trust and referred to the Health and Safety Executive. There were effective systems to report incidents. However, in some areas we were unable to identify clear systems and processes to evidence post incident feedback, shared learning and changes in practice resulting from incidents.

The percentage of staff that had undertaken mandatory training and received an annual appraisal was well below the trust compliance target of 85%, particularly within outpatients departments. It was unclear if this was a recording issue, but meant the trust could not be assured staff had the necessary training.

Paediatric resuscitation equipment was contained within the adult trolleys within the CT and main radiology department. Staff were unaware of this which posed a potential risk. We saw patient personal information and medical records were mostly managed safely and securely. Evidence-based guidance was available however there was limited evidence of audit to demonstrate effectiveness. This included IR(ME)R related audits.

All of the patients we spoke with across the department told us they were very happy with the services provided.

The management team were in the process of reviewing capacity and demand for outpatient clinics and recognised the need to address the rate of clinic cancellations by the hospital. Trust-wide data showed 16.8% of patients waited more than 30 minutes to be seen. Most referral to treatment targets were met including all cancer related targets. Medical imaging was not meeting the 6 week target referral to treatment target; however improvements had been made.

There was no centrally held list of all patients requiring a review or follow-up appointment.

An outpatient's services strategy had been drafted in December 2014. However, this lacked detail. A review of outpatient services had started to audit the current outpatient service delivery and clinical work streams but this was not yet completed. There were limited key performance indicators for outpatients. Radiology discrepancy and peer review meetings in February & March 2015 had been cancelled; this meant that the Royal College of Radiology (RCR) standards that the minimum frequency of meetings should be at least every two months had not been met, Eight meetings had been held in the period April 2014 to March 2015.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

There is a legal requirement to protect the public from unnecessary radiation exposure. We saw that there were some doors with no signage that had unrestricted entry to x-ray controlled areas. This was raised with the trust and referred to the Health and Safety Executive.

There were effective systems to report incidents. However, in some areas we were unable to identify clear systems and processes to evidence post incident feedback, shared learning and changes in practice resulting from incidents.

The percentage of staff who had undertaken adult and children's safeguarding training was well below the trust compliance target of 85%. Mandatory training was well below the trust's target compliance rate of 85% particularly within outpatients departments. It was unclear if this was a recording issue, but meant the trust could not be assured staff had the necessary training.

Paediatric resuscitation equipment was contained within the adult trolleys within the CT and main radiology department. Staff were unaware of this which posed a potential risk.

There was no evidence available to demonstrate patient call alarms were checked on a regular basis.

We saw patient personal information and medical records were mostly managed safely and securely.

Incidents

- Four patient-related incidents regarding outpatients at the hospital had been reported between September and December 2014. All were reported as causing low or no harm.
- Nine patient-related incidents had been reported for the same period regarding diagnostic related services. Three were recorded as causing low or no harm.
- There had been no never events in 2014 within outpatients & diagnostic imaging services (never events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented).
- Staff were aware of how to report incidents using the electronic incident reporting system. Most staff said they had received training on how to report incidents.
- Most staff reported they received some feedback when they had reported incidents.
- We saw from the Radiation Safety Committee September 2014 and Clinical Governance Sub Group (Radiation) February 2015 minutes that radiation incidents were recorded at these meetings and agreed follow up actions recorded and progress against the actions monitored at subsequent meetings.
- We also saw from these minutes the trust continued to report radiation incidents to the Care Quality Commission (CQC) under IR(ME)R and respond to actions as determined by CQC. Staff reported that the decision to report incidents to CQC were made at the clinical governance meeting and were supported with technical information from the medical physics team.
- A root cause analysis (RCA) was completed on all serious incidents and these were documented onto the trust's electronic incident reporting system. These were also monitored and reviewed at clinical governance meetings.
- We saw information regarding the Duty of Candour was displayed on screen-savers at the hospital. Not all staff were aware of the duty, but gave examples of being open and honest when things went wrong.
- All of the staff we spoke with were able to describe how they reported incidents and how they used the trust's incident reporting system.
- Staff we spoke with told us that incidents were discussed informally and at departmental meetings. Some staff said they received feedback following incidents. However, we were unable to identify clear systems and processes to evidence post incident feedback, shared learning and changes in practice resulting from incidents with departmental staff.
- The mangers within diagnostic imaging acknowledged there needed to be some improvement in incident management including the quality of reports, investigations, actions and review. The managers told us that as part of the service improvements an external learning company had been invited to support medical imaging.

