Care Quality Commission

Doncaster and Bassetlaw Hospitals NHS Foundation Trust

Doncaster Royal Infirmary

Quality Report

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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

Doncaster Royal Infirmary 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.

Doncaster Royal Infirmary 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 800 beds. The hospital also provided emergency and urgent care and outpatients and diagnostic imaging.

We inspected Doncaster Royal Infirmary as part of the comprehensive inspection of Doncaster and Bassetlaw NHS Foundation Trust. We inspected the hospital on 14 – 17 and 29 April 2015.

Overall, we rated Doncaster Royal Infirmary as requires improvement. We rated it good for being caring and well-led and requires improvement for responsive, effective and safe.

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.
- Clostridium difficile (C. difficile) rates for the trust (44 cases) were within trajectory (45 cases) for the Trust for 2014/15.
- 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.
- The Summary Hospital-level Mortality Indicator (SHMI) (01-Jul-13 to 30-Jun-14) showed no evidence of risk. The Hospital Standardised Mortality Ratio indicator (01-Jul-13 to 30-Jun-14) showed an elevated risk.
- Records indicated compliance with mandatory training and appraisal rates were generally low across the services. It was unclear in some areas if this was a recording issue; in any event, the trust were not assured that staff had received necessary training.
- Within diagnostic imaging, there were some doors with no signage that had unrestricted entry to x-ray controlled areas.

We saw areas of outstanding practice including:

- The Integrated Discharge Team was a beacon of good practice, as recognised by the 2015 National Award for Collaborative Leadership and was very active in providing a discharge planning service to all adult in-patients. The Frailty Assessment Unit was another example of effective collaborative working; the service enabled rapid assessment of elderly patients and person-centred care planning.
- Selected Serious Incidents were rerun in the Clinical Skills department with the team originally involved in the incident to identify learning points.
- 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 arrangements for the initial assessment of patients, including the use of streaming and triage, and add streaming / triage to the risk register
- The trust must ensure appropriate numbers of medical, nursing and support staff of the required skill mix are available in the emergency department

Summary of findings

- The trust must ensure patient waiting times are reduced to ensure the 95% target for patients seen within four hours is met and maintained
- The trust must ensure patients' pain symptoms are assessed, and pain relief administered promptly for all groups of patients.
- 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, emergency department and critical care unit that facilitates the prevention and control of infection.

In addition the trust should:

- The hospital should review how the privacy and dignity of patients is maintained, particularly in the central (overflow) area of the emergency department
- The hospital should review equipment in the emergency department to check appropriate and adequately serviced, working equipment is available.
- The hospital should take steps to support and develop working arrangements between the emergency department and other specialities within the trust
- The hospital should review arrangements for sharing with staff lessons learned from root cause analysis and investigation of incidents
- The hospital should consider reviewing its audit programme for evidenced based guidance to include the review of adherence to clinical guidance
- The hospital should record and monitor daily temperatures of fridges used for storage of medicines
- The hospital should review and complete actions identified in CQC's review of health services for children looked after and safeguarding, September 2014
- The trust should review the need for diabetes management to be included in the mandatory training programme for trained nurses.
- Medical services management should seek assurance that deprivation of liberty is being appropriately assessed and an order sought where required.
- The trust should review access to an emergency buzzer system on M1, M2 and G5.
- The trust should review the midwife to birth ratio.
- The trust should review the rates of induction of labour and non-elective caesareans.
- The trust should consider employing a specialist diabetes midwife.
- The trust should review the management of medicines on the maternity unit, particularly the area the home birth trolley/ drugs are kept.
- The trust should consider having a designated bereavement area in maternity.
- The trust should review the domestic abuse policy to ensure it is consistent with NICE guidelines
- The trust should continue to manage patient flow to reduce the number of outliers in surgery and gynaecology.
- The trust should review the need for a standardised way of ensuring cleaning has taken place (environment and equipment).
- The trust should ensure that it has effective assessments and plans in place for any evacuation of the critical care unit.
- The trust should take action to improve the provision of storage facilities across the critical care unit.
- The trust should improve the standards of infection prevention practice on the critical care unit.

Summary of findings

- The trust should as part of its overall patient pathway management ensure that patients on the critical care unit are discharged in a timely fashion to a more suitable environment.
- The trust should consider in its overall development strategy a more suitable location for its critical care unit.
- The trust should review segregation of children from adults in the recovery areas of the theatres.
- 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 review the system for recording mental capacity assessments for patient's unable to be involved in discussions about DNACPR decision
- The trust should support staff involved in receiving bodies into the mortuary with adequate training to carry out the role
- 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 to monitor the effectiveness of services within outpatients and diagnostic imaging.
- The trust should review actions to improve safety and privacy within the medical imaging department particularly for inpatients who attend the department on beds.
- 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.

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 concerns as to the triaging or initial clinical assessment of patients which were not on the risk register. During streaming staff were unable to administer pain relief. At night there was no dedicated triage or streaming nurse: staff within the department undertook this according to demand. There were insufficient numbers of nursing staff for the safe operation of the service. The department were facing significant challenges in recruiting emergency medical staff. There was insufficient working equipment available for staff to use. During the previous 12 months the trust had not consistently maintained the 95% target for patients seen within four hours. The standard of cleanliness and adherence to hygiene procedures was variable. Mandatory training was not up to date although an action plan had been prepared to improve the level of training compliance. The department used national guidelines; audits undertaken demonstrated a mix of good and poor results. The emergency department had implemented an electronic patient record system widely used in the NHS and systems were in place to safeguard vulnerable adults and children. Some actions identified from the CQC review of health services for children looked after and safeguarding in September 2014 were still in progress. Patients were cared for with empathy and with respect to their dignity. Privacy and dignity of patients was difficult to maintain because the limited environmental facilities did not support patient privacy. Most patients and relatives felt involved in their care and treatment. Staff demonstrated a good level of rapport in their interactions with patients and relatives. Staff provided emotional support to patients and their relatives. The recently opened clinical decision unit provided excellent facilities for patients. Medicines were appropriately prescribed and administered. Controlled drugs were stored and stock recorded appropriately. There had been no recent never

Summary of findings

events and root cause analysis investigation of incidents was undertaken, although lessons learned were not shared consistently. Staff were aware of their responsibilities under the duty of candour requirements.
Patients received adequate nutrition and hydration. Staff could access clearly displayed information for each patient and patients were requested for their consent. Staff had received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLs). Arrangements for staff appraisals were in place. A clinical education team provided the lead for staff training arrangements which supported staff working within their competencies. The outcomes of complaints were analysed to identify themes and trends.
The trust's plans for the department involved significant reorganisation and the joint vision for the care group was shared by staff in the department. Working relationships between nursing and medical staff were good but there was limited interchange with some specialities. There were good working relationships with physiotherapists and occupational therapists.
The administration of pain relief was identified as a concern and pain management in the department had been included in the risk register. Governance arrangements had recently been reviewed to reflect changed departmental structures. Recent changes in leadership arrangements had presented some challenges which had been escalated and senior staff spoke positively about the new leadership team. There was an open culture in the emergency department.

Medical care

Good

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 selected Serious Incidents were rerun in the Clinical Skills department with the team originally involved in the incident to identify learning points.
Clostridium difficile (C. difficile) rates for the trust (44 cases) were within trajectory (45 cases) for the Trust for 2014/15. The wards were generally well

Summary of findings

equipped. All medical nurses were expected to be trained in Immediate Life Support skills and most units had achieved over 60% training rates; however three wards had training levels at 43-45%. There was a trust-wide quality metrics audit framework for ward managers to complete (Ward Quality Assessment Tool). Audits were undertaken to monitor compliance with guidance, such as hand hygiene audits. Results seen showed good levels of compliance. The Trust responded to the outcome of the Sentinel Stroke National Audit Programme (SSNAP) for 2013/14 and the National Diabetes Inpatient Audit (2013) by taking action to improve the quality of service and care provided.

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%.

Seven day services were widespread with seven day consultant cover, 24 hour seven day pathology services and numerous allied health professional and specialist teams also providing seven day services.

Patients generally provided very positive feedback about the care provided by nursing staff. Patient buzzers were answered promptly in most areas visited. Many patients were positive about the staff ensuring that they understood the plan of care. Some patients were aware of their care plan and treatment objectives and felt fully involved but others were less clear in their understanding and wanted more information. Patients and family members said that medical and nursing staff were approachable and responsive if they did raise concerns. Staff were described as attentive, eager to help and asking if they needed anything on a regular basis. Several said how the staff made sure that they understood what was planned and provided reassurance when needed.

The trust was seeking to improve mortality and morbidity (national comparative data) performance through seven day working and this was reflected in the improved provision of seven day consultant cover for general medicine and specialist services including the Integrated Discharge Team, therapists and the diabetes specialist team. Discharge arrangements were managed by a multidisciplinary

integrated discharge team. Medical outliers were managed through a trust-wide escalation process using a RAG rating on the whiteboards in order to reduce inappropriate transfers within the hospital. 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.
Staff were generally positive about the leadership and the levels of engagement with their line management through to executive level. The culture of the organisation was one of open communication and this was confirmed by many of the staff we spoke to.

Surgery **Good**

Incidents were reported and effectively investigated, and lessons were learned. The wards and departments were mostly clean and well maintained. However, there were worn floors and dust and dirt on trolleys and autoclaves in the theatre sterile supply unit. We found medicines and records were managed appropriately. The service responded appropriately to clinical risk in patients, although not all staff had received safeguarding training. There were some shortages of nursing and surgical staff; the trust were aware of this and were actively recruiting to fill the vacancies.
We found evidence-based care and treatment which was audited in the wards and departments. There was a system for the provision of pain relief to patients although it had been identified there were delays in the provision of analgesia to patients referred to the surgical assessment ward by their GPs. We found effective systems for the provision of nutrition and hydration to patients. Patient outcomes data did not show the trust to be an outlier in any area of practice.
Mandatory training records showed compliance with the 85% target for achievement of this was poor. However, the majority of staff we spoke with told us they were up-to-date with their mandatory

training. There were systems in place for yearly appraisal. We found that the surgery services were caring and that patients received compassionate care. We found evidence of service planning and delivery to meet the needs of local people.
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, however the number of patients who had to wait longer than 18 weeks from referral to treatment (admitted) breached the operational standard.
We found that the trust had systems in place that assisted in meeting the needs of people who used the service.
The surgical care groups at Doncaster were well-led with a vision and strategy for the service and systems of governance, risk management and quality measurement in place.

Critical care

Good

Overall critical care services at Doncaster Royal Infirmary were judged as good.
There were 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 overall, though as a relatively new care group unit further focus was required on the development of the unit in terms of space and facilities.
The service met the individual needs of patients whilst they were on the unit. Early discharges and out-of-hours discharges were similar to other units, and out of hours discharges to the ward were slightly above that of other similar units. There were some concerns regarding patients being discharged from the critical care unit delayed by over four hours.
Within safety, concerns were identified with regard to the environment and the risks associated with evacuation in the event of a fire and distance from other services that were required for the effective functioning of the unit. The poor use of storage and the impact this had on infection prevention risks and the practices for nursing patients with infections.

Summary of findings

Maternity and gynaecology

Requires improvement

Overall maternity and gynaecology services require improvement.

Midwifery and nursing staffing levels at Doncaster Royal Infirmary did not always meet the ratio recommended (Safer Childbirth RCOG 2007). The interim head of midwifery met with the director of nursing on a monthly basis to discuss staffing levels and plans for ensuring the service had appropriate capacity and capability to meet the needs of women. The hospital had a safe staffing escalation policy which included a process to be followed in the event of sudden staffing shortfalls.

The maternity unit closed eight times between July 2013 and December 2014. In March 2015, the EPAU was closed for five days due to staffing problems.

Medical staffing was in line with national recommendations for the number of births. However, there were two consultant and two middle grade vacancies. Medical staff told us this could impact on their workload.

Participation in mandatory training was between 0% and 100%. It was variable across all the wards, clinics and departments. Training attendance for infection prevention and control was very poor, as it was for resuscitation, fire safety and information governance. Participation in safeguarding adults and children training was variable in the unit and was between 75%- 100%.

There was a multidisciplinary approach to the care and needs of women. We observed examples of considerate and compassionate approaches in the care and treatment of women. Feedback from women about the standard of care they received was positive. Women were treated with kindness, dignity and respect during their care and treatment.

The individual needs of women were taken into account when planning the support needed during their pregnancy, although there were a high proportion of induced births and non-elective caesarean sections. The number of home births was lower than the England average.

On the whole, maternity ward areas were visibly clean and equipment was in date and in working order. Medicines were managed appropriately.

The gynaecology services were negatively impacted upon by the number of patients outlying on the ward from other specialties.

Summary of findings

Arrangements were in place to safeguard women and children from abuse, but some staff were not fully aware of the procedures around domestic abuse. Serious incidents were monitored and action taken when things went wrong. There was an open and transparent culture that encouraged reporting and learning from adverse incidents
The maternity and gynaecology services were led by a committed team. Consultants told us that midwifery management of the service was very good. The hospital has recently been awarded the highest level of the UNICEF Baby Friendly Initiative.

Services for children and young people

Good

We rated effective, caring, responsive and well-led as good. Safe was rated as required 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 meet the needs of the children and young people using the service. Nurse staffing levels on the children's wards did not meet current national guidelines.
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 in place to manage risk.

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. Hotel services staff were not adequately trained or supported in the receipt of bodies to the mortuary and we were not assured by the trust's arrangements for the storage of bodies in the mortuary in a way that respected the dignity of patient's after death. 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 seven day face to face assessment service. 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. The development of an electronic referral/alert system had seen an increase in referrals to the end of life care team in a timely manner. A business case had been developed as a result and the trust board had committed

investment in expanding the end of life 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

We rated outpatients and diagnostic and imaging as requires improvement. Safe and well-led required improvement; effective was inspected but not rated and caring and responsive were good.

There is a legal requirement to protect the public from unnecessary radiation exposure. We saw that there were 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. Not all areas had been addressed when we revisited as part of an unannounced inspection 10 days later. 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. Imaging and nursing staff reported that a safety handover of the patients from the wards did not occur. Inpatients were left waiting in beds on the main corridor of the department with no escort. This practice potentially created safety risks.

Records showed the number of staff that had received mandatory training and an annual appraisal was below the trust compliance target of 85%, particularly in outpatients. We saw patient personal information and medical records were mostly managed safely and securely. 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.

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. Most referral to treatment targets were met including all cancer related targets. There was no centrally held list of all patients requiring a

Summary of findings

review or follow-up appointment. Medical imaging was not meeting the 6 week target referral to treatment target; however improvements had been made.

Staff we spoke with were aware of the trust overall vision and strategy and were positive about the recent and future management of medical imaging and outpatients. An outpatient's services strategy had been drafted 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.

Doncaster Royal Infirmary

Detailed findings

Services we looked at
Urgent and 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 and diagnostic imaging

Detailed findings

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Background to Doncaster Royal Infirmary

Doncaster Royal Infirmary 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

Doncaster Royal Infirmary 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 800 beds. The hospital also provided emergency and urgent care and outpatients and diagnostic imaging.

We inspected Doncaster Royal Infirmary as part of the comprehensive inspection of Doncaster and Bassetlaw NHS Foundation Trust. We inspected the hospital on 14 – 17 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?
- Is it caring?

Detailed findings

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

Each year the hospital treated around 150,000 patients along with 95,500 patients receiving emergency care (combined figures for Doncaster Royal Infirmary and Montagu Hospital). There were 296,282 outpatient attendances between January and December 2014 at Doncaster Royal Infirmary.

The maternity service at Doncaster hospital delivered 2,752 babies between April and December 2014.

There were 5663 children's admissions between July 2013 and June 2014. Of these 98% of which were emergencies, 1% were day cases and 1% were elective. There were 9227 children's outpatient admissions between January and December 2014.

The trust had 5,800 staff which included 600 medical and 2,500 nursing staff and had a 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	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Requires improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement

Notes

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Urgent and emergency services

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

Information about the service

Doncaster Royal Infirmary emergency department received 143,393 attendances between July 2013 and January 2015, which represented 250 patients per day attending the department on average. Approximately 20% of these patients were children. Of the total number of patients attending between April and December 2014, 18.3% of these resulted in an admission to hospital, which was below the England average of 21.9%. The emergency department was open 24 hours a day, seven days a week.

The emergency department included a major's area which consisted of 13 beds, a central area used for additional patients, and an ambulance receiving area with separate reception staffed by nurses. The unplanned care, or minor's area, was nurse led with consultant support. Unplanned care consisted of six bays, five for adults and one for paediatric patients, a plaster room and an eye room. In the walk-in waiting area there were three small cubicles, a triage room, and three treatment rooms. The GP out of hour's service also used a treatment room. A further three rooms with dual access led off the separate paediatric waiting area. Paediatrics was open 24 hours with a paediatric specialist nurse on duty.

The department opened an extended clinical decision unit (CDU) in February 2015. The new facility provided 15 beds for patients who were unsuitable for discharge, but who did not require admission to an inpatient ward. The CDU included five single sex bays with en-suite facilities including isolation facilities for one patient, kitchen and seating area and could be adapted from 15 beds to 12 beds with four chairs to reflect the needs of patients. Patients were admitted to the CDU when they required further observation, assessment, or diagnostic tests.

We spoke with 30 patients and their relatives, and 40 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.

Urgent and emergency services

Summary of findings

There were concerns as to the triaging or initial clinical assessment of patients, which were not on the risk register. During streaming staff were unable to administer pain relief. At night there was no allocated triage nurse; staff within the department undertook this according to demand. There were insufficient numbers of nursing staff for the safe operation of the service. The department were facing significant challenges in recruiting emergency medical staff.

There was insufficient working equipment available for staff to use. During the previous 12 months the trust had not consistently maintained the 95% target for patients seen within four hours. The standard of cleanliness and adherence to hygiene procedures was variable. Mandatory training was not up to date although an action plan had been prepared to improve the level of training compliance. The department used national guidelines; audits undertaken demonstrated a mix of good and poor results.

The emergency department had implemented an electronic patient record system widely used in the NHS and systems were in place to safeguard vulnerable adults and children. Some actions identified from the CQC review of health services for children looked after and safeguarding in September 2014 were still in progress.

Patients were cared for with empathy and with respect to their dignity. Privacy and dignity of patients was difficult to maintain because the limited environmental facilities did not support patient privacy. Most patients and relatives felt involved in their care and treatment. Staff demonstrated a good level of rapport in their interactions with patients and relatives. Staff provided emotional support to patients and their relatives.

The recently opened clinical decision unit provided excellent facilities for patients. Medicines were appropriately prescribed and administered. Controlled drugs were stored and stock recorded appropriately. There had been no recent never events and root cause analysis investigation of incidents was undertaken, although lessons learned were not shared consistently. Staff were aware of their responsibilities under the duty of candour requirements.

Patients received adequate nutrition and hydration. Staff could access clearly displayed information for each patient and patients were requested for their consent. Staff had received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLs). Arrangements for staff appraisals were in place. A clinical education team provided the lead for staff training arrangements which supported staff working within their competencies. The outcomes of complaints were analysed to identify themes and trends.

The trust's plans for the department involved significant reorganisation and the joint vision for the care group was shared by staff in the department. Working relationships between nursing and medical staff were good but there was limited interchange with some specialities. There were good working relationships with physiotherapists and occupational therapists.

The administration of pain relief was identified as a concern and pain management in the department had been included in the risk register. Governance arrangements had recently been reviewed to reflect changed departmental structures. Recent changes in leadership arrangements had presented some challenges which had been escalated and 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

There were concerns as to the triaging or initial clinical assessment of patients. Issues related to triage or initial clinical assessment was not on the risk register. In order to investigate further the concerns identified with the initial review of patients, we undertook an unannounced inspection when we found some changes to improve the initial assessment of patients, including children, had been made. Staff undertaking streaming were unable to request or administer pain relief and pain was not assessed. At night there was no dedicated triage or streaming nurse: staff within the department undertook this according to demand. Following our inspection the trust reviewed the patient pathways within the emergency department as a matter of priority. The trust shared with CQC the results of its monitoring following changes made to streaming and triage. The preliminary results indicated that patients were receiving safer, more responsive care and patient and staff satisfaction had improved.

Nursing staff were insufficient for the safe operation of the service. Management, nursing and support staff each identified the shortage of suitably skilled staff in the department as their most significant concern. Steps were being taken to recruit skilled nursing staff and also support staff and to review skill mix. 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.

The central overflow area was cramped, and did not support patient privacy. There was insufficient working equipment available for staff to use. The department has worked jointly with an external equipment supplier to develop pressure relieving mattresses for patient trolleys which were being trialled in the resuscitation area. The recently opened clinical decision unit provided excellent facilities for patients who required further observation, assessment, or diagnostic tests.