Duty of Candour

Outpatients and diagnostic imaging

- We saw information regarding the Duty of Candour was displayed on screen-savers at the hospital. Not all staff were aware of the duty, but gave examples of being open and honest when things went wrong.

Cleanliness, infection control and hygiene

- The departments overall appeared clean, tidy and uncluttered. Patient waiting and private changing areas were clean and tidy. We saw cleaning records and schedules which showed clinic rooms and equipment were cleaned regularly.
- The trust policy was that all staff should be bare below in clinical areas and comply with hand hygiene guidance. We observed staff complied with the policy. Soap dispensers and hand gel were available in clinic rooms. Hand hygiene posters were visible.
- Monthly hand hygiene and cleanliness audits were undertaken. The average compliance rate for cleanliness audits within the Diagnostic and Pharmacy Care Group, over a six month period (October 2014 to March 2015) was 91% for Bassetlaw District General Hospital. Hand hygiene audits were submitted to the infection prevention and control team as part of the infection prevention and control accreditation scheme. The results showed high levels of compliance.
- Staff were aware of procedures to follow if patients were known to have a communicable infection.
- All respondents in an outpatient experience survey undertaken between January and March 2015 stated the departments were very or fairly clean.
- Sharps boxes were available and mostly signed and dated in accordance with trust policy.

Environment and equipment

- There is a legal requirement to protect the public from unnecessary radiation exposure. This includes clear signage on all doors that enter into an 'x-ray controlled area' to warn patients and staff not to enter the room of the red light is on. As we had identified lack of signage at other locations, we reviewed this at the unannounced inspection 10 days after our initial inspection. We saw that there were doors within the hospital with no signage. This meant there was a risk that patients would be unaware that they should not enter. This information was shared with the senior managers of the trust.
- The main outpatient's clinics and diagnostic facilities were purpose-built and fit for purpose. There was sufficient seating available in waiting areas.
- Resuscitation equipment was readily available for staff to use if needed across outpatients and diagnostics departments. Equipment was checked daily. We saw a paediatric defibrillator was available for use within the CT and main radiology department. During the course of the inspection, we established that following a risk assessment, paediatric equipment was contained within the adult trolleys and a paediatric back up trolley was available in emergency department. Staff we spoke with were unaware of this which posed a potential risk.
- The trust kept an inventory of imaging equipment.
- During the course of our inspection we observed that specialised personal protective equipment was available for use within radiation areas. Staff were seen to be wearing personal radiation dose monitors and these were monitored in accordance with legislation.
- There were systems and processes in place to ensure the maintenance and servicing of imaging equipment.
- There was no evidence available to demonstrate patient call alarms were checked on a regular basis.

Medicines

- Medicines were mostly stored securely. Where this was not the case, this was brought to the attention of the manager.
- Drug fridge temperatures within the outpatients department were checked regularly, however they were outside of the expected range on the day of inspection and had previously been up to 12.7º centigrade. This meant there was a risk that the effectiveness of the medicine could be reduced. We raised this with the manager at the time of inspection.
- Within medical imaging, we found that medicines were stored and checked correctly.

Records

- Records were stored in lockable covered trollies.
- Staff reported that records were available in a timely manner for clinic appointments. They spoke positively about the response from the medical records if records were not ready. This supported the trust report that 0.01% of patients are seen in outpatients without the full medical record being available.
- We looked at three outpatients records and found these were appropriately completed and entries signed, dated and timed.
- The imaging department had a central electronic patient records database, the Reporting Information

System (RIS). We looked at a total of four patient electronic records on RIS and saw each record included comprehensive detail of the patients imaging history. We also saw imaging request cards were also scanned into the electronic patient records.
- There was no evidence available to demonstrate that the quality of patient records were audited.
- The Picture Archiving and Communications System (PACS) is a nationally recognised system used to report and store patient images. This system was available and in use across the trust.
- We saw there were systems and processes employed to ensure the patient safety prior to MRI scans. The receptionist ensured patients completed a safety checklist and these were retained indefinitely.
- We looked at 12 completed checklists with the manager and we saw two of the checklists were incomplete. One had not been signed by the radiographer and a second, one of the questions had not been completed but the checklist had been signed by the radiographer. The remaining 10 were completed and signed correctly. The manager agreed to raise the issues identified with the staff.

Safeguarding

- The majority of the staff we spoke with were aware of their responsibilities to safeguard adults and children and on who to contact in the event of concern.
- For the outpatients departments, we looked at training data for clinical staff in outpatients including eye clinic. We found that 36% of staff had received adults safeguarding training and less than 20% had received children's' safeguarding training at Level 1, 2 or 3.
- Across the medical imaging departments (trust-wide), 81% of clinical staff had received adults safeguarding training. There was no specific data for diagnostic imaging at Bassetlaw District General Hospital.