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. A link nurse for infection prevention and control had developed action cards to support nursing a patient who needed to be isolated for reasons of infection control. However, the standard of cleanliness and adherence to hygiene procedures was variable.

Controlled drugs were stored and stock recorded appropriately. Medicines were appropriately prescribed and administered. The monitoring of medicine fridge temperatures was intermittent, although we did not find evidence that the fridge was operated with temperatures out of range.

There had been no recent never events and the most recent severe pressure ulcer acquired in the department had occurred 65 days previously. No falls incidents or hospital acquired infections were reported. Root cause analysis investigation of incidents was undertaken, although lessons learned were not shared consistently with staff. Staff were aware of their responsibilities under the duty of candour requirements.

The emergency department used an electronic patient record system widely used in the NHS. Patient records were mainly complete. Systems were in place to safeguard vulnerable adults and children. Medical staff were automatically prompted through the information system to complete safeguarding assessments for children who presented in the department. Training staff confirmed that all appropriate staff received safeguarding training, or arrangements were in place for them to attend. However, not all medical staff we spoke with could confirm they had received appropriate safeguarding training. Some actions from the CQC review of health services for children looked after and safeguarding in September 2014 were still in progress. Senior staff were aware of training arrangements being made for safeguarding women or children with, or at risk of, female genital mutilation or associated abuse.

Mandatory training was not up to date within the emergency department. An action plan had been prepared to improve the level of training compliance. A dedicated training programme for statutory and mandatory training was 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. Staff spoke positively about the impact of the department's dedicated trainers and the training they delivered.

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.
- At the time of our inspection, the most recent severe pressure ulcer acquired in the department had occurred 65 days previously. At our unannounced inspection this had extended to almost 80 days without a hospital acquired pressure ulcer (HAPU). No falls incidents or hospital acquired infections were reported. A root cause analysis investigation was undertaken for each HAPU.
- 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. However, some nursing staff we spoke with expressed frustration as to the lack of feedback about incidents they had reported.
- We found some evidence that the culture for the reporting of incidents was changing. Management and medical staff we spoke with told us that previously, there was a poor culture of incident reporting. However with the implementation of a formal electronic reporting system, the department had seen the number of incidents reported rising, and subjectively, the quality of information included within the reported incidents improving. This was confirmed by a review of recently reported incidents.
- We reviewed the investigation reports for three serious incidents which occurred in 2014. The investigation reports included recommendations, an action plan and arrangements for shared learning. The investigation report was 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.
- Learning from incidents was disseminated to medical staff through emails and weekly teaching sessions. Examples were training that was provided for junior medical staff following an incident of a missed diagnosis on ECG interpretation. Another incident led to the local deputy coroner holding a training session with junior medical staff as to what to report to the coroner, and a formal guideline was developed within the hospital. However, lessons learned were not shared consistently with locum medical staff. Locum doctors we spoke with were unaware of recent serious incidents within the department. They were not included in the teaching sessions or in the email dissemination of learning from incidents.
- Clinical governance meetings were held monthly within the department, during which each death that took place within the department was reviewed and classified as "no concern", "mild concern" or "significant concerns".

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. Staff we spoke with were aware of their responsibilities under the duty of candour requirements.

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 variable.
- A link nurse for infection prevention and control (IPC) was in place. The link nurse had developed action cards to aid the cleaning of clinical equipment, and to support

where the patient needed to be isolated for reasons of infection control. An environmental audit report was prepared of identified breaches of cleanliness standards which included actions and was fed back to staff. The link nurse maintained an infection prevention and control display board with guidance for staff about aspects of IPC and the current IPC audit score of 89% was displayed. The domestic cleaning audit for 3 April 2015 indicated a score of 95% was achieved and an audit failures report was prepared.

- We observed that cleaning schedules were displayed in the main waiting area. A cleaning checklist tool was used daily to indicate areas requiring cleaning which was completed by support staff. No checks were in place to indicate when cleaning solutions which required replacement every 24 hours, were prepared.
- When we visited the emergency department we observed the standard of cleanliness was variable. Bins for waste disposal were marked clearly for the intended contents. Disposable curtains were in use. Hand hygiene techniques we observed were followed in some, but not all, instances. Some cubicles were visibly clean, although some computer monitors and keyboards were dusty and marked by spillages.
- In the ambulance triage area, the sharps bin was located on the floor, with no rotating aperture. Items of equipment stored in this area was not marked to indicate whether they were ready for use. We found some toilets were clean whilst others, intended for male and female patient use, were dirty and stained.
- In the resuscitation area, we observed in a bay prepared for patient use that the trolley mattress was soiled, the work surfaces were cluttered with equipment and a member of nursing staff prepared medicine for intravenous application without first washing their hands or using sterile gloves. In another cubicle we saw the sharps bin was full. In the resuscitation bay reserved for paediatric patients, stored trolleys were soiled and the sharps bin, with an open aperture, was stored on the floor, which presented a particular risk to paediatric patients.
- In the unplanned care area, we observed that a cubicle was very cluttered, access to the hand hygiene wash basin was blocked by a chair, two patient trolleys were soiled and slight dust was present on the floor and at high levels. In the central overflow area, a cleaning bucket and mop were stored and floors were visibly dirty and dusty in places.
- In the sluice room, access to the sink was obstructed with commodes and bed pans, which were not labelled to indicate they were ready for use. A mixer tap was not fitted at the hand basin, so that compliance with hand hygiene techniques was difficult.

Environment and equipment

- The emergency department major's area consisted of 13 beds although we were informed the trust had plans to extend this. Medical staff told us that the department handled more than this number of patients at any one time on a day to day basis. During our inspection, we observed on several occasions that at least six additional patient trolleys were placed within the central overflow area, which occurred when all the beds were occupied. With six patient trolleys, the central area was cramped, with minimal room to manoeuvre between beds. The unplanned care, or minor's area, consisted of six bays, five for adults and one for paediatric patients, a plaster room and an eye room. In the walk-in waiting area there were three small cubicles, a triage room, and three treatment rooms. The GP out of hour's service also used a treatment room. A further three rooms with dual access led off the separate paediatric waiting area; we were informed that paediatrics was open 24 hours with a paediatric specialist nurse on duty.
- The department opened an extended clinical decision unit (CDU) in February 2015. The new facility provided 15 beds for patients who were unsuitable for discharge, but who did not require admission to an inpatient ward. The CDU included five single sex bays with en suite facilities including isolation facilities for one patient, kitchen and seating area and could be adapted from 15 beds to 12 beds with four chairs to reflect the needs of patients. Patients were admitted to the CDU when they required further observation, assessment, or diagnostic tests.
- We observed basic care, including the administration of intravenous antibiotics being given in the central overflow area of majors. There was no additional nursing staff available to provide care for patients occupying the central area, potentially compromising on the overview of these patients. There was no clear protocol as to which patients should be nursed in this area. There was a revolving policy of taking patients into cubicles when they needed episodes of care such as physical examination, but brought back into the majors area when the examination was completed.

- We found there was insufficient working equipment available for staff to use. When we visited the department in the evening we found there was a shortage of patient trolleys. When a patient needed a hoist, staff needed to visit a ward to obtain one. In the resuscitation area, we found several items of equipment were overdue for safety checks. We were informed that nine patient trolleys had been condemned, prior to arranging for their repair and a further 23 new trolleys had been ordered. Some items of equipment were dirty or not labelled to indicate they were ready for use. We spoke with a member of staff who had just returned from a ward to borrow a hoist for use in the department, only to find there were no slings so that a further visit was required to obtain these. The member of staff also informed us that the emergency department did not have access to bladder scanners. Staff told us that ECG machines were often broken or missing from the department. During the week prior to our inspection, only one ECG machine was available. Staff said a significant amount of time on each shift was spent searching for working equipment, which potentially increased the risk to the patient and extended their waiting time in the department.
- Staff told us they encountered problems obtaining pressure relieving equipment after 5pm when the equipment library closed. On some occasions staff needed to visit a ward to borrow pressure relieving equipment. When we returned to the department for our unannounced visit, we checked the last test date for a selection of equipment and found it was in date, with equipment signed as checked.
- The department had worked jointly with an external equipment supplier to develop pressure relieving mattresses for patient trolleys two of which had been trialled in the resuscitation area. 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.

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.
- Where incidents related to medicines had occurred, we saw that these were reported.
- The monitoring of fridge temperatures we found was intermittent. A fridge temperature monitoring book was used, which was not completed in January or February 2015, on only five days in March 2015 and on eight days in April 2015. However, we did not find evidence that the fridge was operated with temperatures out of range.
- Medicines were observed to be appropriately prescribed and administered. Medications within the department were prescribed electronically. Allergies were also documented electronically and we saw evidence of allergies being checked prior to administration of antibiotics.

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 found consultant medical staff were given protected time to review all images taken within their shift with a radiologist to ensure that there were no errors made in reporting. If any discrepancy in reporting occurred, patients were contacted and additionally, images were held in a bank to be used for education.
- We reviewed the patient records for nine patients who arrived in the department, including one patient who was readmitted. We found the notes were mainly complete. Some items of information requiring clarification were discussed with the department at the time of our inspection.

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. On reviewing clinical notes, we saw evidence of appropriate risk assessments being performed, including escalation to the safeguarding team when safeguarding concerns were suspected.

- Junior medical staff told us that they 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 safeguarding training was up to date for only about 60% of nursing staff and 35% 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. Nursing staff we spoke with confirmed they had received safeguarding training. However, not all medical staff we spoke with could confirm they had received appropriate safeguarding training.
- 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. 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. Staff we spoke with confirmed that learning had been shared following paediatric safeguarding incidents in the department.
- 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. Figures showed for example, 28% of nursing staff had received adult and paediatric resuscitation training, 3% infection prevention and control training and 48% patient moving and handling training. The target was for 85% to have received training.
- Medical staff were not up to date with training. Figures showed for example, 10% and 20% of medical staff had received adult and paediatric resuscitation training respectively, 0% infection prevention and control training and patient moving and handling training.
- We discussed the information with senior staff, including two members of staff responsible for emergency department training. 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.
- We observed in the department a training and education board was displayed with planned training sessions available through the department. Training was usually planned two months in advance.

Assessing and responding to patient risk

- Patients who arrived into the department by ambulance were brought in through a dedicated entrance and were triaged immediately.
- We found escalation criteria guidance was used for deteriorating patients. Any breach reports were reviewed at the commencement of a shift. Staff acknowledged that the resuscitation area represented a significant pressure point in the system and if two patients arrived within 30 minutes escalation was used. In majors, escalation was used if five patients were waiting more than two hours to be seen; in minors, if nine patients were waiting more than two hours to be seen. Staff escalated to the site manager, the general manager or the executive on call and reviewed the allocation of staff to each area of the department. Nursing staff felt they worked well with medical staff in using the escalation process and staff in critical care and

theatres were supportive. Paediatric consultants could be called to attend the department. Early Warning Scores were calculated in the electronic patient record, and produced alert triggers for the intervention by staff.An early senior review system (previously Rapid Assessment and Treatment Service) was operated by medical staff. The early senior review area was staffed by a middle grade doctor or consultant locum staff. Doctors were allocated for four hours to the early senior review of patients, before they moved into another area of the department. Patients who arrived by ambulance or deteriorating patients were seen here.

- There were significant concerns raised and witnessed in the immediate triaging or initial clinical assessment of patients who walked into the emergency department. Patients who walked into the department were required to check in at a reception desk. Adjacent to the reception desk, a qualified nurse (sitting behind a glass pane), streamed the patient as requiring review from the paediatrics team, review within the unplanned admission centre, review within the urgent care centre by co-located general practitioners, or requiring admission to hospital through the emergency department majors area.
- Patients requiring review from the paediatric / unplanned care or majors' teams then waited in a queue to be seen by the emergency team. There was no triaging or initial clinical assessment of these patients, and no observations taken on arrival to the department. Medical staff within the department raised serious concerns with us about the lack of triage. 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.
- During our inspection, we saw a child brought in after suffering a first seizure. Their mother reported that they were clammy, sweaty and listless. There was more than a 60 minute delay in performing observations on the child or initiating treatment.
- Medical staff in the department provided details of two patients who had delays to treatment, as they had walked into the department and experienced a delay in having first observations done. There had been a delayed diagnosis of a diabetic emergency and another patient was in the waiting room for over an hour prior to collapsing.
- On reviewing the clinical incident forms during the previous three months, we saw an incident documented in February 2015, of a patient who had suffered a head injury. They were not triaged for over six hours at which point they were found to have a decreased consciousness level. An urgent scan showed a large sub-dural haematoma, and they were intubated and transferred to the local neurosurgical unit.
- Medical staff told us that they had tried to raise concerns regarding the lack of triage on numerous occasions, but didn't feel listened to. They were told that there was insufficient staff to provide the service. Following the inspection, senior managers told us that recruitment of the nursing team to full establishment was in progress in order to provide a triage system. In the interim, there was no plan to address this situation. Senior managers told us that issues related to triage were not on the risk register. We reviewed the most recent risk register and did not find evidence of the triage system on it.
- We observed 10 patients who arrived in the department to be registered. The nurse spoke to one out of these 10 patients. We concluded that the time to triage of 15 minutes was not always being met, and the 60 minute time to see a clinician was not being met. Sometimes two patients registered at the same time. However, following the inspection senior managers informed us that during the inspection the reporting of some waiting times was inaccurate due to IT issues, which were in the process of being resolved.
- We found streaming were unable to request or administer pain relief; pain was not assessed. When the process reverted to triage after 10pm, significant delays occurred, some patients were not triaged, and their initial contact after considerable delay, was with medical staff. The streaming nurse informed us that there was usually a GP on duty but this was not the case on the day of our visit, which added to the delays to see a doctor.
- During our unannounced inspection we observed that children who were streamed were seen by a paediatric nurse in a timely manner. However, we found that at night there was no allocated triage nurse and reception staff phoned through to the department if they were concerned about a patient. Otherwise a nurse in majors looked at the computer display periodically to check if a patient had arrived.
- We observed a child accompanied by their parent who arrived following a head injury, with symptoms of

drowsiness. The streaming nurse sent the parent and their child to the paediatric waiting room to wait to be seen. No observations or detailed triage assessment was undertaken. This presented a risk to the child. After our intervention the triage nurse undertook initial observations.

- In the major's area, we observed the evening handover. Staff displayed limited knowledge of the patients they were caring for and needed to review the computer system to determine what the plan of care was.
- Following the inspection we explained our concerns about the streaming and triage process to the trust. The trust agreed to review the patient pathways within the emergency department as a matter of priority. The trust introduced a revised streaming and triage process for patients attending the unscheduled care service and arranged a plan to monitor the effect of the revised streaming process.
- In order to investigate further the concerns identified with the initial review of patients who arrived in the department, we returned unannounced on 29 April. Managers told us the time of streaming was now being recorded, which had changed since our previous visit. We were informed that all children were now been triaged, usually by a paediatric nurse. When a paediatric nurse was unavailable triaging took place in the unplanned care area. Streaming took place between 10am and 10pm, sometimes assisted by a triage nurse who conducted initial assessment and observations. A member of nursing staff told us they were triaging earlier and doing some "see and treat". They said the department had been triaging most of the morning and had now resumed streaming. When streaming finished at 10pm, triage would be resumed. They told us that one nurse was always allocated to stream and some staff were allocated to unplanned care. The decision to start triaging again was taken by nursing staff when they noticed a build-up of patients requiring triage on the unplanned care screen.
- The trust shared with CQC the results of its monitoring following changes made to streaming and triage. The preliminary results indicated that patients were receiving safer, more responsive care and patient and staff satisfaction had improved. The trust was undertaking further analysis of individual instances where longer waits occurred and to implement a dashboard of streaming performance.
- 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 and 35% of emergency department staff had received training. Information we reviewed showed that scores for pressure ulcers acquired in the department had improved. We reviewed the assessments for two patients with pressure ulcers who presented in the department. After discussion with staff, the status of one patient assessed as green was reassessed as amber.

Nursing staffing

- Acuity and nursing establishment was calculated using the BEST assessment tool. This indicated that in the morning 12 nurses were required to staff the rota, with four support staff. During peak late hours, 15 qualified nursing staff were required, with four support staff. At night, 11 qualified nurses and four support staff were required. During our inspection, and on reviewing previous rotas, we found these showed that the nursing establishment was often operating with no more than 50% of shifts filled. The trust provided further data that showed fill rates for March ranged from 69% to 86%.
- The recruitment of staff to the department included a number of junior nursing grades. Hence, there was a differential skill mix amongst the nursing team. Senior nursing staff explained to us the steps that were being taken to recruit skilled nursing staff and also support staff. For example, six WTE band two support staff were being recruited to act as "patient champions" to support the introduction of intentional rounding of patients in the department.
- Management, nursing and support staff we spoke with each identified the shortage of suitably skilled staff in the department as their most significant concern. This included the recently opened clinical decision unit. Following the inspection senior managers provided assurance that recruitment to these posts was in progress. 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 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.

- Senior nursing staff told us they were undertaking a skill mix review and preparing an action plan to minimise fluctuations in staffing levels in the department. Nurse managers allocated staff to teams on a daily basis based on availability and an assessment of the requirements for staff, in the various areas of the department. This reflected the higher dependency of patients in some areas, for example majors and resuscitation. The unplanned care area was nurse led and we were informed that the clinical decision unit was also prioritised. A member of nursing staff was allocated to a "floor support" role.
- There was separate duty allocation rota for paediatric nursing staff. The department tried to ensure a paediatric nurse was on duty every day. At the time of our inspection and on reviewing rotas, we saw this was the case.
- Emergency care practitioners (paramedics with extended skills) were used when available although they were not allocated to support in the main department.
- We received information from 12 patients who attended a focus group who commented negatively on the staffing levels in the emergency department at the weekend.

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. The department were facing significant challenges in recruiting emergency medical staff. Senior managers informed us that the trust planned a development programme for middle grade medical staff.
- According to College of Emergency Medicine guidelines, and based on the number of attendances to the department, approximately 10 full time equivalent doctors were required on the rota. At the time of inspection, there were two substantive posts filled by consultants, four long term locum consultants and two long term agency consultants. Short term agency medical staff were also used. The department had four long term locum consultants and four long term middle grade doctors.. Of the 16 medical staff required to fill the registrar rota, seven of these were permanent staff. We reviewed the medical staff rota which showed that three members of medical staff were absent due to sickness.
- The department had introduced staggered starting times for consultant staff which reflected the requirement for medical staff at peak times for the department.

Major incident awareness and training

- We were informed that the arrangements for responding to major incidents were being reviewed although a review of these arrangements was not included in this inspection.

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. There remained, however, significant challenges identified from the national audits, which were yet to show significant improvement.

Arrangements were made for patients to receive adequate nutrition and hydration. Food and refreshments were made available to patients if they felt hungry or thirsty. Patients who had been in the department for some time were offered food. In the CDU,

a hot food trolley was available at lunchtime and in the evening. The department was recruiting support staff as patient champions; the role was to include intentional rounding to check if patients required food and drink.

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 information was displayed clearly on discretely placed screens in each of the main areas of 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. Staff had received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLs) in the previous 12 months. Staff mainly demonstrated a clear understanding of the MCA, of their responsibilities and of DoLs procedures.

Staff had received an appraisal in the last 12 months, or arrangements were in place for them to receive this. Several members of staff gave examples of their appraisal supporting them in how they wished to progress their career. Nursing staff felt well inducted into the department and well supported, although induction was variable for locum staff. A clinical education team provided the lead for staff training and signing off staff competencies. We observed that staff worked within their competencies.

We observed good working relationships between nursing and medical staff within the department. However, there was limited interchange with medical, care-of-the-elderly and surgical specialities. There was some evidence that the lack of joint working had a significant impact on the flow of patients through the department. There were good working relationships with physiotherapists and occupational therapists that provided rapid assessment for patients within the CDU as well as the wider emergency department This was supported by a dedicated discharge co-ordinator.

The administration of pain relief was identified as a significant 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. However, we observed some poor practice in the provision of analgesia during the inspection.

Evidence-based care and treatment

- The department used NICE and CEM guidelines 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.

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 significant 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 spoke with nursing staff who said they used a patient group direction (PGD) for administering certain medications and they asked patients about pain assessment on attendance. Although established pathways were available, staff said they may not always administer pain relief. For paediatric patients, we were informed that if the child was in acute pain, pain relief was discussed with medical staff within 15 minutes.
- We observed poor practice in the provision of analgesia during the inspection. We observed a patient with dementia complaining of acute pain. As the pain symptoms continued the inspector asked nursing staff if pain relief had been administered, and pain relief was then given to the patient. We observed a 10 year old child admitted to the department with a possible fracture who was clearly distressed with pain. They were initially "streamed" as requiring review within the paediatric section, but waited for over 60 minutes to receive analgesia.
- At our unannounced inspection, we observed a patient who had sustained a fracture. We observed that the patient was in some distress whilst nursing staff attended to them. When the patient requested pain relief, this was not given. After the inspector intervened, a further delay occurred before pain relief was administered. No time was allowed for the pain medication to take effect before the patient was expected to move themselves from the trolley, dress and go home.