Mandatory training

- We reviewed mandatory training figures across the outpatient department including eye clinic. Data showed that no nursing staff had received resuscitation training in the outpatients department and 6% in the eye clinic. The trust target was 85%.
- Data showed that within outpatients, 75% of nursing staff had received fire safety training, 55% health and safety training and 53% moving and handling training. No staff were recorded as receiving infection control training.
- All of the staff we spoke with told us they received ongoing mandatory training, although some were due refresher training, and they were responsible for ensuring they kept up to date.
- Mandatory training included eLearning modules and face to face events.
- We spoke with the self-appointed mandatory training coordinator for medical imaging. They told us that they took on the responsibility for monitoring and recording the mandatory training status for all of the radiology staff in June 2014. They send the information to all of the departmental managers with any information with regards to any planned trust mandatory training sessions.
- Since taking over this responsibility and following audit from June 2014 to December 2014 we saw from the evidence provided that significant improvements in the overall mandatory training compliance had been achieved. For example fire training in June 2014 showed 34% in December 2014; this had risen to 92% in March 2015. Information Governance, Safeguarding and resuscitation training also showed significant improvements between June and December 2014 with plans to re audit in June 2015.
- Staff reported they had not received mandatory training in conflict resolution training as these courses were not available. The trusts lone working policy identified that all staff who work alone should receive this training. Lone working was part of the duties of the imaging staff.

Assessing and responding to patient risk

- There is a legal requirement to protect the public from unnecessary radiation exposure. We saw that there were some doors with no signage that had unrestricted entry to x-ray controlled areas. This was raised with the trust and referred to the Health and Safety Executive.
- We saw that local rules were produced and available for staff to follow when undertaking radiation procedures involving the use of diagnostic X- rays April 2015. Managers and staff confirmed that the local rules were available within all of the diagnostic imaging areas.

Outpatients and diagnostic imaging

- The manager confirmed the trust had arrangements in place to seek advice from an external Radiology Protection Advisor (RPA) in accordance with the relevant legislation.
- The RPA's had produced an annual report in compliance with relevant legislation and actions from the inspections were picked up and monitored through the trusts Radiation Safety Committee.
- The principal function of the Radiation Safety Committee is to ensure that clinical radiation procedures and supporting activities in the trust are undertaken in compliance with ionising and non-ionising radiation legislation. The committee meets twice each year and receives reports from the appointed Radiation Protection Advisers, ensuring all recommendations are achieved.
- The manager of the service was the appointed and Radiation Protection Supervisors (RPS) and clinical governance lead for the entire imaging service and attended both the Radiation Safety Committee and clinical governance meetings.
- The service used an adapted version of the WHO surgical safety checklist, the Radiology Peri-Procedure Verification Checklist when carrying out all non-surgical interventional radiology procedures. There was no audit evidence available on the use of this checklist.
- Nurses employed in the department recorded the patients observations prior to and during non-surgical interventional radiology procedures. Early warning scores were recorded to detect any deterioration in the patient's condition during their procedure.
- Imaging request cards included pregnancy checks for staff to complete to ensure women who may be pregnant informed them before exposure to radiation. Imaging requests were scanned into the patient's electronic records.
- Within the outpatient's clinics, staff were able to describe action they would take if a patient's condition deteriorated. We saw an example of this during our inspection.
- Systems were in place to contact an emergency response team when required.

Radiology and Nursing staffing

- Staffing levels in the outpatients clinics were regularly reviewed and based on the previous year's activity.
- Sickness levels were above the trust average at over 5% and bank staff had been used. For Bassetlaw district General Hospital there had been an average of 7% bank nurse usage from January to December 2014.
- There was a registered nurse in charge of each clinic we visited.
- Specialist nurses held a range of outpatient clinics.
- The departmental manager told us that at the time of inspection the medical imaging service was staffed by five full time radiographers and three part- time staff including evening cover. This was in addition to additional rotational staff from Doncaster Royal Infirmary. CT and MRI services were covered by staff on rotation from Doncaster Royal Infirmary. Ultrasound was staffed by 4.2 whole time equivalent, permanent staff. Nine radiographers had recently been recruited and were due to commence into post from June/July 2015.
- Specialist nurses also rotated from Doncaster to support interventional radiology procedures at Bassetlaw district General Hospital.
- Staff sickness within medical imaging was on average below the trust target of 3.5%.
- Staffing and recruitment was on the departments risk register.

Medical staffing

- The individual Care Groups were responsible for identifying and managing the medical staffing for the outpatients clinics. Medical staff were allocated to individual clinics. For March, across the trust 594 clinics had been cancelled or changed; this was frequently due to availability of medical staff due to annual leave, study leave or on-call commitments.
- There were 12 full time radiologists across the trust and two part time radiologists and we were told there were plans to recruit a further three additional radiologists.
- Five out of the seven interventional radiologists provided on call and discussions were ongoing to provide a regional system and network of on call interventional radiologists.

Major incident awareness and training

- The trust had major incident and business continuity plans in place. We saw these were available to staff.
- Staff we spoke with were aware of these plans and how to access them.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Evidence-based guidance was available however there was limited evidence of audit to demonstrate effectiveness. This included IR(ME)R related audits. Radiation Exposure/ DRLs were not audited regularly. Patient's records were not routinely audited.

Staff had not received an annual appraisal. Performance against the trust target of 85% was low, particularly within outpatients.

Some systems were in place to assess staff competency to undertake aspects of their role. Staff with the imaging department experienced difficulties in obtaining support from the trust to maintain and keep up to date with their continuing professional development (CPD).

Staff had not received training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Evidence-based care and treatment

- Staff had access to evidence-based guidance via the trust intranet.
- The trust had an Ionising and Non Ionising – Radiations Safety Policy. The policy included the principle radiation legislation, local rules and description of the duties to be undertaken by staff in accordance with the legislation.
- The trust was aware of recommended national reference doses for radiation exposure. Diagnostic reference levels (DRL's) are used as an aid to optimisation in medical exposure.
- IR(ME)R advice and trust policy was that radiation exposures doses should be audited against the DRL's on a regular basis. Staff told us that there were no recent DRL audits available. Senior managers confirmed that there were plans to audit doses against the DRL's across the Trust.

Pain relief

- Staff confirmed that patients were prescribed pain relief, as needed.
- Local anaesthetic was available for minor procedures undertaken in the clinics.

Patient outcomes

- Managers confirmed there were no recent clinical audits undertaken across the diagnostic imaging service.
- There was limited evidence of audit planed across the general outpatients. The audit schedule for 2015/16 consisted of the outpatients experience survey.
- For July 2013 to June 2014 the trust's 'follow-up to new' rate (the ratio of follow up appointments to new) was better than the England average for Bassetlaw District General Hospital.
- An outpatient clinic reconciliation slip was completed for each patient. This recorded the attendance and outcome for each patient.

Competent staff

- For the outpatients departments, we looked at data for nursing staff in Bassetlaw District General Hospital outpatients and found that 33% of staff had received an appraisal between April 2013 and April 2014; 22% of staff had an appraisal between April 2014 and December 2014. The trust target was 85%.
- Across the trust's medical imaging department, 77% of staff had received an appraisal between April 2013 and April 2014; 69% of staff had an appraisal between April 2014 and December 2014. The majority of the staff we spoke with told us they received appraisals.
- Staff told us they could access e-learning via a trust-wide subscription to a national nursing journal. Staff had used this and gave examples of development modules they had completed.
- Staff with the imaging department reported that they had experienced difficulties in obtaining support from the trust to maintain and keep up to date with their continuing professional development (CPD). Senior managers acknowledged there had been historical problems in staff accessing support for CPD. They also told that the care group had plans in place to address and support staff access to CPD.
- Nine members of staff were trained and qualified to undertake the role of radiation protection supervisor (RPS). Two were based within nuclear medicine and the remaining seven based within diagnostic radiology.
- The trust provided evidence of competence update for one its RPS in 2015. There was no other evidence provided for the remaining eight.

Multidisciplinary working

Outpatients and diagnostic imaging

- Specialist radiologists were part of the multi-disciplinary teams for example, gastrointestinal and breast multi-disciplinary teams.
- Staff reported good working relationships within multidisciplinary teams. Specialist nurses ran clinics alongside medical staff. We spoke with members of the multidisciplinary team in some clinics and they gave positive examples of multidisciplinary working.

Seven-day services

- The medical imaging services provided at BDGH included plain film x-rays available 24 hours a day. CT scans were available Monday to Friday with an additional on-call service. An MRI service was available 12 hours a day, 7 days a week. Ultrasound was available seven days a week. Most other services were provided Monday to Friday.
- Outpatient clinics ran Monday to Friday.