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?'
- Availability of food for emergency patients featured in the complaints the department received. The department was recruiting band two support staff as patient champions; the role was to include intentional rounding to check if patients required food and drink. Nurse managers told us that pending the recruitment of this group of staff, rounding was undertaken intermittently.
- We observed that food and refreshments were made available to patients if they felt hungry or thirsty and asked for refreshments. Staff confirmed that food was always accessible from a fridge in the department. We spoke with patients who had been in the department for some time and found they had been offered food. Staff we spoke with confirmed this. We observed one patient with their carer who complained of being hungry, and we found staff had gone to get some food for them. Patients were offered sandwiches at lunchtime. In the CDU, a hot food trolley was available at lunchtime and in the evening.
- One patient we spoke with complained of not being offered water. Another patient we spoke with was given water in the department during their admission. We observed that a baby in reception was given a small amount of water by nursing staff.
- Patients who attended a focus group commented on the "blandness" of the food available in the department.

Patient outcomes

- Unplanned re-attendances to the emergency department 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. 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. There remained, however, significant challenges identified from the national audits, which were yet to show significant improvement.

Competent staff

- The trust provided us with data as to staff appraisals although it was unclear from this what proportion of staff in the emergency department had received an appraisal. However, we found staff we spoke with had received an appraisal in the last 12 months, or arrangements were in place for them to receive this. Although not all members of staff felt the appraisal process had been particularly meaningful for them, several members of staff gave examples of their appraisal supporting them in how they wished to progress their career.
- 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.
- We found evidence there was limited in-reach to the emergency department from medical,

care-of-the-elderly and surgical specialities. We found the lack of joint working had a significant impact on the flow of patients through the department. For example, on occasions patients were required to wait for prolonged periods for specialist review. Relations with the paediatric department were a notable exception to this, where we found strong working relations reported.

- A pilot programme was in place to review the presence of acute medical unit doctors within the emergency department. Although this was successful, we found it was felt to be unsustainable as it placed growing demands on the medical team.
- We found good working relationships with physiotherapists and occupational therapists that provided rapid assessment for patients within the CDU as well as the wider emergency department This was supported by a dedicated discharge co-ordinator.
- The service could access child and adolescent mental health services (CAMHS) via another provider. There was an onsite presence for mental health services at Doncaster Royal Infirmary.

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

- Medical and nursing staff could access current information for each patient in the department. The information was displayed clearly on discretely placed screens in each of the main areas of the department.
- 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. This meant, for example, that some medical staff were unfamiliar with the preparation of electronic notes.
- 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. Primary care information, for example, summarised GP patient information relating to prescribed medications in the community, was available to staff 24 hours a day.
- Within the majors area we saw a notice board at the staff base with stroke information which included the name of the stroke practitioner on call today and bleep information. We observed that in the first floor staff area a notice board was provided to inform staff of newsworthy items related to their role.

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.
- 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.
- 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. We observed that nursing and support staff were caring and compassionate in their interaction with patients. Conversations demonstrated an empathetic and caring attitude by staff.

Paediatric patients with their families receiving appropriate care and interactions with paediatric nursing

staff. Initial care by the paediatric nurse was followed up promptly by input from medical staff. Relatives of paediatric patients told us they were happy with the care their child received.

Patients were positive about the care they received. Patients confirmed that the interaction of staff was respectful of their dignity. Patients and their relatives in the paediatric area told us they had experienced quality care from a children's nurse. We observed paediatric nursing staff had good interactions with children.

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; they were happy with staff explanations and said that staff made them feel comfortable.

Staff demonstrated a good level of rapport in their interactions with patients and relatives. We saw that relatives were included in discussions. In the paediatric area, patients and relatives told us they were happy with the explanations they had received from staff. However, one relative who had waited some time with their child told us they were unhappy about the lack of explanation from staff.

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.

When information about patients was discussed in the department, confidentiality was not always maintained consistently. Patients received care and treatment in areas of the department which did not cater for their privacy and dignity.

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. 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.
- We observed paediatric patients with their families receiving appropriate care and interactions with paediatric nursing staff. Initial care by the paediatric nurse was followed up promptly by input from medical staff. Relatives of paediatric patients told us they were happy with the care their child received.
- We spoke with several patients who were positive about the care they received. One patient told us, "It's lovely care, I can't complain, it defies everything you hear about the NHS. It is excellent care and I'm very happy." Another patient told us, "They can't do enough for you." Patients confirmed that the interaction of staff was respectful of their dignity. Patients felt that staff listened to them.
- We spoke with patients and their relatives in the paediatric area who told us they had experienced quality care from a children's nurse. We observed paediatric nursing staff had good interactions with children.
- We reviewed concerning information from a complainant about aspects of caring in the department. This was being investigated by the trust at the time of our inspection.
- The environment of the emergency department was not conducive to maintaining the patient's dignity in all circumstances. Privacy was difficult to maintain. We observed six male and female patients on trolleys in the central overflow area of majors in touching distance of one another and with no screening to maintain their privacy. At our unannounced inspection we observed that in the central overflow area, male and female patients were present and a privacy screen was used, which made staff observation difficult. In the paediatric waiting area, we observed that individual cubicles were used for discussions with patients.
- At our unannounced inspection during an early senior review we observed a patient on a trolley not in a cubicle and less than a metre away from three members of medical staff discussing another patient. The conversation could be clearly overheard. During staff handover which took place in the major's area, information about patients was discussed directly in front of other patients. In the unplanned care area, we

observed streaming took place in a public area. This meant that confidentiality was not being maintained. We found that patients received care and treatment in the central overflow area of majors on a daily basis. This area did not cater for the privacy or dignity of patients.

Understanding and involvement of patients and those close to them

- Patients and relatives felt involved by staff in their care and treatment. Most patients told us that staff listened to them and had informed them of what was happening; they were happy with staff explanations and said that staff made them feel comfortable.
- 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. In the paediatric area, patients and relatives told us they were happy with the explanations they had received from staff. However, one relative who had waited some time with their child told us they were unhappy about the lack of explanation from staff.
- We saw that 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. For example, we observed nursing and support staff explaining to a patient a transfer to x-ray so that the patient understood what to expect. Another patient who attended the department with a relative and required an intravenous injection received an explanation of their hospital admission and reassurance as to their medications.
- Three patients who attended a focus group commented that staff were not "listening" to patients' symptoms. Staff we spoke with felt that often patients just needed time for them to sit down and offer reassurance.

Emotional support

- 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.

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

(for example, to feedback?)

Requires improvement

During the previous 12 months, the trust had not consistently maintained the 95% target for patients seen within four hours. The time patients spent in the department between 4 and 12 hours was worse than the England average. Streaming was being undertaken as a pilot following some changes to the layout of the department. At peak times when the three assessment rooms in the paediatric unit became full, this could cause delays.

The department opened the refurbished Clinical Decision Unit (CDU) in February 2015 which provided excellent facilities for patients who required further observation, assessment, or diagnostic tests. During the design of the new CDU, architects worked jointly with the trust's dementia team to ensure that the department was dementia friendly. We observed a patient with dementia who was waiting in the majors overflow area for a significant length of time, which was confusing and potentially disturbing for the patient, although external care staff provided some support. Patients with learning disabilities had access to a learning disabilities link nurse. This nurse however catered to the needs of patients throughout the hospital.

The department had reviewed with commissioners the types of patients accessing care through the emergency department, and to check if these patients were better served by seeing a GP. Approximately 20% of patients were deemed to be appropriate for review by a GP. A plan had been agreed to expand the availability of a GP on-site within the emergency department from October 2015.

The department had recently upgraded patient trolleys to ensure that they were able to cater for bariatric patients. An agreement was in place with the ambulance service so that if a bariatric patient was identified as requiring review in the hospital, a call would be made to alert staff in the department. 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.

Complaints were investigated and outcomes from the investigation were identified. Complaints were reviewed by an experienced emergency department nurse in conjunction with the complaints department. The department analysed the outcomes of complaints to identify themes and trends.

Service planning and delivery to meet the needs of local people

- During the design of the new CDU, architects worked jointly with the trust's dementia team to ensure that the department was dementia friendly. This included ensuring sympathetic colours were used for decoration of the unit. Staff from the department were involved in working with the trust's estates department during the design consultation stage. A member of nursing staff with an interest in the subject was engaged in the design of the unit.
- A joint exercise was undertaken by an emergency consultant and commissioners to review the types of patients accessing care through the emergency department, and to check if these patients were better served by seeing a GP. Approximately 20% of patients were deemed to be appropriate for review by a GP. Since this joint exercise a plan had been agreed to expand the availability of a GP on-site within the emergency department. The service was due to be co-located in the department from October 2015. This would provide patients with ease of access to primary care services.
- We found there was no formal policy in place as to the types of patients who would receive care and treatment in the central overflow area. Patients who were nursed there would often be subject to a number of bed moves into cubicles, to receive examinations or to have medications administered. We observed they were subsequently returned to the central overflow area to ensure other patients could access the limited number of cubicles.

Meeting people's individual needs

- At our unannounced inspection we observed a patient with dementia who was waiting in the majors overflow area for a significant length of time, which was confusing and potentially disturbing for the patient, although external care staff provided some support. We also observed a patient with dementia who arrived in the department without carer support. Ambulance staff provided some initial support.
- We found some members of staff, including support workers, had a particular interest in working with this group of patients and had received some training to support this. However, they told us they did not often have opportunity to work with patients with dementia. Some staff told us they had expressed an interest in attending the dementia training, but had not received the training.
- Patients with learning disabilities had access to a learning disabilities link nurse. This nurse however catered to the needs of patients throughout the hospital. We found there was no formal policy in place to ensure patients with a learning disability were reviewed by the learning disabilities link nurse on admission. Working with patients with a learning disability was included in mandatory training.
- We spoke with staff in the department about caring for patients with a learning disability. Staff said that the patient sometimes arrived in the department with a patient passport, which they found helpful. This was noted on the patient's electronic record.
- The trust had recently changed over their trolleys to ensure that they were able to cater for bariatric patients. An agreement was in place with the ambulance service so that if a bariatric patient was identified as requiring review in the hospital, a call would be made to alert staff in the department.
- 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 March 2015. From June 2014 to December 2015, the trust did not consistently achieve the target for patients seen within four hours and was below the England average for six of seven months. For the period January to March 2015, the trust's performance was better than the national average, however they did not meet the 95% target for patients seen within four hours. The percentage of emergency admissions waiting four to 12 hours from the decision to admit until being admitted was analysed 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.
- Patients who attended a focus group commented negatively on the length of time taken to obtain a diagnosis, particularly at the weekend.
- We were informed by the trust executive that in the winter of 2014-15 the trust was commended for its resilience in relation to four hour waits. 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.
- We found during periods of high surgical activity there could be delays in the transfer of care of surgical patients to the admissions unit. Following our visit managers informed us that for April 2015, there was a delay in surgical on-call doctor review on six occasions compared to a delay due to bed availability on 38 occasions.
- Staff told us that at times of peak demand, patients queued in the ambulance bay and also waited in ambulances. Staff informed us that in the week previous to our inspection, on one day 16 patients who had arrived by ambulance were queuing waiting to be seen. Handover from the ambulance was planned to take place within 30 minutes. Managers confirmed that the department had recently arranged with the ambulance service for a maximum of four patients in the ambulance reception area, where patients were reviewed by a qualified nurse. If more than four patients were waiting, they waited in the ambulance vehicle. The ambulance service rang ahead to the department to notify of earliest time of arrival.
- Unplanned care was nurse led, supported by medical staff. Patients arrived in unplanned care in the walk in waiting area. From 10am patients were streamed by a nurse located in the unplanned care reception area. Streaming did not take place at night. Streaming was being undertaken as a pilot following some changes to the layout of the department. Patients who arrived by ambulance but did not require urgent care were seen in unplanned care.
- Paediatric patients were admitted within 15 minutes of arrival wherever possible, The paediatric nurse undertook triage for paediatric patients. For children under one month of age, a member of the medical staff was informed on their arrival. We found that a qualified nurse accompanied children being admitted to the ward. At peak times when the three assessment rooms in the paediatric unit became full, this could cause delays. At busy times a nurse from the paediatric ward came to the emergency department to collect the child being admitted.
- Early senior review (previously, rapid assessment and treatment) had recently been introduced, involving a consultant or member of middle grade medical staff. A

discharge coordinator was based in the CDU and a transfer team was available to accompany patients to wards. Senior staff and the site coordinator held daily meetings in the morning, at 12.30pm and at 4pm to check waiting times and to review patient flow through the department. The performance prediction board displayed in the department showed that 91.7% of patients were being seen within four hours.

- At our unannounced inspection we observed there were 13 patients in the department that had been waiting for more than four hours. One patient had waited more than six hours. Four patients were waiting for general medical beds. For unplanned care, the waiting time to be seen was one hour 22 minutes. Paediatric patients were being seen after a 30 minute wait. We saw uncorroborated evidence that at our unannounced inspection the four hour standard was being achieved, with a compliance level of 96.1%.

Learning from complaints and concerns

- Information about complaints received by Healthwatch for 2014-15 included 14 complaints related to the emergency department, and also nine compliments.
- 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. Complaints were acknowledged within five working days.
- We reviewed a selection of nine complaint investigations. We saw that an investigation plan was followed and outcomes from the investigation were identified. Complaints were reviewed by an experienced emergency department nurse in conjunction with the complaints department. The outcomes of complaints investigations were discussed in senior staff meetings and shared with staff.
- The department analysed the outcomes of complaints to identify themes and trends. Information we reviewed in the department showed that 24 complaints were received in January 2015, six in February 2015 and 14 in March 2015. The main themes arising from complaints in the previous quarter included, for example, five related to missed fractures, five concerned delays in admission, and five related to lack of information provided for relatives. This information was displayed on a noticeboard in the staff area. Staff were encouraged to submit suggestions for improvement. Managers confirmed the downward trend in the number of complaints received.

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 restructure included co-location of the acute medical unit with 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 some risks current in the department and action being taken to mitigate these risks. However, some senior nursing staff we spoke with were not aware of the contents of the risk register.

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. Meetings of emergency department band seven nursing staff were held regularly, although not all eligible staff attended these. Formal one-to-one meetings for staff with their line manager were held less frequently than previously, although weekly drop in sessions for staff in the department were held with matrons.

Recent changes to the leadership arrangements had presented some challenges for urgent and emergency care which had been escalated to the executive team and the medical director had been asked to take oversight of the department. Senior staff spoke positively about the new leadership team. The executive team were seen as visible and accessible. There were good working relations between nursing and medical staff in the department. Junior staff spoke positively of the support they received from both senior nurses and from consultant staff and felt they listened to any concerns. However, some staff also gave examples of difficulties they had encountered in engaging with managers.

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 within the department. There was now a more open communication and the culture felt relaxed and focused. Staff were approachable and friendly and worked well as a team. Evidence of low morale with some staff in the department was largely attributable to issues encountered with staffing. Some staff told us they did not feel engaged by senior managers and did not feel that concerns they raised were adequately acknowledged.

The emergency department engaged with patients and the public through the NHS Friends and Family Test. The department used volunteers in the unplanned care area to ask patients questions about the NHS Friends and Family Test. The trust was introducing text feedback for patients to submit their response. The department opened the extended clinical decision unit in February 2015 and staff were consulted and engaged during the planning stage. Additional time was allowed for in the project to ensure staff involvement and consultation.

The trust's integrated discharge team received an award which recognised their work in enabling delays and avoidable admissions to be reduced. The department worked jointly with commissioners and an external equipment supplier to develop pressure relieving mattresses for patient trolleys. The link nurse for infection prevention and control had developed an innovative approach to support barrier nursing where the patient needed to be isolated for reasons of infection control.

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 restructure included co-location of the acute medical unit with the emergency department. We were informed that the five year plan awaited final sign-off by the trust board.
- 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. We found there was recognition of the challenges that the department faced, but there was also a continued priority of delivering safe care for patients. However, 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, limitations in the facilities of the department and the impact this had on patient privacy and dignity; the impact of staff shortages; the use of locum staff and recruitment; and ambulance handover, were included. We found some senior nursing staff we spoke with were not aware of the contents of the risk register.
- We spoke with the clinical governance lead for the emergency department and senior medical staff. We found the board to ward exchange of information had been minimal. Medical staff within the department expressed some frustration at needing to escalate issues, such as concerns about the triage system of walk-in patients, and difficulties in acknowledging the associated risks on the risk register.

- 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. The clinical governance meeting for the emergency department staff felt enabled them to start to work together as a team.
- Meetings of emergency department band seven nursing staff were held regularly, although not all eligible staff attended these. Staff we spoke with told us that team meetings for band five nursing staff were not held and formal one-to-one meetings with their line manager were held less frequently than previously, although they met with their manager informally. The level of communication depended on the team and the leader involved. Nursing and support staff we spoke with said they would raise any concerns with their line manager and most felt confident to do this. Lead roles in the department included infection control, trauma and safeguarding.

Leadership of service

- 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. We found there was a difficult relationship between the consultant staff within the emergency department and the clinical care group leaders. There were concerns raised by the medical staff in the department of being micro-managed and equally concerns raised by the care group leaders of inertia to change. The issues had been escalated to the executive team and the medical director had been asked to take oversight of the department.
- 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 executive team were seen as visible and accessible.
- Each band seven nurse was responsible for managing a team of nursing and support staff. We found there were good working relations between nursing and medical staff in the department. Junior staff spoke positively of the support they received from both senior nurses and from consultant staff and felt they listened to any concerns. However, some staff also gave examples of difficulties they had encountered in engaging with managers.

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. There was now more open communication and the culture felt relaxed and focused. Senior nursing staff told us the department was close knit and supportive. Staff were approachable and friendly and worked well as a team.
- With the appointment of the new leadership team, significant change had been brought about and morale had improved. Senior staff in the department spoke positively of their role in introducing an open culture of raising concerns and of the operational focus on helping staff on a day to day basis. Staff felt able to raise concerns.
- When we asked staff to explain the culture, they said it varied, depending on whether the department was fully staffed. This helped to maintain the focus on the patient rather than targets. Several members of nursing and support staff told us they loved their job and really enjoyed working in the department. It was a good supportive environment to work in.
- We found evidence of low morale with some staff in the department which were largely attributable to issues encountered with staffing. Staff told us they often felt overworked and undervalued.

Public engagement

- The emergency department engaged with patients and the public through the NHS Friends and Family Test. For February 2015, the department received 414 responses which represented a 9.6% response rate. The net promoter score was 34%, which was also the score achieved in January 2015. For the trust overall, 87% of patients recommended the hospital since the Test commenced in 2013.
- The department used volunteers in the unplanned care area to ask patients questions about the NHS Friends and Family Test. 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. A text was sent to patients who agreed to take part within 48 hours of their discharge from the department.

- Comments and suggestions from patients and the public were also received through the PALs service and through Healthwatch. For example, information received by Healthwatch for 2014-15 included nine compliments. The development of intentional rounding in the department using band two support staff as patient champions was in response to comments received form patients.

Staff engagement

- The board of governors for the foundation trust were actively involved and consulted in connection with developments in the department.
- During the planning of the new CDU, the trust's estates department and the architects involved staff from the emergency department during the design consultation stage. A member of nursing staff with an interest in the development was engaged in the design of the unit. The trust's dementia team were consulted to ensure that the department was dementia friendly. Senior managers told us they had requested additional time was allowed for in the project to ensure staff involvement and consultation was included.
- 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.

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.
- The department opened an extended clinical decision unit (CDU) in February 2015. The new facility provided 15 beds for patients who were unsuitable for discharge, but who did not require admission to an inpatient ward. The CDU included five single sex bays with en suite facilities including isolation facilities for one patient, kitchen and seating area and could be adapted from 15 beds to 12 beds with four chairs to reflect the needs of patients. Patients were admitted to the CDU when they required further observation, assessment, or diagnostic tests.
- The trust's integrated discharge team received an award which recognised their work in enabling delays and avoidable admissions to be reduced This involved working jointly with commissioners, the local authority and neighbouring health trusts to develop the integrated discharge team. This ensured that patients with complex health needs received an initial assessment while in hospital and the team decided on next steps in the care pathway. This provided an increased focus for patients on rehabilitation and reablement. Earlier intervention minimised delays in transfer of care from hospital and significantly increased the number of patients who remained in their home 90 days after discharge.
- 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 two of which had been trialled in the resuscitation area. 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.
- The link nurse for infection prevention and control had developed action cards to support barrier nursing where the patient needed to be isolated for reasons of infection control. The link nurse had designed barrier nursing signs to be placed near cubicles and trolleys so that support staff, for example porters, were aware of the need to observe barrier nursing without breaching confidentiality for the patient.

Medical care (including older people's care)

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

Information about the service

Medical services at Doncaster Royal Infirmary (DRI) have approximately 318 inpatient beds covering renal medicine, elderly medicine, stroke services, endocrinology, cardiology, haematology, gastroenterology and a 45 bedded medical assessment unit. Specialties within these medical services are managed by three Care Groups: the Emergency Care Group, Musculoskeletal (MSK) and Frailty Care Group and Specialty Services Care Group.

There were 33,700 admissions between July 2013 and June 2014 to medical services at DRI. These were predominately for general medicine services (69%) with 14% for clinical haematology services, 10% for medical ophthalmology and 8% for other medical specialties.

We visited Wards 16, 17, 18, 22, 24, 25, 26, 27, 28, 32, Endoscopy, Haematology & Oncology Day Unit, Haemodialysis Unit, Mallard, Kestrel, Kingfisher, the Frailty Assessment Unit and the Medical Assessment Unit. We also interviewed 70 members of nursing, medical and administrative staff including ward and unit staff, the Intermediate Discharge Team, the Diabetes Specialist Team, bed managers and core service senior managers as well as 22 patients and one carer.

Summary of findings

We rated medical care (including older people's care) as good for safe, effective, caring, responsive and well-led.

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 selected Serious Incidents were rerun in the Clinical Skills department with the team originally involved in the incident to identify learning points. There had been no Never Events in medical care services at Doncaster Royal Infirmary in the reporting period February 2014 to January 2015

Patient safety improvement actions included introducing the 'Hypo Box' containing items used to treat patients who experienced an episode of low blood sugar. The wards were generally well equipped but members of staff on the Medical Assessment Unit raised concerns about availability of electronic blood pressure machines for the 45 bedded unit. All medical nurses were expected to be trained in Immediate Life Support skills and most units had achieved over 60% training rates; however three wards had training levels recorded at 43-45%.

There was a trust-wide quality metrics audit framework for ward managers to complete (Ward Quality Assessment Tool). Audits were undertaken to monitor compliance with guidance, such as hand hygiene audits. Results seen showed good levels of compliance. The Trust responded to the outcome of the Sentinel

Medical care (including older people's care)

Stroke National Audit Programme (SSNAP) for 2013/14 and the National Diabetes Inpatient Audit (2013) by taking action to improve the quality of service and care provided.

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%. In 2014/15 the Trust trialled an alternative electronic recording system but ended that trial due to system issues. For 2015/16 they were beginning a new project dealing with the process, system, quality, training and compliance issues.

Each of the care groups were committed to achieving seven day services as demonstrated in their three year operational plans. Seven day services were widespread with seven day consultant cover, 24 hour seven day pathology services and numerous allied health professional and specialist teams also providing seven day services. Patients we spoke to confirmed that explanations and choices were given by staff so they could agree to or decline tests or procedures.

The average FFT response rate for April 2015 for medical services at Doncaster Royal Infirmary was 32.4%, which was above the Trust average of 30.4% and the England average of 25.6%. During our inspection we witnessed staff behaving in a caring and respectful manner towards their patients. Patients generally provided very positive feedback about the care provided by nursing staff. Patient buzzers were answered promptly in most areas visited. Many patients were positive about the staff ensuring that they understood the plan of care. Some patients were aware of their care plan and treatment objectives and felt fully involved but others were less clear in their understanding and wanted more information. Patients and family members said that medical and nursing staff were approachable and responsive if they did raise concerns. Staff were described as attentive, eager to help and asking if they needed anything on a regular basis. Several said how the staff made sure that they understood what was planned and provided reassurance when needed.

The trust was seeking to improve mortality and morbidity (national comparative data) performance through seven day working and this was reflected in the improved provision of seven day consultant cover for general medicine and specialist services including the Integrated Discharge Team, therapists and the diabetes specialist team. Discharge arrangements were managed by a multidisciplinary integrated discharge team including a social worker, therapists and nursing staff. Discharge dates were monitored and reviewed daily via Board rounds to assist with patient flow and bed management. Discharge delays were acknowledged but were related by staff to the complexity of patient needs, delayed assignment of social workers and availability of community based services and equipment. Medical outliers were managed through a trust-wide escalation process using a RAG rating on the whiteboards in order to reduce inappropriate transfers within the hospital.

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.

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.

Staff were generally positive about the leadership and the levels of engagement with their line management through to executive level. Junior staff in less well staffed areas voiced less confidence in the senior leadership due to the ongoing workload pressures experienced on the wards. The culture of the organisation was one of open communication and this was confirmed by many of the staff we spoke to.

Medical care (including older people's care)

Are medical care services safe?

Good

We rated medical services as good for safety.

There had been no Never Events in medical care services at Doncaster Royal Infirmary in the reporting period February 2014 to January 2015. 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 selected Serious Incidents were rerun in the Clinical Skills department with the team originally involved in the incident to identify learning points.

Clostridium difficile (C. difficile) rates for the trust (44 cases) were within trajectory (45 cases) for the Trust for 2014/15. A post-infection root cause analysis was conducted for each case and we saw evidence of actions being identified and reviewed for progress.

Patient safety improvement actions included introducing the 'Hypo Box' containing items used to treat patients who experienced an episode of low blood sugar. The wards were generally well equipped but members of staff on the Medical Assessment Unit raised concerns about availability of electronic blood pressure machines for the 45 bedded unit. All medical nurses were expected to be trained in Immediate Life Support skills and most units had achieved over 60% training rates; however three wards had training levels at 43-45%.

Incidents

- Nursing staff told us they were aware of how to use the system to report incidents. Feedback was received from their line manager by most staff in a variety of ways including team meetings, email and information posted on staff room display boards. We saw evidence of feedback of incident trends being displayed.
- Incidents were reported using the electronic Datix system. Feedback on incidents and shared learning was discussed at the ward managers' monthly meeting with their Matron. Feedback from the root cause analysis of serious incidents that occurred on the wards was communicated by the ward manager.
- There was a new section on the electronic incident reporting form to record how the Duty of Candour was met for moderate and serious incidents and staff we spoke to were aware of this.
- There had been no Never Events in medical care services at Doncaster Royal Infirmary February 2014 to January 2015.
- 761 patient safety incidents were reported between September and December 2014 within medical services which were rated as 16 severe harm, 45 moderate harm, 172 low harm and 524 no harm caused. Of the severe harm incidents, one related to a fall, 11 related to pressure ulcer development and four related to management of deteriorating patients, a missed diagnosis and an omitted medication. The most commonly reported incidents overall related to witnessed and unwitnessed patient falls and pressure ulcers.
- 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. Selected Serious Incidents were rerun in the Clinical Skills department with the team originally involved in the incident to identify learning points.
- The lead diabetes specialist nurse reviewed all incident reports relating to diabetes and evaluated trends. These were reported to the Patient Safety Review Group and the Specialties Care Group governance group.
- 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.

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care including the incidence of urine infections while catheterised, falls, pressure ulcers and deep vein thrombosis. The wards recorded the Safety Thermometer information electronically monthly and this data fed into trust-wide reporting to the Board.
- There was an inconsistent approach to the display of Safety Thermometer results, but most wards displayed the audit results.

Cleanliness, infection control and hygiene

- Ward areas appeared clean. Cleaning checklists were completed by housekeepers and the outcomes recorded electronically. These showed high levels of compliance.
- There had been two attributable cases of MRSA bacteraemia for the trust in 2014/15. Neither of these was attributable to medical services.
- Clostridium difficile (C. difficile) rates for the trust (44 cases) were within trajectory (45 cases) for 2014/15. Of these cases, 22 occurred in medical services during that period. A post-infection root cause analysis was conducted for each case and we saw evidence of actions being identified and reviewed for progress.
- Monthly infection control audits were undertaken and recorded electronically. Data from the most recent audits showed high levels of compliance with for example: hand hygiene and urinary catheter management. This data was also displayed on some of the wards but not all.
- Personal protective equipment and alcohol hand gel was available at the entrance to, and throughout, the wards. We observed mostly good practice in using the hand gel although we did observe instances of nurses not using gel between patients.
- We observed that staff wore personal protective equipment and most staff applied the principles of infection control; however we saw more than one instance of isolation room doors 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 wards were well lit, clean and tidy.
- Resuscitation equipment was generally checked daily with few exceptions. The 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. Suction and defibrillator equipment was also checked.
- Emergency equipment included a 'Hypo Box' containing items used to treat patients who experienced an episode of low blood sugar. This had been introduced as part of the action plan in response to the trust results for the national diabetes management audit (NaDIA).
- The wards were generally well equipped but members of staff on the Medical Assessment Unit raised concerns with regards to availability of equipment such as electronic blood pressure machines. We were informed that there were four machines for the unit and one staff member felt that time was wasted looking for them.
- We noted that in two areas, hoists were being borrowed by adjacent wards. A new hoist was on order in one of those areas.
- One ward had new blood pressure machines on order as well as a business plan for more arterial blood gas machines and more electric beds to improve the quality of care
- There was a future plan for iPads to be used in one acute care area to transfer patient observations straight onto the electronic whiteboard.
- Equipment was noted to be labelled with the last service date and the equipment examined was in date.

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.
- Some 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.
- Medicines were securely held in locked cupboards within a locked treatment room.
- Controlled drug cupboards were closed and locked. Controlled stationary was held securely and controlled drug stock levels were counted daily with few exceptions.
- Antibiotic therapy was monitored by the JAC system; wards received daily reports of antibiotic therapy prescribed on the ward and highlighted any antibiotic prescriptions without stop dates.
- Pharmacy services were available seven days a week.

Records

- The wards used a range of risk assessment and care pathway documentation and those nursing records reviewed were noted to be well completed.
- However gaps in the recording of blood sugars were noted for two patients, where testing was not done as frequently as stated on the care plan.
- It was noted on the Medical Assessment Unit that medical records were left unattended in the corridor and not held securely. In other areas, medical records were noted to be held more securely.

Safeguarding

- The trust had a safeguarding lead nurse and clinician.
- The trust has a Strategic Safeguarding People Board chaired by the executive lead for safeguarding with remit to manage the trust assurance processes in relation to safeguarding. Alerts and referrals are reviewed and managed by the corporate safeguarding team. Staff on the wards were aware of what to do in the case of a safeguarding concern; however recorded training levels were low in some areas. The target training level for safeguarding adults training was 85% - the training levels for registered nurses by ward ranged from 25 - 82% across the medical services with an average level by ward of 50%. It was noted that the recorded adult safeguarding training levels for wards specialising in care of the elderly ranged from 40% - 75%.
- Child safeguarding training levels were similar with recorded training levels across medical services ranging from 16% - 82% and an average level by ward of 48%.
- All the ward / unit managers interviewed were aware of the training levels on their ward and had plans in place to increase these by ensuring staff were scheduled to attend.
- A safeguarding adults and children newsletter was available for staff to read on the intranet.

Mandatory training

- The trust had a programme of statutory and mandatory training for all staff.
- Training levels were notably low amongst nursing staff for the majority of medical wards for Conflict Resolution (average 20%), Infection Control (average 9%) and Information Governance (average 41%). It was noted that the Haemodialysis unit achieved good levels of training across all topics.

Assessing and responding to patient risk

- Doncaster Royal Infirmary (DRI) used a combined risk screening and assessment tool that incorporated a review of risks associated with infection control, pressure ulcer development, malnutrition (using the malnutrition universal screening tool), falls and the need for safety sides, moving and handling, continence, alcohol screening and safeguarding adults and children. Six records were examined and found to be completed appropriately.
- The National Early Warning System was in use to identify deteriorating patients. Assessment of the score was seen on to be a routine part of recorded vital signs observation charts examined.
- All the nurses were expected to be trained in Immediate Life Support skills and most units had achieved over 60% training rates; however three wards had training levels 43-45%.
- We were shown a system on the intranet that allowed staff to notify the End of Life team and Tissue Viability Team of referrals. Response times were reported to be good and usually the same day; this was confirmed by nursing staff when interviewed.
- One ward had reduced their incidence of Grade 3 and 4 pressure ulcers by ensuring that pressure areas were checked within two hours of admission and taking action on the results of the assessment such as obtaining a pressure relieving mattress.
- The Frailty Assessment Unit received patients with two or more of the following conditions acute confusion, dementia, falls, reduced mobility, incontinence and breakdown of their care package. Each patient received a rapid comprehensive assessment including medical, social and rehabilitation assessments to determine how best to manage current risks and facilitate an appropriate pathway towards discharge.
- Non Invasive Ventilation (NIV) therapy was managed on the respiratory wards. NIV was initiated by the physiotherapists and they were responsible for resolving any problems that arose during treatment in the first instance. Monitoring of blood gases was undertaken by medical staff. No incident reports were submitted related to NIV treatment in the period September to December 2014. Updates on non-invasive ventilation training were available and staff on the respiratory wards were supported to attend.

Nursing staffing

Medical care (including older people's care)

- 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 staffing needs at a local level on the medical wards. Expected and actual staffing levels were clearly displayed on each ward.
- The trust RAG rated each ward against a local framework for staffing levels on a monthly basis: green where actual available hours were 5% below planned, amber where 5 and 10% below planned and red where more than 10% below planned. The RAG rating applied equally to over establishments.
- Actions to mitigate the risk of understaffing due to vacancies and sickness included bed closures. For example, 8 beds were closed on Ward 17 at the time of inspection to manage nurses per bed ratios as a result of vacancies in registered nurse posts.
- The Medical Assessment Unit (MAU) had deficits of more than 10% of the overall planned staffing hours: 83% in March and 85% in April 2015. The unit had 45 beds and 92 staff and in April, registered nurse hours (including agency staff) planned for days were 70.8% filled compared to 99% for clinical support staff. Registered nurse hours planned for nights were 73.5% filled compared to 106% for clinical support staff. We were told by nursing staff on MAU that the target ratio of nurses to patients was 1:7; however on the day of the inspection it was1:9.
- Actions being taken to improve MAU staffing levels included: training a cohort of Band 3 support workers to cannulate, staffing a reception area to manage answering phone calls and directing visitors, recruiting an Advanced Nurse Practitioner to support the acute physicians and recruiting a number of Band 6 nurses to strengthen expertise on every shift.
- Ward 25 was another area that had suffered staffing shortages in March. The unit had 24 beds and registered nurse hours (including agency staff) planned for days in March were 76.3% filled. In April, this had risen to 92%; however during the week of the inspection in April, there was one day when one registered nurse plus the ward manager covered the ward for the 12 hour day shift with three support workers. The week prior there was one permanent nurse rostered each night with one agency nurse supporting.
- The Frailty Assessment Unit had 16 beds and reported maintaining a 1:5 nurse to patient ratio.
- The trust Nursing Workforce Information Report (April 2015) reported that "across the organisation, ward nurse staffing levels were recorded in 49 incident reports in March 2015, of which ten reported low harm (delayed or omitted care and staff missing breaks); 39 incident forms reported high acuity and dependency levels for the number of staff available but no harm events."
- Nurse staffing incident reports were investigated by the Head of Nursing and matrons to ensure actions were taken and learning points identified.

Medical staffing

- General and Acute Medicine had increased their consultant numbers over the last five years by approximately 16 consultants. Consultants in acute medicine were working on a rota for two consultants covering 12 hours per day, seven days a week. This was supplemented by three general physicians on call over the weekend who visited the medical wards and the routine consultant led teams across the working week. The trust has been identified in the national High Intensity Specialist Led Acute Care (HISLAC) research project as a positive outlier in the number of specialist working at weekends compared to the weekdays. The Medical Assessment Unit had adequate medical staffing cover; however at night there was a Foundation Year One doctor (F1), two Senior House Officers (SHO - one for admissions and one for the wards) and a Specialist Registrar to cover all the medical wards. This was described by junior medical staff as sometimes not enough to see multiple sick patients at the same time and the registrar was often in A&E to review referred patients.
- Weekend ward rounds including the medical outliers were conducted by three consultants who split the workload into three clinical areas plus one consultant covering the Medical Assessment Unit. Each of these consultants was supported by an F1 or SHO.
- Additional consultants were currently being recruited to stroke medicine, gastroenterology and endocrinology; the latter was in response to the results of the national diabetes audit. The number of substantive acute physicians had increased from one to nine.
- Medical handover was observed and assessed to be thorough and well-led by the registrar. There was a handover at 0830, 1630 and 2030 when all medical doctors attended MAU to handover patients with outstanding tasks.

Medical care (including older people's care)

Major incident awareness and training

- The Trust had a major incident plan in place and staff we spoke with were aware of this.
- The intranet location of the latest version of the plan was highlighted in the staff newsletter Buzz April 2015

Are medical care services effective?

Good

There was a trust-wide quality metrics audit framework for ward managers to complete (Ward Quality Assessment Tool). Audits were undertaken to monitor compliance with guidance, such as hand hygiene audits. Results seen showed good levels of compliance. The Trust responded to the outcome of the Sentinel Stroke National Audit Programme (SSNAP) for 2013/14 and the National Diabetes Inpatient Audit (2013) by taking action to improve the quality of service and care provided.

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%. In 2014/15 the Trust trialled an alternative electronic recording system but ended that trial due to system issues. For 2015/16 they were beginning a new project dealing with the process, system, quality, training and compliance issues.

The trust was seeking to improve mortality and morbidity (national comparative data) performance through seven day working and this was reflected in the improved provision of seven day consultant cover for general medicine and specialist services including the Integrated Discharge Team, therapists and the diabetes specialist team.

Each of the care groups were committed to achieving seven day services as demonstrated in their three year operational plans. Seven day services were widespread with seven day consultant cover, 24 hour seven day pathology services and numerous allied health professional and specialist teams also providing seven day services. 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.
- 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.
- 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 using the malnutrition universal screening tool (MUST) as part of the admission process 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

- The rolling 12 month HSMR at Doncaster Royal Infirmary (DRI) was 109.5 as at March 2015. The target at the Trust was to achieve an HSMR of 102. The elevated HSMR was noted on the assurance framework and subject to regular reporting to the Board of Directors. An action plan was in place to improve the quality of coding and mortality reviews at specialty level. 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.

- 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.
- There was an annual audit plan in place for medical services at DRI and local audit included evaluating the Early Supportive Discharge (ESD) Assessment Intervention and Outcome for stroke patients. It was estimated that 630 bed days had been saved as a result of ESD with the average length of hospital stay being 9 days.
- 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 trust achieved an overall rating of 'D', on scale of A – E, with E being the worst, in the Sentinel Stroke National Audit Programme (SSNAP) for 2013/14. Since then the trusts overall score has continued at the same level with results for October to December 2014 showing a score of 'D'. The main areas for improvement included staffing levels, access to specialist assessments (particularly psychology), provision of thrombolysis and discharge processes. We reviewed the trust SSNAP action plan and noted that progress was being monitored.
- The National Diabetes Inpatient Audit (2013) showed 18 /21 indicators as worse than the England median at DRI. Management had responded to the outcome of the audit by expanding the diabetes specialist nurse team and recruiting another diabetes consultant. The specialist team provided seven day working, saw 25-50 patients per day, conducted follow-up of referrals, were involved in staff training, developed a hypoglycaemia pathway and audit form and changed the care pathway for managing diabetes ketoacidosis evidenced by a revised treatment and monitoring chart. It was planned to include diabetes management as part of mandatory training.
- The National Institute for Cardiovascular Outcomes Research Heart Failure audit (2012/13) showed a lower (38%) than the England average (78%) input from specialists for heart failure patients at DRI. There was less consultant input than the England average (33%:51%) and less patients cared for on a cardiology ward (21%:50%) but higher (98%) than the England average (91%) percentage of patients received an echocardiogram. 97% of heart failure patients received discharge planning compared to the England average (83%); however 47% 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 (83.5%:94.3%). The proportion of nSTEMI patients who were referred for or had angiography during admission was higher than the England average (98%:77.9%).
- There was no evidence of risk related to in-hospital mortality outliers.
- The overall average length of stay for patients receiving elective general medical services (3.1 days) was below the England average (3.9 days) for 2013/2014; however the average length of stay for non-elective stroke medicine at Doncaster Royal Infirmary was higher (16.3 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 complex discharges and social and community services resources. On the day of inspection there were 12 delayed discharges in the hospital.
- There were slightly more observed readmissions than expected for the medical service: ratio of elective readmissions - 107, ratio of non-elective readmissions – 102. (Source: HES Jul 2013-Jul 2014).