Access to information

- An outpatient experience survey undertaken between January and March 2015 showed 81% of respondents were aware they could request copies of letters sent between the hospital team and their GP. We saw this was displayed in the clinics.
- 98% of respondents were happy with the amount of written information given to them regarding their condition.
- CT radiology reports out of hours were outsourced to an external provider under contract. There were systems and processes in place for monitoring the quality, tracking and timings of outsourced radiology reporting.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had policies and procedures in place for staff to follow in obtaining consent from patients.
- The majority of general outpatient and x-ray procedures were carried out using implied consent from the patient and we were told this was not documented. The trusts consent procedures were followed when performing more complex or invasive radiological procedures.
- Some staff we spoke with told us they were aware of the Mental Capacity Act and Deprivation of Liberty Safeguards, but most had not received any training. The trust had recently implemented a new approach (from February 2015) to delivering Mental Capacity Act and Deprivation of Liberty Safeguards training as part of the safeguarding training programme.

Are outpatient and diagnostic imaging services caring?

Good

All of the patients we spoke with across the department told us they were very happy with the services provided. We observed that staff were courteous when caring for patients and were seen responding to patient's individual needs in a timely manner.

Patients and their relatives we spoke with said that processes and procedures were explained so they understood their care. Results of an outpatient survey showed all respondents felt they had enough time with the healthcare professional, they were listened and felt able to ask any questions they had.

Compassionate care

- An outpatient experience survey was undertaken between January and March 2015. All respondents stated the receptionist was courteous, that staff introduced themselves and that they were given enough privacy and dignity during their appointment.
- All of the patients we spoke with across the department told us they were very happy with the services provided.
- We observed that staff were courteous when caring for patients and were seen responding to patient's individual needs in a timely manner.
- Care was provided in individual consulting rooms; we noted that doors were shut to ensure privacy.
- Chaperones were available and notices were in place advising patients to ask. The trust had guidance available for staff on the use of chaperones.
- A number of clinics used a ticket system for calling patients for appointments. This meant that a number was called rather than the patient's name to allow for privacy.
- The trust had used 'Your opinion counts' feedback forms. We saw these were mostly positive. Negative comments were about waiting times and not being informed.

Outpatients and diagnostic imaging

- The trust had introduced the friends and family test within outpatients two weeks before our inspection visit. The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. We saw 28 completed cards and these were all positive.

Understanding and involvement of patients and those close to them

- An outpatient experience survey undertaken between January and March 2015 showed all respondents felt they had enough time with the healthcare professional, they were listened and felt able to ask any questions they had. Patients who had tests felt the process was explained in a way they understood.
- Patients and their relatives we spoke with said that processes and procedures were explained so they understood their care.
- Within medical imaging department we saw patients and people close to them being consulted prior to procedures and staff were attentive to their needs and we saw no undue delays evident for treating walk in and out patients.

Emotional support

- We spoke with clinical nurse specialists who described their roles and how they offered emotional support.
- A psychotherapist held outpatients clinics weekly.

Are outpatient and diagnostic imaging services responsive?

Good

The management team were in the process of reviewing capacity and demand for outpatient clinics and recognised the need to address the rate of clinic cancellations by the hospital. Trust-wide data showed 16.8% of patients waited more than 30 minutes to be seen.

Most referral to treatment targets were met including all cancer related targets. Medical imaging was not meeting the 6 week target referral to treatment target; however improvements had been made.

There was no centrally held list of all patients requiring a review or follow-up appointment. Some lists were held by individual consultants which could be a risk in that patients could become 'lost' in the system, though we did not identify any at the time of the inspection.

There were positive examples of meeting patient's individual needs.

Service planning and delivery to meet the needs of local people

- The management team were in the process of reviewing capacity and demand for outpatient clinics. This was part of a 'right sizing' project. It was recognised that demand for clinic appointments had increased. There was increased collaboration across the care groups to ensure the service was planned and delivered to meet patient need; however it was recognised that there was further work required.
- Choose and book was used in approximately 80% of cases at BDGH.
- Patients were able to choose to be seen at the hospital site of their choice, depending on clinic availability.
- Waiting areas provided access to drinks and most we saw had sufficient seating.
- Mobile CT and MRI sessions were planned to increase capacity when required to avoid future breaches of access targets. A business case for a second CT and MRI scanners had been developed.
- We were also told that the radiology reporting workload was not sustainable with the increasing demands on the service and in the longer term routine reporting may have to be outsourced.

Access and flow

- Medical imaging was not meeting the 6 week target referral to treatment target. Data showed that at March 2015, 96.7% of patients waited less than 6 weeks from referral for a diagnostics test against a target of 99%. This meant a total of 280 patients were waiting more than 6 weeks; this was improved from 565 patients in January 2015.
- The radiology department had recently commissioned a new radiology information system (RIS). There had been a number of system problems which included several patients not being visible on the RIS system. This caused a sudden spike in the number of referrals to be booked

and put the department in a breach position in May 2014. These patients were entered onto the system manually. There were plans to address the system issues to prevent recurrence.