Competent staff

- Appraisal rates for nursing staff within medical services for 2013/14 were reported in December 2014 as between 0% and 47% 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 producing inaccurate data.
- 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%.
- The AMU had recently recruited up to establishment and had eight Band 6 nurses undergoing staff development including conducting appraisals and sickness management for junior staff.
- 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

- The Integrated Discharge Team – a partnership of staff from four Doncaster-based agencies, Doncaster and Bassetlaw Hospitals, Doncaster Metropolitan Borough Council, Rotherham, Doncaster and South Humber Foundation Trust and Doncaster Clinical Commissioning Group, won the National NHS Leadership Recognition Awards for Outstanding Collaborative Leadership. The multidisciplinary team included social work, physiotherapy, occupational therapy, adult mental health and nursing professionals who aim to achieve all initial assessments within 24 hours.
- Staff from medical, nursing and allied health professional groups were observed to have good working relationships on the wards. Multidisciplinary meetings were held Monday to Friday. The discharge processes were supported by ward-based discharge coordinators.
- The acute physiotherapy services team had a base within the acute medical floor and was able to facilitate timely intervention and discharge planning.
- The Frailty Assessment unit provided a good example of multidisciplinary working as all patients received a comprehensive assessment including a medical, rehabilitation and social assessment. A physiotherapist, occupational therapist and social worker worked on the unit daily. As the unit aimed for a two-day length of stay, every patient was discussed every day by a multidisciplinary group which included the Integrated Discharge Team to assess discharge needs.

Seven-day services

- The Trust was seeking to improve mortality and morbidity (national comparative data) performance through seven day working and this was reflected in the provision of seven day consultant cover for general medicine and specialist services including the Integrated Discharge Team, therapists and the diabetes specialist team.
- Pathology services became a 24 hour seven day service eighteen months ago.
- Consultant presence was seven days per week in most specialties. Consultant ward rounds were conducted daily and it was reported from several of the ward managers that this had improved the discharge processes at the weekend. This was further supported by the Integrated Discharge Team providing seven day services.
- Allied health professionals including occupational therapy, and physiotherapy also provided seven day services. Speech and language therapy provide a six-day service to acute stroke patients. The haematology and oncology day unit also provided a seven day service.
- Physiotherapists told us that covering the needs of patients seven days a week stretched their services at times as there were no bank or agency therapists available to support vacancies or sickness absence. Their duties at Doncaster Royal Infirmary included management of NIV which was managed by nursing staff at Bassetlaw Hospital. The difference in service management was related to historical arrangements at each hospital.
- Pharmacy provided seven day services with more limited hours at the weekend. There was a pharmacy service based on the Medical Assessment Unit.
- The Transient Ischaemic Attack (TIA) Clinic was a seven day consultant led service that operated 365 days a year.

Access to information

- Staff told us there was sufficient information in patients care records to enable them to care for patients appropriately.

- 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.
- The 'at a glance' board to monitor the status of patients quickly was a commonly used tool in clinical areas.
- Care summaries were sent to the patient's GP and the patient on discharge.
- Patient information leaflets were displayed in some of the clinical areas.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Ward staff were clear about the processes to follow to establish whether 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. There was an older people's mental health nurse who could assist with assessment of patients with dementia and cognitive impairment.
- 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 staff behaving in a caring and respectful manner towards their patients. Patients generally provided very positive feedback about the care provided by nursing staff. Patient buzzers were answered promptly in most areas visited. Many patients were positive about the staff ensuring that they understood the plan of care. Some patients were aware of their care plan and treatment objectives and felt fully involved but others were less clear in their understanding and wanted more information. Patients and family members said that medical and nursing staff were approachable and responsive if they did raise concerns. Staff were described as attentive, eager to help and asking if they needed anything on a regular basis. Several said how the staff made sure that they understood what was planned and provided reassurance when needed. An average of 93% of patients in medical services recommended the service compared to the Trust average of 95% and the England average of 95.4%.

Compassionate care

- The average FFT response rate for May 2015 for medical services at Doncaster Royal Infirmary was 36%, which was above the Trust average of 29.9% and the England average of 25.9%. An average of 93% of patients in medical services recommended the service compared to the Trust average of 95% and the England average of 95.4%
- During our inspection we witnessed staff behaving in a caring and respectful manner towards their patients including asking whether they were comfortable, offering additional drinks, using humour appropriately, giving explanations of planned care, asking whether they were in pain and being encouraging and cheerful during interactions with patients.
- We also witnessed staff talking to relatives and carers in an empathetic way when explaining discharge plans.
- Patient buzzers were answered promptly in most of the areas visited and patients were generally very positive about care provided. One relative we spoke to was concerned at how busy nursing staff were and preferred to come in to feed the patient themselves. Patients and relatives noted how busy nurses were at night and another patient said how she had to occasionally wait to go to the toilet which she found upsetting due to her lack of mobility.
- 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.
- We noted posters displayed prompting staff to use "Hello my name is …"

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.

Medical care (including older people's care)

- Many patients were positive about the staff ensuring that they understood the plan of care. Some patients were aware of their care plan and treatment objectives and felt fully involved but others were less clear in their understanding and wanted more information.
- Patients and family members said that medical and nursing staff were approachable and responsive if they did raise concerns.
- The Trust was introducing a Care and Compassion pledge mat in April 2015 which listed pledges to the patient about keeping them safe and involving the patient in decision-making about their care. For example to avoid pressure ulcers forming, patients were encouraged to change their position in bed or tell the nursing staff if they felt uncomfortable and wanted to change position.

Emotional support

- Patients we spoke to described staff as attentive, eager to help and asking if they needed anything on a regular basis.
- A patient with visual impairment said that staff were always available to help him
- We observed nurses being supportive during a discussion about what happened during an endoscopy with a patient and their relatives.
- Several said how the staff made sure that they understood what was planned and provided reassurance when needed.

Are medical care services responsive?

Good

Discharge arrangements were managed by a multidisciplinary integrated discharge team including a social worker, therapists and nursing staff. Discharge dates were monitored and reviewed daily via board rounds to assist with patient flow and bed management. Discharge delays were acknowledged but were related by staff to the complexity of patient needs. Medical outliers were managed through a trust-wide escalation process using a RAG rating on the whiteboards in order to reduce inappropriate transfers within the hospital.

Service planning and delivery to meet the needs of local people

- In line with the Urgent Care Model being developed by Bassetlaw 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.
- The Care of the Elderly team were involved in a number of developments with community and social care colleagues. These included working with Doncaster CCG as part of the intermediate care review, developing the role of the Community Geriatrician and working with Bassetlaw CCG to develop the role of Consultant Geriatrician both in the acute hospital setting and within the community.
- Negotiations were taking place to reach an agreement to support a rota sharing system which would ensure 24/7 consultant cover for Acute Cardiology. A final meeting of cardiologists and managerial leads from participating Trusts was planned to take place over the coming months to finalise detail.

Access and flow

- Medical services at Doncaster Royal Infirmary received patients with general and acute medical conditions. Discharge arrangements were managed by the Integrated Discharge Team working with social services, community services and GPs.
- Discharge delays 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.
- The bed management team was made up of three Band 6 and 13 Band 7 nurses all of whom were Advanced Life Support trained. There were three bed management meetings a day at 8.30am, 12.30pm and 4pm. These meetings were attended by senior nurses from all specialties and used an electronic whiteboard to monitor A&E activity and a telephone link with Bassetlaw Hospital to monitor the patient flow position there.
- When patient flow was of particular concern then a further meeting would be held at 6pm. A list of medical

outliers was supplied to junior doctors on a daily basis to ensure that their location was clearly communicated. Those patients on non-medical wards were reviewed and managed by their medical consultant team.

- Medical outliers were transferred to other specialty wards when beds were unavailable on the relevant medical ward. In December 2014, the daily average number of medical outliers in DRI was 45, with an average of 16 outliers per day being lodged in trauma and orthopaedics, 13 in special surgery, 9 in general surgery and 7 in gynaecology. In April 2015, this had reduced to an average of 22 outliers per day being lodged on non-medical wards.
- Medical outliers were managed through a trust-wide escalation process using a RAG rating on the whiteboards in order to reduce inappropriate transfers within the hospital. green meant that the patient was appropriate to be boarded out to another ward; amber meant that the patient would only be transferred if necessary and red indicated that the patient should not be moved. There was a veto on patient moves after 10pm unless medically necessary.

Meeting people's individual needs

- The diabetes specialist team was continuing to develop following expansion and had introduced improvements to the management of hypoglycaemia and diabetic ketoacidosis. The trust was recruiting another diabetes consultant and planning a more robust diabetes foot care service.
- There was a room on the Medical Assessment Unit used to talk to relatives and break bad news.
- Patients with learning disabilities had access to a trust-wide resource through the learning disabilities nurse. Working with patients with a learning disability was included in mandatory training.
- The largest ethnic minority groups in the local area were Asian and Polish and interpreters were available to assist with communication needs on demand. Leaflets in languages were available on demand.
- Mallard ward was a 16-bedded unit developed as the designated ward for patients living with dementia and suffering from delirium and had a less cluttered and clinical environment to meet their needs.
- The Frailty Assessment Unit had been open for a year was set up to conduct a rapid and comprehensive assessment of elderly patients admitted for reasons such as an increase in confusion, dementia, falls or reduced mobility. The unit took a multidisciplinary approach to assessment and planned for discharge or transfer from the unit within two days to reduce the impact of taking the patient out of familiar surroundings. Each patient was discussed by the full team twice a day to ensure that the outcome of their assessments was monitored and a personal care plan developed.
- There was a ward designated to receive all acute stroke patients with seven day consultant cover and a stroke specialist nurse who assessed the individual needs of stroke patients. The Early Supportive Discharge (ESD) Assessment for stroke patients was evaluated and identified that patients found it beneficial to see the therapist on the ward who would then see them at home after discharge. Where appropriate, all patients received information on the ongoing management of their condition either verbally, in written format or both.

Learning from complaints and concerns

- The Trusts captures and monitors all complaints and concerns via their DatixWeb 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 seen to be 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 the 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.

Staff were generally positive about the leadership and the levels of engagement with their line management through to executive level. Junior staff in less well staffed areas voiced less confidence in the senior leadership due to the ongoing workload pressures experienced on the wards. The culture of the organisation was one of open communication and this was confirmed by many of the staff we spoke to.

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, the implementation of seven day services and 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.**
- **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 brought 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.**

Medical care (including older people's care)

- **The Ward Managers we interviewed felt well supported by their Matrons and Head of Nursing and Quality. There were senior sister meetings held monthly, one to ones held monthly and ward team meetings were also planned monthly to communicate and cascade key messages.**
- **Junior staff in less well staffed areas voiced less confidence in the leadership due to the ongoing workload pressures experienced on the wards.**

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.**
- **The staff newsletter Buzz included awarding the star of the month to outstanding individuals or teams. In April this was awarded to Ward 25, the discharge ward which opened in January 2015. It was given in recognition of the effort made to create a new team from ward staff from other areas and the running of the ward a success.**

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.**
- **The ICE system was in use throughout the hospital and provided the wards with a paperless system for ordering and labelling tests and receiving test results.The trust had implemented the ward based Quality Assurance Tool (QAT) which included patient surveys, staff surveys and various assessments of quality and safety.**
- **The Integrated Discharge Team was a nationally recognised beacon of good practice in collaborative working and was very active in proving a discharge planning service to medical patients.**
- **The Frailty Assessment Unit was another example of effective collaborative working enabling rapid assessment of elderly patients and person-centred care planning.**

Surgery

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

Information about the service

The surgery services at Doncaster Royal Infirmary were managed by three care groups: Musculoskeletal and Frailty, Speciality Services and Surgery. The care groups managed 10 surgical wards, along with surgical departments and a suite of operating theatres. The operating theatres consisted of seven main theatres, three trauma and orthopaedic theatres, two women's services theatres, and two obstetric theatres. There was an emergency 24-hour theatre service provided at this location. There was also an Endoscopy suite which has achieved JAG (Joint Advisory Group on GI Endoscopy) accreditation.

During our inspection we visited the surgical wards and departments, the endoscopy suite, as well as the operating theatres and theatre sterile supply unit. We spoke with 30 members of staff, 14 patients, and reviewed over 10 sets of records.

Summary of findings

We found that systems were in place so that incidents were reported and effectively investigated, and lessons were learned. The wards and departments were mostly clean and well maintained. However, there were worn floors and dust and dirt on trolleys and autoclaves in the theatre sterile supply unit. We found medicines and records were managed appropriately. Safeguarding systems were in place and the service responded appropriately to clinical risk in patients, although not all staff had received safeguarding training. There were some shortages of nursing and surgical staff; the trust were aware of this and were actively recruiting to fill the vacancies.

We found evidence-based care and treatment which was audited in the wards and departments. There was a system for the provision of pain relief to patients although it had been identified there were delays in the provision of analgesia to patients referred to the surgical assessment ward by their GPs. We found effective systems for the provision of nutrition and hydration to patients. Patient outcomes data did not show the trust to be an outlier in any area of practice.

Mandatory training records showed compliance with the 85% target for achievement of this was poor. However, the majority of staff we spoke with told us they were up-to-date with their mandatory training. There were systems in place for yearly appraisal. We found

Surgery

that the surgery services were caring and that patients received compassionate care. We found evidence of service planning and delivery to meet the needs of local people.

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; however the number of patients who had to wait longer than 18 weeks from referral to treatment (admitted) breached the operational standard.

We found that the trust had systems in place that assisted in meeting the needs of people who used the service.

The surgical care groups at Doncaster were well-led with a vision and strategy for the service. There were systems of governance, risk management and quality measurement in place. Staff we spoke with felt there were systems in place that allowed them to be kept appropriately informed.

Are surgery services safe?

Good

We found that systems were in place so that incidents were reported and effectively investigated, and that staff were able to learn the lessons of incidents in order to improve practice.

The NHS safety thermometer was used in the trust as a measurement tool, with its use audited to improve compliance. The wards and departments were mostly clean and well maintained, with staff observing infection control and hand washing procedures. However, there were worn floors and dust and dirt on trolleys and autoclaves in the theatre sterile supply unit.

We found medicines and records were managed appropriately. 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.

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

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

Incidents

- Between September 2014 and December 2014 there had been seven serious incidents within the surgical services at Doncaster Royal Infirmary. Of this number four were pressure ulcers and four were falls. In each case actions were recorded. No never events were reported by the trust for this location
- The service used a risk register to itemise risks. We reviewed the risk register for surgical services based at Doncaster which contained 63 risks. The list included a description of the risk and the actions that had been taken to mitigate the risk.
- We reviewed serious incident investigation reports which were prepared by the service in order to provide a record of the trust's investigation of these incidents. These included action plans with timeframes for the completion of these actions.

- On the urology ward we reviewed files that contained details of serious incident investigations within the trust. These files were made available to all staff on the ward so they could keep themselves up-to-date. We reviewed an incident that included a full root cause analysis regarding hospital acquired category three pressure ulcers.
- Staff explained to us that incidents are reported on the intranet's electronic incident reporting system. These were 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 departmental level. There was no consistent method of feedback, for example information was shared at handover or through bulletin boards in staff areas.
- Senior staff on the surgical assessment ward told us that learning from incidents was shared with them by the matron. This was shared with staff through a newsletter they produced called; "SAW News". Any suggestions about possible changes in practice from staff were communicated to staff through a 'feedback board' on the wall in the staff room. The board was divided into different areas with post-it notes from staff placed in an area designated for suggestions. These suggestions could then be passed to the matron and care group governance groups.
- We spoke with four qualified nurses and two health care assistants on the two gastro intestinal (GI) wards. They told us that they knew how to report incidents using the electronic reporting system. We found that root cause analysis of incidents and action plans were posted on notice boards, and placed in the communications book.

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 indicators: 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 operating theatres and wards and infection control procedures were in place.
- Standard operating procedures were in place for hand washing and deep cleaning of the theatres and day unit.
- In the wards we visited we found that infection control audits were regularly undertaken and the results displayed on the walls for both patients and staff to view. Overall these showed compliance with infection control standards.
- Wards were clean and well maintained. However, we found that parts of the theatre sterile supplies unit were not clean. In parts of the unit the flooring was patched up with sticky tape and trolleys and autoclaves were dirty, dusty and worn.
- On the urology ward we spoke with a link nurse for infection control. They told us they liaised with the trust's infection control team and updated staff at ward meetings on infection control theory and practice. The ward's infection control statistics were displayed in an easily readable chart on the main corridor wall of the ward. The charts showed that there had been no recent incidents of c-difficile or MRSA (methicillin-resistant staphylococcus aureus). We found evidence of regular infection control audits, information on infection control theory and practice and a commitment to preventing the spread of infection amongst staff.

- 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 underlying this business case was to reduce infection rates, and thereby reduce readmission rates and improve discharge planning.
- We spoke with nursing staff on ward 6, a trauma and orthopaedic ward, who told us that surgical patients were routinely screened for MRSA. There was also a system of segregation in place to protect them from possible cross infection from non-surgical patients.
- Not all wards routinely screened all patients for MRSA. On the GI wards we found this was done for high risk patients. One of the GI wards, ward 20, had found following an audit that there had been a recent increase in cases of MRSA colonisation.
- In the orthopaedic operating theatres we found there was a rolling twice a year programme of wall cleaning.
- Within the operating theatres there was a higher than national average infection rate for knee surgery, at 3.9%. A mapping exercise had been undertaken and an action plan was being implemented to reduce the incidence. The actions included a change of skin preparation liquid (skin prep), the introduction of single use tourniquets, and greater continuity of cleaning staff.

Environment and equipment

- We found that the theatre sterile supplies area of the main theatres area of the Doncaster Royal Infirmary was old and in need of upgrade and repair.
- Within the main operating theatre suite, maintenance occurred when required, however there was no regular planned preventative maintenance programme.
- However, in the orthopaedic theatres we did see evidence of planned preventative maintenance. The laminar flow system was maintained every two years, whilst there were daily laminar flow checks by theatre staff. Regular upkeep and maintenance of laminar flow systems are required to keep joint surgery patients free from infection.
- All resuscitation trolleys were regularly checked by staff from the operating theatres. 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).
- We found that fridge temperatures were monitored and recorded by staff on the wards and in the operating theatres.
- We found that fluids used for infusions were appropriately stored and kept within date.

Medicines

- We observed medicines being dispensed to patients on ward 6, a trauma and orthopaedic ward. The drugs' trolley was connected to a wireless laptop which gave details of patients' medication regime. We observed this system being interrogated by nursing staff before they dispensed the medications to patients.
- We found that medicines, including controlled drugs, were appropriately stored in secure environments.
- We found that the service employed advanced nurse practitioners with prescribing. Some of these staff rotated to Bassetlaw District General Hospital.

Records

- We found that there was a mixture of paper and electronic patient records in use.
- We reviewed eight sets of patient records. We found these had been appropriately completed and included the required risk assessments. We also viewed a set of admission notes. All these paper records were legible, dated, and signed by the person completing them.
- 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.
- The operating theatres used the integrated patient operating care pathway (IPOC) for both minor and major procedures. The standard for operating theatres. We reviewed three sets of records which were all correctly completed, signed and dated.
- We also reviewed the WHO in the patient records we viewed on the wards. This showed that these checklists followed the patient on their post-operative journey.

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.
- On the GI wards we spoke with senior staff and reviewed safeguarding records. These showed that there was a comprehensive approach to safeguarding involving a multi-disciplinary team approach.
- We found that not all staff had completed safeguarding training. Trust data showed that 38% of anaesthetic medical staff had undergone safeguarding adults and children training against a compliance target of 85%. It did not give the level of the training which could have been either at levels 1, 2 and 3. No areas had achieved the trust target: the highest recorded percentage of staff was on ward 21, the GI surgery ward, where 75% of nursing staff had completed safeguarding training.

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 53% of nursing staff in the operating theatres had received adult resuscitation training and 100% fire safety training. However, none were recorded as having received paediatric resuscitation training.
- The figures were not clear with some groups being recorded more than once.
- All staff we spoke with in the operating theatres told us they had undertaken their mandatory training.
- We reviewed the theatre training records which corroborated these statements.
- We spoke with staff on the surgical assessment ward (SAW) who told us they were up-to-date with their mandatory training. They told us that the training was held over one or two days each year. This was not reflected in the trust's training records.
- We found the same situation in other wards where staff told us they felt they were up-to-date with their mandatory training, but this was not reflected in the trust's training records.
- The trust could therefore not be assured that their training records were up-to-date.

Assessing and responding to patient risk

- We found appropriate assessments of surgical patients were undertaken prior to admission, and on the day of admission.
- 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 pace. We spoke with the ward manager for the surgical assessment ward who told us they had two new staff nurses who were starting on the week following the inspection.
- Some staff on the wards reported difficulties in recruiting to all the vacant posts. 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.
- Wards had minimum staffing levels. We spoke with the ward manager for the surgical assessment ward who explained that on their 24 bedded ward they had four

trained nursing staff and two health care assistants on the day shift. One of the trained staff acted as a coordinator organising the work of the ward. At night they had two trained nursing staff and two health care assistants. This provided a ratio of registered nurses to patients that was in accordance with national guidance.

- There was also an assessment room where patients referred by their GP were assessed. This was in operation between 8am and 8.30 pm and was run by a surgical nurse practitioner supported by a clinical support worker. The ward manager also told us that a recently appointed surgical nurse practitioner would start work in June, covering the hours of 4pm to 12am.
- We spoke with nursing staff on ward S12, the head and neck ward, who told us they were under establishment by three qualified nurses. Although the posts were advertised, they had received no applicants.
- On other wards we visited we also found evidence of small numbers of qualified nursing vacancies. This was normally covered by staff from a bank of qualified nurses provided by NHS Professionals (NHSP).
- 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 spoke with six members of staff and the matron, and reviewed the staffing establishment figures and the off-duty e-roster. This showed there was an acceptable level of staffing.
- 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.
- We spoke with the senior managers responsible for the service who told us that a business case had been presented for more recovery staff.
- 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.
- With regard to the urology service it was stated that a new consultant was appointed in March 2015.

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.
- In the operating theatres the major incident call-out plan was practiced once every six months.

Are surgery services effective?

Good

We found evidence-based care and treatment which was audited in the wards and departments. There was a system

for the provision of pain relief to patients although it had been identified there were delays in the provision of analgesia to patients referred to the surgical assessment ward by their GPs. We found effective systems for the provision of nutrition and hydration to patients. Patient outcomes as reported by national audit data did not show the trust to be an outlier in any area of practice. In most cases they were either side of the mean average.

Mandatory training 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.

There was evidence of effective multidisciplinary working. We saw 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.
- On the GI wards we found that these audits had found there to be increase in falls amongst medical outliers.
- 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, between 88 and 100.

Pain relief

- 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 there was a procedure for the provision of pain killers, including controlled drugs, with such drugs prescribed to be used when required.
- We saw pain relief being provided promptly. For example, on ward 6, a trauma and orthopaedic ward, we observed a patient telling nursing staff that they were in pain and analgesia was administered within a few minutes. The administration was recorded in the patient's electronic drug record.
- We spoke with a patient who told us that their experience of receiving pain relief when they required it, on their journey from A&E to the surgical assessment ward, was good.
- We found that on the wards audits had been undertaken into the provision of pain relief to patients.
- Nursing staff on the surgical assessment ward (SAW) told us that patients admitted by their GPs sometimes had to wait for pain relief for up to four to five hours. This was because they had to wait for a junior doctor to come on the ward and prescribe them pain relief medication.
- In the operating theatres we found staff appropriately setting up and managing epidural and patient controlled analgesia (PCA) pain control systems.

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 the wards used the malnutrition universal screening (MUST) tool to identify patients who required support with their nutrition and hydration.
- 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.
- 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 were better than the England average.
- The National Hip Fracture Database annual report for September 2014, produced by the Royal College of Physicians, compared Doncaster Royal Infirmary performance against the overall performance of other hospitals in England, Wales and Northern Ireland. For patients with a hip fracture having surgery on the day of admission, or the day after, 63.5% of patients at the hospital met this standard against an overall performance of 71.7%.

Surgery

- For patients presenting with a fragility hip fracture being offered a formal hip fracture programme, 20.9% 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 53.7% 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 incidence of pressure ulcers within the service than in the overall national findings.
- With regard to deaths within 30 days, the hospital recorded 8.3% of patients dying within this time frame compared with 8.4% nationally.
- Overall the findings showed that the service at Doncaster Royal Infirmary was comparable with the national overall findings for England, Wales and Northern Ireland; except for patients presenting with a fragility hip fracture being offered a formal hip fracture programme.
- 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 was 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.

Competent staff

- Staff told us that they received yearly appraisal, and had their skills revalidated every two years. For example, a support worker told us they had recently undertaken a revalidation process and had been found to be competent in their advance role.
- Staff said that although they did not have regular one-to-one clinical or management supervision they could meet up and discuss any issues with the ward manger when either of them felt this was necessary.
- On the GI wards the matron and six members of the nursing staff who told us that one day a year was set aside for mandatory training.
- 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%.
- The urology ward staff told us that they had close links with the palliative care team. This included taking part in the national gold standards framework for palliative care.
- We found that there was a 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. There was also evidence of staff working with care homes.

Seven-day services

- The operating department offered a seven day service for surgical emergencies.
- We observed a handover between the general surgical night team and the team on during the day. This involved five middle grade and junior staff, and one consultant. This involved a review of the in-patients, including those on the surgical assessment ward where it took place. This hand-over between night and day services took place seven days a week.
- There were consultant ward rounds at the weekends, and middle grade doctors from medicine and surgery were available to discharge patients seven days a week.
- There was an out-of-hour on-call consultant rota for surgeons and physicians.
- There was a senior nursing management presence seven days a week. Out-of-hours this took the form of a hospital site manager as a first point of contact. The site manager could then escalate any issues to on-call hospital managers, or on-call consultant surgeons or physicians.

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

- We spoke with nursing staff that were knowledgeable about the procedures for obtaining consent. This included for patients who had impaired capacity.
- They also told us when it was appropriate to use the provisions of the Mental Capacity Act, and the associated Deprivation of Liberty Safeguards.
- 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 assessed not to have capacity.
- We reviewed consent forms including one for cataract extractions. These included all relevant information. Similar consent forms were available for other surgical procedures.

Are surgery services caring?

Good

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 majority of patients we spoke with told us they had a good experience of care during their stay in the hospital.
- The "Friends and Family" test results for March 2015 were available for seven surgical wards. These showed that between 86% and 100% of patients would recommend the service they received. On the trauma and orthopaedic St Leger ward 43.15% of patients completed the survey with 100% recommending the ward. The lower score of 86% occurred on ward 21, the female GI (gastrointestinal) ward, based on a response rate of 70.18%.
- We found that the "Friends and Family Test" results were displayed on the wards we visited.
- 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

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.
- They told us staff were very supportive and eager to help.
- They also told us staff were kind and thoughtful, and always asked them questions so as to check on how they were.

Are surgery services responsive?

Good

We found evidence of service planning and delivery to meet the needs of local people. This included plans for the rebuilding and redesign of the ophthalmic department and the operating theatres.

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.

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

- We visited the ophthalmology department which was going through a period of change with a plan for the construction of a new department. We reviewed the plans for the new department which had been shared with staff who had contributed to the design process.
- We spoke with clinical directors, matrons and senior managers, who described the strategy for their care group specialties. This included the redesign of the emergency surgical pathway with the construction of two new wards on an emergency surgical floor, which would include an expanded surgical assessment ward. This would include a redesign of the operating theatres.
- There was a surgical assessment ward (SAW) which took emergency surgical admissions from the accident and emergency department (ED) and direct from GP's (GP admissions).
- The proportion of patients whose operation was cancelled for non-clinical reasons between October to December 2014 was as expected for the trust.
- 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.
- The clinical director responsible for the musculoskeletal and frailty care group, which included trauma and orthopaedics, told us there was a strategy for the construction of an orthopaedic day surgery ward.
- 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 Royal infirmary this would involve staff from all sites.
- The surgical care group operational plan for 2015 – 2017 identified the need to develop a business plan to increase the capacity in the main theatres at Doncaster Royal infirmary.
- The musculoskeletal and frailty group's operational report for 2015 – 2017 identified that the orthopaedic theatre assessment unit (OTAU) did not provide a good environment for patients who were awaiting surgery

and was not able to accommodate post-operative patients. The service had developed a business case for the development of a new orthopaedic theatre and ward block.

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.
- 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.
- 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%.
- For all specialties we found that access to beds for elective surgery was affected by emergency medical patients being placed on surgical wards.
- We spoke with senior nursing staff across the surgical wards told us that their service to emergency surgical patients was constrained by the admission of medical patients. During the inspection we saw that five out of 11 beds on a surgical ward were occupied by patents with medical needs. Access to staff who had the authority to discharge patients meant situations occurred when patients ready for discharge had to wait for a medical doctor to discharge them.
- 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 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.
- Winter bed pressures and a lack of theatre capacity had constrained the care group's ability to meet the referral to treatment targets.

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.

- We also found that 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 was 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.
- 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. 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.
- 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 at Doncaster 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 at ward level. Some staff felt confused about the new systems although it was acknowledged they had only recently been introduced.

Staff we spoke with felt there were systems in place that allowed them to be kept appropriately informed. The surgical assessment ward had brought in an innovative system of using a 'feedback board' on which staff could post both problems and solutions.

Vision and strategy for this service

- We found that the trust's vision, and the local visions for the wards and departments we visited, was 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.
- 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.

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.

Surgery

- 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 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 were three care groups that managed the surgical specialties. These were Musculoskeletal (MSK) and Frailty; Speciality Services; and Surgical. Each of them was 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.
- This structure was relatively new and a number of staff we spoke with found it confusing, especially as with regard to management responsibilities. Some staff we spoke with felt that the changes had not been communicated effectively enough to people.

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

- Staff we spoke with felt there were systems in place that allowed them to be kept appropriately informed.
- Engagement between management and staff in the wards and theatres took different forms. In some wards discussions took place during hand-over of shifts and ward meetings, whilst others took place during minuted meetings with agendas. Although there were differences in approach it was clear that an effort was being made by ward managers and matrons to find the best way to communicate with staff.
- The ward manager on the surgical assessment ward told us that they communicated with staff on the ward through a newsletter called; “SAW News”. Staff could contribute to the newsletter or take part in post-it note discussions using a ‘feedback board’ in the staff room. We found that this board was used by staff with one section designated for issues, whilst another part of the board was used for post-it notes staff had put up solutions.
- We saw examples of staff engagement, including in the ophthalmic department where staff were involved in the redesign and modernisation work taking part in the department. In a room set aside for the purpose staff could view the plans which were displayed on the wall, and make suggestions which they could also attach to the wall. A log was kept of these suggestions which fed into the redesign process.
- The trust using patient-led assessments of the care environment (PLACE). These assessments involved local people assessing how the environment supports patient’s privacy, dignity, food, cleanliness and general building maintenance.

Innovation, improvement and sustainability

- 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 Doncaster Royal Infirmary comprised of 20 beds in a mixture of bays and single rooms. The unit is located on the 7 floor of the main hospital building and has expanded over the years to its current size. Bed occupancy is in line with the England average for adults and hovers around the 82% mark.

Summary of findings

Overall critical care services at Doncaster Royal Infirmary were judged as good.

There were 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 overall, though as a relatively new care group unit further focus was required on the development of the unit in terms of space and facilities.

The service met the individual needs of patients whilst they were on the unit. Early discharges and out-of-hours discharges were similar to other units, and out of hours discharges to the ward were slightly above that of other similar units. There were some concerns regarding patients being discharged from the critical care unit delayed by over four hours.

Within safety concerns were identified with regard to the environment and the risks associated with evacuation in the event of a fire and distance from other services that were required for the effective functioning of the unit. The poor use of storage and the impact this had on infection prevention risks and the practices for nursing patients with infections.

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 the environment and the risks associated with evacuation in the event of a fire and distance from all other services that were required for the effective functioning of the unit. The poor use of storage and the impact this had on infection prevention risks and the practices for nursing patients with infections.

Medicines management was effective, though the service would benefit from additional pharmacy staff time allocated to them. Performance data for the unit was acceptable with most within acceptable limits or improving.

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; the data provided was for a four month period between September and December 2014. During these dates there were a total of 59 incidents affecting patients. There were 28 classed as 'no harm', 26 'low harm', four as 'moderate harm' and one as 'severe harm'. Just over 59% of reported incidents were pressure sores, the vast majority were classed as no harm or low harm. However, the four moderate harm incidents and one severe incident were also related to pressure sores.
- The severe harm incident was fully reviewed and a root cause analysis (RCA) completed and assessed by the RCA Review Panel.
- 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 and two nurses 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.
- A serious incident occurred over 12 months prior to the inspection and involved displacement of a tracheostomy tube (A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe to help with breathing). From the incident it became compulsory on the unit for three people to turn patients who had a tracheostomy tube).
- We spoke with two consultant intensivists and they confirmed that all cases of mortality and morbidity were reviewed; these took place at all monthly team meetings.

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, would be a notifiable safety incident and that patients should be informed of the incident.
- There was awareness within the multidisciplinary team (MDT) to be open with patients about incidents and the suggested practice of involving patients in RCA.

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 was on the seventh floor of the hospital block and was not purpose-built; the space had previously been used as a hospital ward and smaller intensive care unit (ICU); the ward and ICU had been merged to create space for the 22 critical care beds.

Critical care

- There were six isolation rooms; two of the isolation rooms were small and there was limited space especially when larger items of equipment were in use.
- We observed the majority of rooms on the unit and it was evident that space, use of space and storage of equipment was an ongoing challenge; the issues identified relating to storage and the environment presented infection control risks and these are discussed under the sub-heading 'cleanliness, infection control and hygiene'.
- There were challenges in the design of the unit to comply with Health Building Note 04-02 Critical Care guidance due to lack of space and layout. This was not on the risk register that we had access to.
- One of the concerns raised by medical and nursing staff was the seventh floor position of the unit. Two main risks from its location were problems associated with evacuating patients in a fire and the physical distance from the unit to other wards / departments such as theatres, accident and emergency (A&E) and imaging, for example, computed tomography (CT) and magnetic resonance imaging (MRI).
- The fire safety risk was on the unit's risk register as a 'red' risk; this was the highest risk category. The risk was described as an inability to evacuate patients from the unit in event of an emergency (i.e. fire). The mitigating statements were that a fire plan was available which included a horizontal evacuation plan.
- We were informed that the horizontal evacuation plan included moving patients to the ward opposite the unit. However, the ward only had a limited number of oxygen points and would struggle to cope with all the patients from critical care in an emergency.
- The second main risk identified, concerned the distance the unit was from theatres, A&E and x-ray imaging. We were informed that, on average, a CT scan was required at least daily and an MRI scan at least weekly. Following our inspection, trust senior management stated that, on average, a CT scan was required three to four times per week and an MRI scan once to twice per month. The distances involved required a risk assessment for each patient and specialised transfer equipment was required; the same equipment used to transfer patients to another hospital.
- If transfer equipment was used, a nurse and a doctor from the unit were required to stay with the patient ensuring a safe transfer and patient monitoring. On occasion, the nursing and/or medical staff used for a transfer were taken from the critical care unit.
- There was a mixture of old and new equipment on the unit. Some of the equipment was identified on the units risk register due to its age and potential to fail. Some of the units infusion pumps, epidural pumps, mattress ventilators and continuous veno-venous hemofiltration (CVVH) pumps were noted on the risk register as a low risk due to 'regular equipment failure'. The mitigating steps were that daily medical engineering checks were performed and there was a rolling programme of equipment replacement.
- Other equipment problems were on the risk register; these related to failure of electrical supply. We were informed that some electrical circuits on the unit were dated and there had been occasions where power had been lost; this meant that the back-up power supplies built into much of the equipment was temporarily relied upon.
- We observed resuscitation equipment including specialist trolleys, such as the airway management trolley. The unit had equipment for both adults and children. Resuscitation equipment was stored in an organised, clean and accessible way. Emergency / resuscitation equipment was required to be checked on a daily basis. We observed that daily checks had been completed in the majority of cases but there were some gaps during the weeks prior to the inspection. Daily checks were not 100% compliant.

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). The report provided by the Trust, for Doncaster Royal Infirmary (DRI) CCU was for 1 July 2014 to 30 September 2014.
- Trends in unit acquired infections, for MRSA BSI and Clostridium difficile (C. difficile), for 1 July 2014 to 30 September 2014 were within expected limits; there were no MRSA BSIs or C. difficile cases.

Critical care

- The number of unit acquired infections in blood showed varying trends over the years and was above the average for other similar units at the beginning of 2014. However, as of quarter two onwards, the numbers had fallen more closely in-line with other similar units.
- We observed the environment of the unit including patient bays, the majority of rooms and the overall layout. The patient bay areas were visibly clean and items close to the patient, such as bed rails, monitors, ventilators and syringe drivers were also clean.
- In some instances, in bays and side rooms, we noted damage to wall plaster, chipped paint on some radiators and patches of exposed rust on some waste bins. Damaged or rusty surfaces made cleaning difficult and less effective.
- All patient bays had blue disposable paper-like curtains on tracks that could be pulled around the patient's bed for privacy; the curtains were all marked with the date they were put up. Most of the disposable curtains we observed were dated 29 October 2014; these had been up for around five and-a-half months and were not due to be changed. We observed some curtains that were dirty which should have been changed before their scheduled change interval.Many of the store rooms and other spaces were cluttered and there were a number of examples of poor storage of equipment and linen, which post a risk of increase infection. An oxygen cylinder store contained a rolled up pressure relieving air mattress inside a supermarket trolley. A small room named the blood gas room contained a photocopier plugged in to electrical sockets, but next to a hand wash basin with wall mounted soap and paper towel dispenser.
- The shower room in zone 1 was used to store mattresses. Linen rooms were mixed with general storage and boxes of equipment were being stored on the floor. The unit had two pharmacy rooms and both rooms were cluttered, especially the room in zone 1; there were numerous boxes on the floor.
- We observed patients being cared for in isolation rooms and in many cases the doors were open and guidance was not being followed. For example, in bed 19 there was a patient with confirmed influenza B infection and the doors were open. There was an Influenza B integrated plan of care (IPOC) in place and an infection control isolation sign on the door. The IPOC and sign stated that the doors should be closed.
- We requested infection control audit results and were provided with data from June and November 2014. The ward environment score for June 2014 was 100% and November 92%. The linen score for both audits was 100%. The equipment score for both months was 100%.
- The percentage score for hand hygiene was 85% for June and 92% for November; in the region of one in ten staff were not complying on a consistent basis with the trust's hand hygiene policy. This was a risk to patient safety. We were concerned how such high scores could be attained given the concerns we had identified.
- Alcohol hand rub and designated hand wash basins were positioned around the unit. However, some designated hand wash basins were not easily accessible and a number hand plugs attached; this is not recommended.

Medicines

- We spoke with the pharmacist and their time was dedicated to the CCU; they worked Monday to Friday 09.00 – 17.30. Weekends and out-of-hours were covered via an on-call rota.
- National Core Standards for Intensive Care Units (2013) sets out recommendations for pharmacy cover in relation to the number of Level 3 beds. We were not assured that the pharmacy service had formally considered its level of compliance with national core standards and / or were working towards being fully complaint.
- Taking in to account the number of beds on the unit and the level of pharmacy input, the level of pharmacy input fell short of national best practice recommendations.
- The pharmacist provided advice to staff, including nursing and medical, and attended ward rounds where they checked each prescription sheet.
- There were drug fridges in the rooms and both had their temperatures effectively monitored. We observed temperature recordings and they were within acceptable ranges.
- When patients were discharged from the unit the pharmacist transferred the list of patient's medications to an electronic system which the wards used; the unit did not have an electronic prescribing system but there were plans for it to be introduced.
- Controlled drugs were stored in a locked cupboard and some were stored in an additional locked cupboard. Storage of medication, including controlled drugs, was audited 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.
- We did observe some poor practice; we saw medication being drawn up in to syringes and left unattended for unreasonable amounts of time. We observed a syringe left unattended outside room 1 and two syringes unattended outside room 3 for over 30 minutes.
- Outside room 8 there was a 50ml syringe of Heparin; it was 'made up' at 08.30 and remained outside room 8 at 10.10.

Records

- We reviewed four sets 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. We did not observe risk assessments for venous thromboembolism (VTE). We were informed the approach to VTE prophylaxis was that all patients that were not contraindicated received pharmacological and mechanical measures of VTE prevention.
- Other key information was also present including assessments of fluid state, review of in-dwelling lines, sedation, 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 two sets of medical records, information was easy to locate and logically set out.
- 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 received safeguarding education at corporate induction and via mandatory training sessions throughout the year. However the data we were provided with indicated that at the time of the inspection only 48% of nursing staff on the unit had received adults or children's safeguarding training against a target of 85%. Following the inspection, we were informed that the trust safeguarding training programme since February 2015 included a two hour basic awareness session at Level 1 for non-clinical staff and a full day training at Level 2 for clinical staff. Safeguarding children training at Level 3 was provided for medical staff internally and for all other staff accessed via the Local Safeguarding Children Boards; a leaflet was also provided on induction.
- Staff we spoke with knew how to access the safeguarding 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.

Critical care

- In data provided by the trust at the time of the inspection there was great variation in the levels of mandatory training that was recorded. For example, 67% of staff were reported to have attended fire training against a target of 85%, and only 13% were reported to have received equality and diversity 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 (CCU) and wards and departments across the hospital in managing the more complex patients and those patients recently discharged from the CCU.
- The outreach team also provided support to staff in developing skills and confidence in managing complex patients.
- The CCU nurse consultant described how funding had been allocated to implement electronic observation tools for EWS which would radically change the referral process to the outreach team; the new system would enable patient deterioration to be captured more effectively.