- The NHS intensive support team (IST) had undertaken a review at the trust and in May 2014 confirmed the trust had made good progress towards sustainable achievement of the referral to treatment (RTT) standards and in implementing the IST recommendations. They recommended further work was undertaken to implement a follow-up patient tracking list and to manage follow-up waiting times.
- We found 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 within the Care Groups. There was a risk that patients may be 'lost' in the current system.
- Performance data for the trust showed that for January to March 2015, 94.7% of patients against a target of 95%, waited a maximum time of 18 weeks from point of referral to treatment for non- admitted pathways.
- For incomplete pathways, 93.8% of patients waited a maximum time of 18 weeks from point of referral to treatment against a target of 92%.
- The trust had achieved their cancer related targets. The 31 day wait for second or subsequent treatment of anti-cancer drug treatments was 100% against a target of 98% and the 31 day wait for second or subsequent treatment of radiotherapy was100% against a target of 94% for January to March 2015.
- The 62 day wait for first treatment from urgent GP referral to treatment was 86.7% against a target of 85% and the 62 day wait for first treatment from consultant screening service referral was 90.5% against a target of 90%. 31 day wait for diagnosis to first treatment- all cancers 97.9% against a target of 96%
- The two week wait from referral to date first seen for all urgent cancer referrals (cancer suspected) was 95.9% against a target of 93%and the two week wait from referral to date first seen for symptomatic breast patients (cancer not initially suspected) was 95.9% against a target of 93%.
- The rate of patients that did not attend (DNA) for out-patients was 8.1% (3301) across the trust for January to March 2015. The trust had not set a key performance indicator for this.
- The rate of cancellations by the hospital was 15.9%. The trust had not set a key performance indicator for this. However, the managers recognised that the cancellations were an area to be reviewed and had produced reports to understand why this was the case.
- The rate of patients who did not wait was 1.1% (35) of the total amount of DNAs.
- Trust-wide data showed 16.8% of patients waited more than 30 minutes to be seen.
- An outpatient experience survey was undertaken between January and March 2015. Results showed 41% of patients reported they were seen early or on time for their appointments; 14% reported waiting more than 30 minutes after their appointment time with 2% stating they waited over one hour. 92% of patents said they were informed about the delay and 63% said they received regular updates.
- On the day of our visit patients with appointments were not left waiting for long periods of time.
- Patients arriving for x-rays from outpatient clinics and walk in GP x-ray services were accommodated into time slots within the department.
- There is no national guidance for radiography report turnaround times (TAT). The radiologist group were planning to set internal key performance indicators for report TAT. We were told at the time of inspection that there was approximately a backlog of 2,000 reports, which equated to 2-3 days' work. There were reporting radiographers who have dedicated reporting time.

Meeting people's individual needs

- Translation services were available for patients to request and these services were available at the main X-Ray reception and through appointment bookings. Staff told us they were aware and knew what procedures to follow to secure the services of translators.
- Staff were able to describe how they cared for patients with memory impairments and learning disabilities and said they would fast track patients through the departments to reduce waiting times for these patients whenever possible. Staff in outpatients they were not always made aware of when a patient was living with dementia.
- We found that staff were focused on meeting the needs of patients with complex needs. We saw one patient with a learning disability attend the department for a scan escorted with their carer. We saw the staff handled

both the patient and carer empathetically and they were fast tracked through the department. We also heard an example of a patient with complex needs and arrangements made to tailor an outpatient appointment experience for that individual.
- We saw a range of information leaflets were available across the departments. Leaflets were sent out with the patient's appointment times in relation to diagnostic imaging for example CT and MRI information leaflets. These leaflets were also available on the trusts website.

Learning from complaints and concerns

- Patients could feedback complaints and concerns in a number of ways, including formally and by completing a 'Your experience counts' form. It was not clear how these 'informal' complaints were monitored.
- Some managers described how they contacted the patient making the complaint to fully understand their concerns.
- Staff told us and we saw from staff meeting minutes that complaints were included for discussion. Within the diagnostic imaging department, two complaints relating to staff attitudes were currently being investigated. Staff had been reminded of their duty to provide a quality service.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

Staff we spoke with were aware of the trust overall vision and strategy. An outpatient's services strategy had been drafted in December 2014. However, this lacked detail and senior managers agreed it required further development.