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 110 registered nursesemployed on the unit. 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.
- Information we were provided with during the inspection, whilst not specific to individual units demonstrated that there were four band 5 vacancies which had been recruited to and staff were waiting to start, and no vacancies at bands 2, 3, 6 or 7.
- Nursing handovers were done for each zone; this ensured the handovers were more manageable.
- We observed and listened in to a nursing handover; the information exchanged was comprehensive and logical. The handover was a structured process followed by all nursing staff.
- 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, if the unit had excessive numbers of staff, they would be asked to support other wards/ departments. For example, the week previous to the inspection some staff were asked to work in accident and emergency and the acute medical unit.
- If agency nurses were required, all agency staff were required to undergo a short induction to the unit before commencing a shift.
- There was always a supernumerary clinical coordinator which is recommended within the Core Standards for Intensive Care Units (2013). However, there wasn't an additional supernumerary nurse in place to support the clinical coordinator which was also recommended within the Core Standards for Intensive Care Units.

Medical staffing

- We spoke with two critical care intensivists; there were 10 critical care consultants and all were part of the rota which provided a suitable consultant to patient ratio.
- All the consultants were intensivists and had undergone specialist intensive care training, they were all Faculty of Intensive Care Medicine (FICM) trained.
- Out-of-hours cover was effectively managed with the number of consultants on the rota. At the time of the inspection, staff told us that one in two weekends was covered by an intensivist. This meant some weekends were covered by an anaesthetist; this wasn't ideal but from January 2016 all out-of-hours cover, including weekends, would be covered by an intensivist. However, further information received from the trust management stated that all weekends were covered by intensivists and from August 2015 there would be an additional consultant working for 12 hours every weekend; half of this group were anaesthetists with an interest in critical care and the others were intensivists.
- During on-call, consultants only covered critical care which, again, met best practice guidance. There was dedicated separate cover out-of-hours for obstetrics and operating theatres.
- The consultants worked block shifts which met best practice guidance; this ensured consistency and continuity of care.

Critical care

- The consultant working patterns ensured that the vast majority of patients were reviewed by a consultant within 12 hours of admission as recommended by core standards for intensive care units (2103). The medical clinical lead in their gap-analysis of service provision for the unit was unable to quantify exactly if all patients were reviewed by an intensivist within 12 hours of admission because of 'poor documentation.'
- We observed a medical handover; it was detailed and captured all the necessary information to ensure appropriate and safe continuity of care.
- In terms of trainees, there were three tiers of training and foundation year 2 doctors followed four monthly rotation between specialities. There were some gaps with the rotation on to critical care and these were being filled with locums. The plan was use staff grade doctors in the near future to replace locums.
- Medical and nursing staff we spoke with spoke positively about the support provided from the medical team and accessibility, including out-of-hours.

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.

Are critical care services effective?

Good

Staff had access to appropriate evidenced based policies, and access to specialist training as required. Pain relief was appropriately stored and administered. Whilst the unit had access to 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 the 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.
- In terms of medical interventions, from our observations and discussions with medical staff, the approaches taken followed up-to-date medical practice.
- Policies we reviewed were based on best practice guidelines and were up-to-date and easily accessible via the intranet.
- The unit had a nurse consultant and part of their role included research and evaluation; this had a positive influence on practice and helped ensure evidence based guidelines were followed.
- There was also 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.
- Some audits had positively influenced clinical practice including use of patient dairies and bed booking processes.
- 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.
- High impact intervention (HHI) 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 HHI 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

- We spoke with a dietician who regularly worked on the unit; they said they visited the unit at some point each day. They visited each patient to assess which patients required nutritional support.
- The British Dietetic Association recommends that there should be 0.05 – 0.1 wte dietician per one bed within critical care; the unit had in the region of 0.38 wte dietetic input; this did not meet best practice guidance. The lead clinician and acute team leader were aware of this.
- There was uncertainty as to whether the existing service provision had been benchmarked against all of the national core standards as set out in Core Standards for Intensive Care Units (2013). Following the inspection, we were informed that the department had reviewed the provision against the Core Standards for Intensive Care Units 2013 and were meeting standards regarding out of hours feed regime and all patients being assessed by a dietician. The service was not currently meeting standard 3 regarding ratio of dietician per bed.
- 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.

Patient outcomes

- We reviewed the ICNARC (Intensive Care National Audit and Research Centre) data for July 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 for the previous four years but data became 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.
- Unit mortality for admissions with severe sepsis was similar to that of other similar units but the average length of stay for such patients had been slightly above average from early 2013 to present.
- 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, as compared with other similar sized units.
- Admissions with pneumonia unit mortality were within average values but there had been a slight increase in Q3 for average length of stay for such patients.
- 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.
- With post-unit hospital deaths, values had been within average ranges for previous years but there had been a significant increase in numbers for Q2 and Q3 of 2014 taking the numbers slightly over the average as compared to other similar units.

Competent staff

- We spoke with the clinical educator about several aspects of staff competency; just under 50% 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. The care provided involved the full multidisciplinary team (MDT) and we found staff worked constructively together.
- Pharmacists were part of most ward rounds at DRI; dieticians did not attend ward rounds. However, both 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.
- The outreach team worked closely with the critical care team and wards / departments across the hospital. The team followed-up each unit discharge to the ward to ensure ongoing care was appropriate and to provide support to ward staff.
- 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

- 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 provided input seven days a week and were available on an on-call basis out of core working hours, Monday to Friday. Occupational Therapy services were available as required during normal working hours seven days a week.Intensive care consultants provided regular presence on the unit on weekends between 08:00 and 15:30. There was on-call support for critical care at weekends outside of these hours and out-of-hours during the week.

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 (include Deprivation of Liberty Safeguards if appropriate)

Critical care

- There was a trust wide policy on consent and related policies including guidance around mental capacity and deprivation of liberty safeguards.
- We were told that the nursing staff performed, where appropriate, a delirium screen and if concerns were raised the CAM-ICU (Cognitive Assessment Method Intensive Care Unit) was performed.
- 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. Relatives considered that they were well informed, but also did not always feel as well supported as they would have wished.

Compassionate care

- We spoke with two patients on the unit and also the close relatives of another patient.
- 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 response to their needs and had no significant concerns. They did describe feeling frustrated when waiting to enter the unit; they described having to wait 25 – 30 minutes on one occasion.
- 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.
- 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

Critical care

- There was a chaplaincy service available and this was provided 24 hours a day seven days a week.
- 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 was recognised that some patients could be emotionally affected after having been a patient on a critical care unit and patient support groups were recognised as a way of providing support and an opportunity for patients to discuss their experiences. Patient support groups were provided and these were nurse led; there was access to a psychologist if required. 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 was good. The service met the individual needs of patients whilst they were on the unit.

Early discharges and out-of-hours discharges were similar to other units, and out of hours discharges to the ward were slightly above that of other similar units. There were some concerns regarding patients being discharged from the critical care unit delayed by over four hours. This was in main due to bed flow across the main hospital site, but it also resulted in a high number of patients being discharged home from the critical care unit.

Staff indicated that the unit had received no complaints directly; staff were not clear who managed complaints.

Service planning and delivery to meet the needs of local people

- Staff identified a number of challenges with regard to service planning. As noted within the safe domain there were specific challenges for the Doncaster critical care unit from its physical location, but secondary to that there were challenges were around the whole service specification for both units at Doncaster and Bassetlaw.
- 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.
- 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.
- 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.
- The trust did not report any breaches of mixed sex accommodation during March 2015.
- In certain circumstances, visiting hours were flexible and this helped support families who had additional support needs.
- 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

Critical care

- We reviewed the ICNARC (Intensive Care National Audit and Research Centre) data for April –– September 2014. Early discharges and out-of-hours discharges were similar to other units, and out of hours discharges to the ward were slightly above that of other similar units.
- The main area of concern was delayed discharges, particularly the four hour delay. The gap analysis document of intensive care services at Doncaster (March 2015) highlighted that some 53% of patients were delayed by over four hours after the decision had been made for their discharge. For the financial year 2014/ 2015 there was 225 patients delayed for discharge beyond 4 hours. This was in main due to bed flow across the main hospital site, but it also resulted in a high number of patients being discharged home from the critical care unit. Some patients were planned to be discharged home from the critical care unit following a period of intensive monitoring when they were reviewed by the medical team at the end of their assessment. This affected the number of patients being discharged home from the unit.
- Staff were well aware of this situation, which they stated were due in the main to the pressure on beds across the hospital. Three meetings were held each day to manage the challenges faced with patient flow.
- It was also stated that there had been around 100 discharges directly home from the unit that year, around two patients per week.
- There had also been around 100 discharges directly home from the unit. Discharging patients directly home from critical care is not ideal; it means that patients have been cared for within an intensive care setting longer than necessary. Relatively well patients would be more aware of their surroundings and able to observe, and understand, the intensive treatment being provided to others, this can be distressing.
- In addition, the facilities on the unit were not suitable for patients not requiring intensive care, for example, there were no shower facilities. In addition to this as patients no longer required critical care support, due to the nature of crucial care services single sex facilities would not be readily available.
- Non-clinical transfers out were around 0.3%; this was a figure within the averages of other similar units.

Learning from complaints and concerns

- We asked for information on the number of formal complaints about critical care for the previous 12 months but this was not provided.
- 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. Trust managers informed us that the governance arrangements enabled leaders in critical care to access transferrable learning points from the surgical care group to the specialty governance meeting.

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 some 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.
- A key issue discussed was the environment of the Doncaster unit, its location and the future plans for the unit.
- 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 2015/16.
- 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 Assessment Unit (MAU) development. For critical care, work included isolation facilities at the Bassetlaw unit.
- The corporate investment committee held in March 2015 discussed briefly an ambitious capital programme for the forthcoming 5 years based on the clinical strategy for the organisation and would consist of a significant number of schemes incorporating refurbishment, relocation and new buildings.
- There were no specific details, or draft plans / ideas, within the meeting minutes, draft capital investment plan or corporate investment committee minutes about the Doncaster critical care unit.
- There was no mention of the immediate plans for the unit in terms of addressing the known concerns, especially in terms of the unit's environment, its location on the seventh floor and high number of delayed discharges.

Governance, risk management and quality measurement

- 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 9 risks associated with critical care. Some concerns have been identified particularly in relation to the evacuation of the critical care unit as outlined in the safe domain, though the controls in place were limited.

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.
- Job adverts were in place for band 5 and band 6 nurses and there was a clear vision as to the running of the unit in its current form.
- 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.
- 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.

Critical care

- The trusts own patient survey dated 2013 had a 47% response rate, and was overall positive in the feedback from patients and their relatives.

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

Doncaster Royal Infirmary 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. Hospital services were provided in a separate building in the women's and children's hospital. Clinic and scanning facilities were located in the hospital.

There was a community hub, which was used as a base for community midwives and support workers. Antenatal and postnatal care was delivered to women in their homes, clinics, children's centres and at general practice locations across the Doncaster region. There was a gynaecology ward, which provided in patient care to women with a range of gynaecological and breast problems, including end of life care. A nurse led early pregnancy assessment unit (EPAU) was located on the gynaecology ward.

The maternity service at Doncaster hospital delivered 2,752 babies between April and December 2014.

During our inspection visit, we visited the antenatal clinic, community hub, central delivery suite, obstetric theatre, EPAU, post-natal ward, and gynaecology ward. We spoke with eight women and 32 staff including midwives, midwifery support workers, nurses, doctors, matrons and senior managers and the patient safety team. We also spoke with the Local Supervisory Authority Midwifery Officer (LSAMO) for the region. We observed care and treatment and looked at five sets of care records. We also reviewed the hospital's performance data.

Summary of findings

Overall maternity and gynaecology services require improvement.

Midwifery and nursing staffing levels at Doncaster Royal Infirmary did not always meet the ratio recommended (Safer Childbirth RCOG 2007). One to one care during labour had been recorded as being between 77% and 84% during 2014; this is lower than the recommended 100% of one to one care.

Medical staffing was in line with national recommendations for the number of births. However, there were two consultant and two middle grade vacancies; these posts were covered by locum doctors. Medical staff told us this could impact on their workload.

There had been 19 stillbirths between January 2014 and January 2015 at Doncaster Royal Infirmary. 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.

Participation in mandatory training was between 0% and 100% according to available records. It was variable across all the wards, clinics and departments. Training attendance for infection prevention and control was very poor, as it was for resuscitation, fire safety and information governance. Participation in safeguarding adults and children training was variable in the unit and was between 75%- 100%.

Maternity and gynaecology

There was confusion regarding the emergency buzzer system and different systems in place on different wards. Some medicines in the home birth trolleys were stored inside specimen pots. These medications lasted two months when not stored in a fridge. There was no method for recording how long these medicines had been in the trolley. Feedback was given to senior staff and action was taken that day to address this issue and to put a safer system in place.

Four of the five National Neonatal Audit Programme (NNAP) questions were below the national standard for Doncaster.

Most 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.

The hospital policy did not contain the NICE recommendation that that women need to be asked as part of routine care, whether they are experiencing abuse, that they are asked more than once as most women will not disclose abuse the first time they are asked, and to be asked about abuse only when they are alone (or with a professional interpreter). Some staff were not fully aware of the procedures around domestic abuse. An awareness audit of the domestic abuse policy carried out by the trust in 2014, showed only 56% of staff were aware that domestic abuse is high risk during pregnancy.

The gynaecology services were negatively impacted upon by the number of patients outlying on the ward from other specialties.

The interim head of midwifery told us she met with the director of nursing on a monthly basis to discuss staffing levels and plans for ensuring the service had appropriate capacity and capability to meet the needs of women. The hospital had a safe staffing escalation policy which included a process to be followed in the event of sudden staffing shortfalls.

There was a multidisciplinary approach to the care and needs of women. We observed examples of considerate and compassionate approaches in the care and treatment of women. Feedback from women about the standard of care they received was positive. Women were treated with kindness, dignity and respect during their care and treatment.

The individual needs of women were taken into account when planning the support needed during their pregnancy, although there were a high proportion of induced births and non-elective caesarean sections. The number of home births was lower than the England average.

Maternity ward areas were visibly clean and equipment was in date and in working order. The gynaecology ward was dusty. The recording of equipment checks was not consistent in all areas. Medicines were managed appropriately.

Serious incidents were monitored and action taken when things went wrong. There was an up to date policy related to Abduction or Suspected Abduction of an Infant/ Child.

The maternity and gynaecology services were led by a committed team, led by the interim head of midwifery who displayed a passion and responsibility for delivering a high quality service. Consultants told us that midwifery management of the service was very good.

The hospital has recently been awarded the highest level of the UNICEF Baby Friendly Initiative.

There was an open and transparent culture that encouraged reporting and learning from adverse incidents.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

Staffing establishments and the skills mix did not always meet national recommendations.

Staffing levels were lower than the recommended ratio of 1 midwife to 28 women. The unit had been working to a 1:32 ratio. We were shown a rota of community midwifery cover. Community midwives were called into the hospital to work when staffing levels required this.

One to one care during labour had been recorded as being between 77% and 84% during 2014; this is lower than the RCOG recommended 100%. It was not clear if the low rate of one to one care had been recorded on the trust risk register. A recent Birthrate Plus® assessment to review midwifery staffing levels had been carried out at Doncaster and the recommendations were due to be presented to the trust board shortly after our inspection.

There had been one never event in February 2015 which involved a retained vaginal pack following a clinical procedure.

There had been 19 stillbirths between January 2014 and January 2015 at Doncaster Royal Infirmary. 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 review had taken place and each case was assessed against the National Patient Safety Agency Stillbirth Toolkit. The information and findings were shared with the Local Supervising Authority Midwifery Officer for the region.

Completion of mandatory training varied greatly across the women's hospital. Participation in mandatory training varied by staff member from 0% to fully completed. Staff training had been postponed or cancelled during periods of peak activity. A large number of staff including registered staff had not received mandatory training for adult or neonatal resuscitation, fire, infection control or health and safety. The target for hospital staff participating in mandatory training is 85%.

Most ward areas looked visibly clean although methods for checking cleaning and vital equipment varied. We observed that the gynaecology ward was dusty. There was dust on bedside curtain rails, low shelves on trolleys and on windowsills. Notices were not laminated on the Infection Prevention and Control (IPC) notice board or on the walls of the ward and patient toilets.

There were gaps in the records for checking resuscitation equipment in some areas. There was confusion regarding the emergency buzzer system and different systems in place on different wards. A room where home birth trolleys were stored was unlocked. The trolleys had medications in them; there was no way to indicate how long the medications had been in the unrefrigerated trolleys. We pointed all of these out to senior staff and action was taken immediately to address the medications. When we visited the same area the next day the room was still unlocked.

Arrangements were in place to safeguard adults and children from abuse, although some staff were not aware of the policy for domestic abuse

There was a dedicated theatre team for maternity which was available 24 hours a day. 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.

Incidents

- There had been four serious incidents reported between February 2014 and January 2015; these were one intrauterine death, a screening issue, an unexpected admission in Neonatal Intensive Care, and one incident logged as 'maternity service'.
- There had been one never event in February 2015 which involved a retained vaginal pack following a clinical procedure. Never events are serious, largely preventable patient safety incidents, which should not occur if proper preventative measures are taken. The hospital had taken appropriate steps to minimise the risk of this event in the future. The case had been investigated and appropriate action taken. This included changing the types of swabs, use of a whiteboard and the new electronic system for checking and counter signing swab numbers.

- There had been 19 stillbirths between January 2014 and January 2015 at Doncaster Royal Infirmary. 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 four cases, different management may have changed the outcome. The review also found in six 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. The information and findings were shared with the Local Supervising Authority Midwifery Officer for the region.
- We looked at investigation reports and RCA's. Action plans were in place and there was evidence of implementation.
- 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.
- 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 saw the patient safety bulletin clearly displayed on some notice boards. The safety team told us they 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 a '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 were shown a sample of results for the gynaecology ward from December 2014 to March 2015; between 92-100% harm free care had been given. The results had been negatively affected by the incidence of pressure ulcers and a recent serious fall with harm.
- The ward manager had implemented the use of 'Safety Crosses'. These are used to highlight incidences and location of MRSA, falls or C.difficile infections. The visual impact of the safety crosses enabled staff to be aware of the safety issues on the ward.

Cleanliness, infection control and hygiene

- The maternity wards and departments mostly looked visibly clean. There was clutter in a variety of areas including gynaecology theatre.
- We observed that the gynaecology ward was dusty. There was dust on bedside curtain rails, low shelves on trolleys and on windowsills. Notices were not laminated on the Infection Prevention and Control (IPC) notice board or on the walls of the ward and patient toilets.
- Recent environmental audits in the months prior to our visit in April 2015 had achieved 87.5%
- There was a cleaning rota and checklist and hand hygiene audit results on the antenatal ward and ward M2 and evidence the cleaning had been audited.
- In other areas there was no audit trail evident for overall cleaning.
- Good hand hygiene was observed; we saw that staff complied with 'bare below the elbows' best practice. They used appropriate personal protective clothing, such as gloves and aprons. Hand sanitising gel dispensers were available at entrances to clinical areas. Staff complied with the standard dress code.
- Women were screened for MRSA before undergoing elective caesarean sections.

Environment and equipment

- Throughout the maternity and gynaecology department, clinical equipment appeared clean although it was noted there was no standard way to indicate when it had last been cleaned.
- There was confusion amongst some staff as to the emergency buzzer system. Some staff on wards, M1, M2 and G5, indicated that there was no emergency buzzer system, though the trust has clarified that there is a system which requires the staff member to push the button in and not pull it out. Staff on other wards told us they would use a variety of methods to alert colleagues

in an emergency. One ward team held the nurse call buzzer down, another ward pressed it three times in quick succession. As staff rotated around the wards and departments there was potential for confusion which may put patients at risk. The trust recognises that it needs to improve the emergency buzzer system to a 'pull out' system and whilst this was within the trusts overall development plans, this specific issue will be dealt with sooner.