A review of outpatient services had started to audit the current outpatient service delivery and clinical work streams but this was not yet completed. There were key performance indicators for outpatients, however, these did not include targets for indicators such as did not attend rates and clinic cancellations. There were plans to address this.

Radiology discrepancy and peer review meetings were inconsistent with the Royal College of Radiology (RCR) Standards. Radiology discrepancy and peer review meetings in February & March 2015 had been cancelled; this meant that the Royal College of Radiology (RCR) standards that the minimum frequency of meetings should be at least every two months had not been met, Eight meetings had been held in the period April 2014 to March 2015. There were plans in place to address this but these were not yet in place. There was no recent evidence of IR(ME)R and clinical audits undertaken across the services.

Staff were positive about the recent and future management of medical imaging and outpatients.

Vision and strategy for this service

- An outpatient's services strategy had been drafted in December 2014. However, this lacked detail and senior managers agreed it required further development.
- A review of outpatient services had started to audit the current out patient service delivery and clinical work streams but this was not yet completed. It was planned this would inform a 'right sizing' plan for the outpatients services. There was a need to work across the trust between the care groups.
- Staff we spoke with were aware of the trust vision and strategy.

Governance, risk management and quality measurement

- A revised clinical governance structure had recently been introduced following the trust management restructure.
- Medical imaging had defined reporting structures that complied with ionising and non-ionising regulations.
- Work to refine departmental risk registers was in progress and we saw up to date risk registers developed on the electronic reporting system.
- Medical staff and senior managers we spoke with acknowledged that radiology discrepancy and peer review meetings were inconsistent with the Royal College of Radiology (RCR) Standards. Radiology discrepancy and peer review meetings in February & March 2015 had been cancelled; this meant that the Royal College of Radiology (RCR) standards that the minimum frequency of meetings should be at least every two months had not been met, Eight meetings had been held in the period April 2014 to March 2015. The purpose of these meetings is to facilitate collective learning from radiology discrepancies and errors with a

view to improving patient safety. There were plans to develop bi-monthly Quality Assurance meetings; we saw the proposed agenda items and it was in accordance with RCR standards.
- The managers we spoke with were not aware of any recent clinical and IR(ME)R audits undertaken across the service. Senior managers told us that a clinical audit plan for medical imaging for 2015 - 2016 had been agreed.
- Staff reported that the quality of the sonographer scans and reports were not audited. The sonographers had recently organised to meet monthly to review interesting cases and planned to invite radiologists to give presentations.
- There were key performance indicators for outpatients, however, these did not include targets for indicators such as did not attend rates and clinic cancellations. There were plans to address this.

Leadership of service

- Outpatients and diagnostic imaging services were part of the Diagnostic and Pharmacy Care Group within the trust. The overall management structure of the care group included a Director, Assistant Director, Clinical Governance Lead, Matron, General Manager, two Business Managers and a HR Business Partner.
- The restructure to the care groups in October 2014 meant the leadership team were relatively new in post.
- The care group managers had undertaken an internal organisational review of the medical, radiographer and nursing leadership for medical imaging services across the trust.
- The imaging department was managed by a senior radiographer (site manager). At the time of inspection the site manager was supported by the Care Group Managers until the appointment of a Head of Service.
- A service improvement plan (February 2015) was in place which included recruitment to key posts including a Head of Service, Deputy Heads of Service and Clinical Leadership roles for each modality. The plan also included service improvements actions to address the services capacity and demands, performance targets, service administration, information systems and procurement of equipment.
- The Chief Executive Officer (CEO) retained overall responsibility for ensuring that systems were in place to manage risks arising out of the use of ionising and non-ionising radiations. We saw formal correspondence and in accordance with the regulations, the CEO had delegated this responsibility to the Diagnostic and Pharmacy Care Group Director.
- Staff we spoke with reported that local leadership was positive.
- Staff were aware of the changes at care group level and could access the relevant information from the intranet.
- Staff we spoke with were overall very positive about the recent and future management of medical imaging and outpatients. It was felt that the present management structure and the direction in which it was going were clear and supportive.

Culture within the service

- The majority of the staff we spoke with had a positive, optimistic and confident view about the recent changes introduced through the care group structure.
- The internal reorganisation of the trust's medical imaging service was still in progress at the time of inspection. Senior managers envisaged the process was likely to continue for several months.

Public and staff engagement

- An outpatient experience survey was undertaken between January and March 2015. All respondents stated they would recommend the outpatients departments to family and friends and that the departments were well-organised and rated the departments as excellent or good. An action plan had not yet been produced.
- The friends and family test had been introduced for outpatients in April 2015.
- Staff felt engaged as part of the care group and the wider trust. The felt they received information, such as via Buzz, the trust newsletter.

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.

Outpatients and diagnostic imaging

- Within the fracture clinic, it had been identified that three patients had developed grade 3 pressure ulcers underneath their casts the previous year. The reasons for this were reviewed and risk criteria had been identified. As a result, patients had an individualised assessment and review plan. The outcome was no grade 3 pressure ulcers had occurred since.

Outstanding practice and areas for improvement

Outstanding practice

- The staff support and training packages provided by the clinical educators in all areas where children and young people were seen in the trust.

Areas for improvement

Action the hospital MUST take to improve

- 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.
- The trust must ensure that medical staff on the critical care unit hold the appropriate qualifications and that this cover is available at all times.
- The trust must ensure that there is appropriate out of hours cover for the critical care unit and that any risks associated with cross cover of services is mitigated.
- The trust must ensure that the public are protected from unnecessary radiation exposure.
- The trust must ensure that staff receive mandatory training.
- The trust must ensure that staff receive an effective appraisal.
- The trust must ensure that a clean and appropriate environment is maintained throughout the theatre sterile supply unit that facilitates the prevention and control of infection.

Action the hospital SHOULD take to improve

- The hospital should reduce patient waiting times to meet the 95% target for patients seen within four hours.
- The hospital should review access to equipment in the emergency department.
- The hospital should continue to take steps to support and develop working arrangements between the emergency department and other specialities within the trust.
- The hospital should record and monitor daily temperatures of fridges used for storage of medicines
- The hospital should review engagement of medical staff with training, particularly in Mental Capacity Act and emergency planning.
- The trust should ensure that appropriate delirium and sedation scores are undertaken and recorded.
- The trust should ensure that appropriate access is available from supporting clinical services where required, including pharmacy, dietetics and the ear, nose and throat departments.
- The trust should review monitoring procedures to record where and why a breach of mixed sex accommodation has occurred and actions taken to avoid a repeat.
- The trust should review the pain evaluation tool incorporated within the NEWS score observations to measure the pain experienced by patients
- The trust should consider the use of a staffing needs acuity tool to record staffing needs more accurately and on a more frequent basis.
- The trust should continue to review staffing on ward C1.
- The trust should review the how toilet facilities can be improved on the cardiology ward to ensure separate designated facilities are maintained for men and women.
- The trust should review maintenance and deep cleaning schedules
- The trust should review documentation of wastage of Controlled Drugs (CD) on delivery suite.
- The trust should review the provision of the service available from the teenage pregnancy midwife and substance misuse midwife at the hospital.
- The trust should consider employing a specialist diabetes midwife.
- The trust should review 24 hour availability of an obstetric anaesthetist.

Outstanding practice and areas for improvement

- The trust should make sure front line staff are aware of their responsibilities in relation to MCA and DOLS.
- The trust should review the individual risk assessment tools with in the children's service. For example, the service should ensure the initial nursing assessment includes nutritional status and nutritional risk assessments.
- The trust should identify a board level director who can promote children's rights and views. This role should be separate from the executive safeguarding lead for children.
- The trust should agree a system for recording mental capacity assessments for patient's unable to be involved in discussions about DNACPR decision
- The trust should make available appropriate equipment for the care of bariatric patients after death
- The trust should review equity of access to palliative and end of life care services across both Bassetlaw DGH and Doncaster Royal Infirmary.
- The trust should identify clear systems and processes to evidence post incident feedback, shared learning and changes in practice resulting from incidents.
- The trust should review the audit programme in outpatients and diagnostics to monitor the effectiveness of services.
- The trust should continue improvements to meet the 6 week target referral to treatment target for medical imaging.
- The trust should review the processes for identifying and managing patients requiring a review or follow-up appointment.
- The trust should further develop the outpatient's services strategy to include effective service delivery.
- The trust should identify and monitor key performance indicators for outpatients.
- The trust should implement plans to ensure radiology discrepancy and peer review meetings are consistent with the Royal College of Radiology (RCR) Standards.
- The trust should consider auditing the call bells within the diagnostic imaging departments.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 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. Medical staff with the appropriate qualification in intensive care medicine.

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.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18 (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed. Adequate numbers of registered children's nurses and medical staff were not available at all times to meet the needs of children, young people and parents. Adequate number of anaesthetic medical staff to provide cover across the hospital.
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(2) (h) The registered person must assess the risk of, and prevent, detect and control the spread of, infections. The theatres' sterile supply room was not clean and had some areas with visible dust.