- There was a robust system for checking resuscitaires (new-born life support) on central delivery suite.
- Resuscitaires and other equipment were kept behind a curtain in a designated area in all rooms on delivery suite until they were needed in order to alleviate anxiety.
- 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 resuscitation trolley in the antenatal clinic had not been checked for two weeks; the 'battle box' (with torches and batteries in) had not been checked on a weekly basis.
- The resuscitation trolley on ward G5 had several missed checks, for example five times in December 2014, once in January, four times in February, and eight times in March.
- There was one birthing pool. There was a ceiling track hoist in this room which could be used in an emergency evacuation if necessary. The birthing pool room was well designed, had a lot of open space so a woman in labour could move around freely. There was provision of large cushioned waterproof furniture and a birthing ball to help women be more comfortable.
- There was sufficient numbers of monitoring equipment. There were Cardiotocography (CTG) machines to monitor baby's heart in every room on central delivery suite. There was also a telemetry machine in the birthing pool room. The birthing pool room had piped Entonox and gases.
- Use of the birthing pool for water births had fallen from 2.38% in April 2014 to 0.32% in December 2014.
- Obstetric theatres were situated across the corridor from the neonatal unit. This meant in an emergency a baby could be quickly transferred.
- The maternity triage area was small; we observed a heavily pregnant woman and her partner standing in the corridor due to a lack of seats in the waiting area until staff brought additional chairs.
- The unit had been built in the late 1990's and staff told us they hoped the environments would be updated.
- There was good provision of home birth equipment. This was well organised and was stored in pull along trolleys in a room within the antenatal clinic area. The trolleys contained necessary equipment and some medicines for use in a home birth situation. A community midwife or support worker could collect the trolleys or they could be sent to a women's home by taxi. However, neither the trolleys nor room door were locked. We pointed this out to senior staff who told us they would take immediate action; however we visited this same area the next day and the room was still unlocked. This room also contained stationary, vacutainers, blood bottles and the adult resuscitation trolley for use in ante natal clinic.

Medicines

- Apart from the medicines in the home birth trolleys, medicines were safely stored in locked cupboards and trolleys in all other clinical area 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.
- Fridge temperatures were checked daily in most areas. The drugs fridge temperature checks on ward G5 had not been carried out nine times in January, eight times in February, 13 times in March, and six times in April (up to 15th April). This meant staff would not know if the medication had been stored within the correct temperature range in between the checks and, therefore, if the medication remained safe to use.
- Some medicines in the home birth trolleys were stored inside specimen pots. These medications lasted two months when not stored in a fridge. There was no method for recording how long these medicines had been in the trolley. Feedback was given to senior staff and action was taken that day to address this issue and to put a safer system in place.
- We found epidural drug wastage was being disposed of correctly.

- 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.
- Ward G5 used an electronic system for recording routine medication 'rounds'. This involved a nurse or doctor logging in to the system, which would then indicate the medications due to be given to individual patients. The system reduced medication errors associated with poor handwriting or omissions by alerting staff if a record had not been made.

Records

- The clinical records we viewed were completed to a good standard. Each record showed a clear pathway of care. There were clear comprehensive assessments in antenatal areas. Paper records were signed and dated appropriately with correct patient identification.
- 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. For example, on delivery suite a dynamic whiteboard was in use for handovers of care rather than the electronic system which had some technical issues and staff who were unfamiliar with the system. Observations such as temperature and blood pressure were also currently recorded on paper for the same reasons.
- Staff told us the software company came to clinical areas regularly and were working 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; there had been some instances of staff being 'locked out'. 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 using it.
- Community midwives are 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 means 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.
- Medical staff told us that the electronic system worked well and that they have had training to enable them to use the system.

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 has recently been recruited to as a separate role for another person.
- There was good awareness of the process to safeguard women and children among the midwifery support workers. They told us any concerns they raised were responded to and they feel confident to do this. In line with best practice and transparent principles they informed women that they would pass their concerns onto a midwife.
- Staff in EPAU also told us they would take action if they noticed unexplained physical injury to women.
- Senior staff told us that midwives attended safeguarding meetings or Common Assessment Framework meetings (CAF) and that this role was taken very seriously. They also told us that this can impact upon ante natal clinics and booked appointments. CAF's are multi-agency process which work in partnership with families in difficulty and agree a 'package' of support to help them.
- There was a teenage pregnancy midwife in post but staff were unable to confirm to us whether there was any guidance or a policy around protecting children against sexual exploitation.
- We were shown the 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. The hospital policy did not contain the NICE recommendation that that women need to be asked as part of routine care, whether they are

experiencing abuse, that they are asked more than once as most women will not disclose abuse the first time they are asked, and to be asked about abuse only when they are alone (or with a professional interpreter). This means that they should be seen alone at least once during the pregnancy, even if normally accompanied by partner or family member.

- We observed posters and information about domestic abuse in the main corridors at the hospital.
- Staff told us they asked women about domestic abuse when they booked in at antenatal clinic for the first time. There was variation in the way this question was asked and sometimes women were asked in front of a male partner.
- Staff told us if they had concerns they would report them to the safeguarding midwife and record the information on the electronic system in a confidential folder. (This kind of information was not recorded in hand-held notes of women out of area).
- Staff also told us the safeguarding midwife would do a Multi-Agency Risk Assessment Conference (MARAC) referral if the risk was deemed to be high.
- In situations of concern, pregnancy liaison meetings took place with social services and relevant specialist midwives such as the substance misuse midwife.
- We were told that community midwives checked GP records to see if there was any known domestic abuse or other safeguarding concerns in the family home.
- Good evidence of safeguarding vulnerable women was evident. We were told that the hospital was used as a safe-haven in emergency situations in the past when a woman had not been able to get to another safe place until the next day.
- We found the service was proactive in safeguarding women at risk of female genital mutilation (FGM). Processes were in place to record if an FGM-related procedure had been carried out on a woman.
- There was an up to date policy related to Abduction or Suspected Abduction of an Infant/ 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.

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.
- Most staff also told us they were unable to confirm what mandatory training they had attended. They said that some training had been cancelled due to clinical work pressures.
- Participation in mandatory training was recorded as between 0% and 100%. It was variable across all the wards, clinics and departments. Training attendance for infection prevention and control was very poor, as it was for resuscitation, fire safety and information governance. This meant staff may not have up-to-date knowledge and skills. The training target set by the trust is 85%. It was unclear if this was a recording issue; however, in any event, the trust could not be assured that staff had attended required training.

Assessing and responding to patient risk

- Midwifery staff used an early warning assessment tool known as the modified early obstetric warning score (MEOWS) 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 MEOWS tools for women who had been identified as being 'at risk'.
- A patient observation audit form was shown to us on ward G5. The audit tool identified whether patient observations such as temperature, blood pressure, respirations, and pain scores had been recorded correctly. It also determined if appropriate escalation had taken place. Ward G5 had attained an average of 85% in 2014. There were five months when it achieved 100%. These were in January, March, May, July and August.
- 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.

- A RAG rating (Red, Amber, and Green) was used in the triage area to ensure women were seen within an appropriate time. Staff told us if a doctor was not available, they could readily call a consultant or a Supervisor of Midwives to support them.
- High dependency care for women in labour was provided in a dedicated High Dependency Unit (HDU). At risk women could be cared for in this area, for example those with pre-eclampsia or heavy bleeding after giving birth.
- Band 7 midwives were trained to care for women in HDU; the band 7's were supernumerary which meant if HDU care was needed, the band 7 midwife were available to deliver the care.
- The coordinator on central delivery suite carried a bleep so she could respond quickly if needed on another ward.

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 birth ratio was 1:31 against the nationally recommended ratio of 1:28. This is recommended by the Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (Royal College of Obstetricians and Gynaecologist 2007). Senior staff told us that last year, in March 2014, the Clinical Commissioning Group agreed for a 1:32 ratio to be in place. We were shown an escalation rota for the specialist midwives. They were utilised to work clinically in times of increased activity. This meant they could not attend to ongoing specialist issues.
- 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.
- Staff told us the unit was in breach of the Royal College of Midwives recommendations with regard to caseloads.
- It was not clear if staffing issues were on the maternity/ gynaecology risk register.
- One to one care during labour had been recorded as being between 77% and 84% during 2014; this is lower than the average for England.
- A recent Birthrate Plus® assessment to review midwifery staffing levels had been carried out at Doncaster and the recommendations were due to be presented to the trust board shortly after our inspection.
- Staff told us that rotas did not always adequately cover shifts. Thirteen percent of all reported incidents in 2014 were related to staff shortages. This had decreased from the previous year.
- Staff told us they had raised concerns about staffing by informing managers and completing incident reports. They also told us their numbers and skill mix in their own area were depleted at times in order to ensure central delivery suite was better staffed.
- In order to achieve safe staffing levels, staff were moved between wards and between Doncaster and Bassetlaw sites. Junior staff told us they were most likely to be moved and this impacted on their morale.
- In March 2015, the EPAU was closed for five days due to staffing problems.
- Some staff told us their workload was "too great". They said they were responsible for several clinical issues at the same time, such as monitoring babies and women, undertaking feeding support and supervising junior staff. One midwife told us she felt "very pressurised" in her job because of the workload and responsibility.
- The two days we visited the gynaecology ward, planned staffing was less than the actual numbers. The hospital 'hard truths' document indicated that only 85% of the planned shifts were filled.
- Staff on the gynaecology ward told us that permanent registered nurses were mainly used to work on the day shift and the night shifts were staffed by one permanent member of staff and an agency or bank nurse plus health care assistants. They told us this put pressure on the permanent staff member as they could be working with someone who was unfamiliar with the ward and patients.
- They told us that recruitment was a problem and that senior managers were aware of the ward pressures.
- Staff we spoke with told us they could swap shifts with colleagues on the same pay band and that most of the time their duty requests were met. They said they liked this flexibility.
- Nurses and midwives 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.

Maternity and gynaecology

Medical staffing

- At the time of our inspection the consultant cover at Doncaster maternity unit was 60 hours per week and was in line with national recommendations for the number of babies delivered on the unit per year. This cover was provided from 8 am to 7pm 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 inspection, there were two consultant vacancies and two middle grade vacancies. These were covered by locum doctors. Medical staff told us this could impact on their workload.
- There was 24 hour anaesthetic cover at Doncaster Royal Infirmary maternity unit
- Junior doctors told us that support from senior colleagues was readily available.
- There was a consultant run elective caesarean section theatre list four days a week. There was a dedicated anaesthetic team for this group of patients.
- 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.
- As part of the hospital five year plan, and in line with the increasing number of births at the hospital, senior managers aspired to have consultant cover for 96 hours a week.

Major incident awareness and training

- Staff who spoke with us were unable to confirm the major incident plans. They were aware of the 'battle box' and its contents including torches batteries and action cards.

Are maternity and gynaecology services effective?

Requires improvement

Four of the five National Neonatal Audit Programme (NNAP) questions were below the national standard for Doncaster.

Most 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.

Although the rate of normal unassisted deliveries had marginally increased in the last part of 2014, the rate of elective caesareans was still high. Non-elective sections accounted for a high percentage of births; the number of home births was very low, with none were recorded in December 2014. One to one care during labour had been recorded as being between 77% and 84% during 2014; this is lower than the average for England.

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 outcomes from audits had helped to make improvements in care, such as the reduction of 3rd and 4th degree trauma after delivery.

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.

The hospital had recently achieved level 3 of the UNICEF Baby Friendly Initiative. This is the highest level which can 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 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.
- The hospital had a 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.

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.
- Most women told us their pain relief had been very good.

Nutrition and hydration

- Women had a choice of meals with took account of their individual preferences.
- The women we spoke to were happy that their fluid and dietary needs had been met.
- Mealtimes were protected, yet there was flexibility to obtain meals for women who were admitted outside of set mealtimes.
- The hospital had recently achieved level 3 of the UNICEF Baby Friendly Initiative. This is a worldwide initiative which encourages hospitals to promote breastfeeding. Figures showed that breastfeeding rates had been variable in 2014 and in the latter part of 2014 only attained an average of around 61%, however this had recently improved.

Patient outcomes

- In April 2014 to March 2015, there had been 3,666 deliveries at Doncaster Royal Infirmary.
- Four of the five National Neonatal Audit Programme (NNAP) (2014) for Doncaster were below the national standard. These included the percentage of babies who had their temperature taken within an hour of birth, the percentage of women delivering pre term babies who received any dose of antenatal steroids, the percentage of babies who received their mother's milk when discharged from a neonatal unit, and the percentage of documented consultation with parents by a senior member of the neonatal team within 24 hours of admission.
- The rate of normal unassisted deliveries had marginally increased to around 69% in the last part of 2014 and this was higher than the England average, the rate of elective caesareans was still over 10%. This is higher than the England average of 8%. Non-elective sections accounted for over 15% of births in December 2014; the England average is 11 %. Deprivation, obesity and prevalence of type 2 diabetes, which was found within Doncaster, can affect these rates. The number of home births was very low; none were recorded in December 2014.
- There was high induction of labour rates although these had fallen slightly from over 32% to around 29%. The hospital uses a red, amber green rating on its Maternity quality dashboard. 'Green' rates for induction of labour are rated at less than 22.5 %. The red indicator relates to those over 28%.
- The hospital had re-audited the management of third and fourth degree trauma in 2014. The rate had reduced from 3.76% to below 1%.
- There was a weekly meeting to discuss caesarean sections from the previous week. There were also perinatal meetings held every month and staff told us these are well attended.
- The management of post-partum haemorrhage (PPH) was audited in December 2014. Actions taken from this audit included changes to the IT system to ensure staff completed a proforma, the use of prompts to alert staff to the management of PPH and the re-iteration to junior medical staff and senior midwives that a consultant must be informed in the case of a 'massive' PPH. 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.
- Since 2010 there had been a high percentage of non-elective neonatal readmissions within 28 days of birth and the trust had been identified by CQC as an outlier. In April 2015, this rate was demonstrated to be within normal limits. 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.
- We were shown the '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.

- One to one care during labour had been recorded as being between 77% and 84% during 2014; this is lower than the average for England. Senior staff told us these results may have been affected by the way the question was worded on the audit response form.
- The proportion of delivery methods were mostly in line with national expectations, the number of breech deliveries was slightly higher than average.

Competent staff

- The majority of staff we spoke with had not had a performance appraisal in the preceding 12 months. This included staff on the gynaecology ward. Senior staff who spoke with us also corroborated that appraisals had not been carried out for over a year.
- The Supervisor of Midwives (SOM) role had been used instead of an appraisal or performance review. Staff told us this had been the situation for at least the preceding two years. Supervision is a statutory responsibility that provides a way for midwives to get support and guidance, it is 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 and they were usually able to contact them across the whole 24 hours.
- 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 encouraged by an 18 month programme of support and were allowed to develop their skills at an individual rate.

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.
- Community midwives told us they had good access to medical support.
- 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.
- We observed effective multidisciplinary team (MDT) handover and communication between midwives and doctors and midwives told us about how they handover 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.
- Staff told us they were aware of MDT guidelines to be used if a woman in labour needed to be transferred by ambulance from a home birth to hospital, or if a neonate needed to be transferred to another unit.
- Midwives told us the midwifery support workers were “invaluable” and worked hard in breastfeeding support and parent education.

Seven-day services

- Doctors we spoke with told us the consultants provided five hours of cover on Saturdays and Sundays. Consultants were also available as an on call basis outside these hours.
- Doncaster maternity unit provided 24 hour, seven days a week theatre and anaesthetic cover.
- Senior managers told us that if the birth rate increased to over 4000 births a year, this would necessitate 96 hour consultant cover, as opposed to the 60 hours currently provided.
- There was access to diagnostic services on a weekend.
- Physiotherapy services were available seven days a week for women who had acute cardio-respiratory problems or patients requiring therapy support in discharge planning.The EPAU opened from Monday to Friday, from 7am to 6pm. Outside of these hours women could be scanned by a doctor from the gynaecology ward if their condition meant they were unable to wait until after the weekend.

Access to information

- We observed good communication between teams. This was either verbal, written or an electronic print out was in place using the SBAR tool. (Situation, Background, Assessment, Recommendation).
- The EPAU recorded attendance and scans in a paper book. This information was not currently linked to electronic records but it was accurately documented.
- Discharge letters were printed and faxed to GP’s in a timely way.

- There was relevant clinical information displayed in the clinical and ward areas for women and their partners to read.
- Pregnant women could also access their own maternity records with their own Wi-Fi network at home.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Records we looked at showed that women were consented appropriately and correctly for surgical procedures.
- Staff told us that women who required a termination of pregnancy were referred to the British Pregnancy Advisory Service (BPAS) which was separate from the hospital and not part of the trust. Staff were aware about consent for a termination of pregnancy and also sensitively described consent for disposal of terminated foetuses and products of conception.
- The consent form in use at Doncaster 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. 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 general lack of awareness of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS), especially on the gynaecology ward. Staff said they had not received training and were unable to describe how they would act to ensure the proper steps were taken to protect someone who did not have capacity. They were unable to confirm how capacity could be determined. They told us they would refer to the safeguarding team between Monday and Friday, but were not aware of how to seek authorisation from deprivation of liberty, how to make a best interest decision for someone or the difference between lawful and unlawful restraint.
- The gynaecology ward took a high number of medical outlier patients, including older people with acute delirium or living with dementia. Some of these patients lacked mental capacity to make decisions about their care and treatment.

Are maternity and gynaecology services caring?

Good

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

Staff on the gynaecology ward had raised money to make a side room into an end of life area for dying patients and their family.

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 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 Doncaster showed that on the whole, women would recommend the unit to someone else. There were instances where 100% recommendation had been attained.
- The gynaecology ward cared for patients at the end of life. Staff had raised money to enable a side room to be converted into a more personalised, comfortable environment for someone who was dying. The area included a room with kitchen facilities for family or carers so they could have some quiet time away from the bedside if needed. Staff told us they hoped to be able to convert another room for similar use.
- Nurses on the gynaecology ward described how they cared for older patients and young women at the end of life, such as those with ovarian cancer. The nurses had a very compassionate approach to the patients and their families.

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
- 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.
- Women in the maternity unit told us their partners had been encouraged to stay with them.
- We observed some difficulties in patients being able to have someone stay with them in the waiting area on the gynaecology ward. The ward had outlier medical and surgical patients, both male and female. Staff told us that when it was busy and patients of both sexes are waiting for a bed, it was difficult to separate them in the waiting area, and sensitive conversations could happen in front of members of the opposite sex. We were told that patients are taken into a small room away from the waiting area to be admitted.
- Senior staff informed us that work was due to begin in changing the use of the waiting area to an assessment unit.

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.
- We saw an example of where a woman had been offered the afterthoughts service.
- There was a specialist bereavement midwife in post to support parents in cases of stillbirth or neonatal death. She 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.
- The bereavement service was very proactive however there were no dedicated bereavement facilities within the unit.
- The bereavement midwife told us she would like to expand the service she offered by cascading bereavement training to staff. There had not been any bereavement training for experienced midwives in the last two years. (Newly qualified midwives had some training with the bereavement midwife)
- Senior staff told us they were planning to make a room on central delivery suite into a designated area which could be used when they knew a woman had to deliver a stillborn baby.
- Some medical staff told us they thought the overall bereavement service was poor and could be improved.
- Nurses in the EPAU told us if they have scanned a woman and she had miscarried or lost the pregnancy, they had a duplicate letter system to avoid the woman receiving any further unnecessary appointments which could cause distress.
- Chaplaincy support was available for bereaved parents. There was an annual service in the hospital chapel for those who have lost babies of less than 14 weeks gestation. Private funeral arrangements needed to be made for pregnancy losses over 24 weeks.
- Staff told us they could access a 24 hour counselling line; they said this helped them to talk about their feelings and to continue caring.

Are maternity and gynaecology services responsive?

Requires improvement

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 other maternity services. There were occasions when capacity and staffing affected the clinic arrangements and interrupted the provision of services in antenatal care. This meant that women experienced longer waiting times.

The maternity unit closed for eight times between July 2013 and December 2014.

There was a high rate of induction of labour in the unit (up to 30% of births). This meant that rooms on the labour suite were occupied for longer periods of time.

The gynaecology ward took a high number of outlier patients from other specialities. This impacted on the response the service gave to gynaecology patients.

Maternity and gynaecology

Staff on the gynaecology ward told us women who were inpatients and needed urodynamic investigations had to attend other parts of the hospital, without an appointment. This had significant impact on the capacity in the urodynamic department. Women had to wait in this area with male patients.

The service responded to the needs of women who needed extra support. There was a range of specialist midwives in post; however there was no specialist diabetes midwife in post. The wellbeing midwife was due to start a service supporting women with mental health needs.

The percentage of women booking in before 13 weeks of pregnancy was a good at around 89%. Doncaster maternity services had low rates 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 told us they 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.
- Doncaster 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. There was no specialist diabetes midwife in post at the trust as recommended in NICE guidelines. Staff told us women could be seen by a diabetes specialist nurse at the unit.
- Staff on the gynaecology ward told us women who were inpatients and needed urodynamic investigations had to attend the urodynamic department and wait with male patients. There were no urodynamic facilities within the women's hospital. There is a Continence Clinical Nurse Specialist in post at Doncaster, it was not clear if she/he is involved in the care of gynaecology patients.
- There was a high incidence of pregnant women who were smokers. Between 25% and 29% of women who booked in to antenatal clinic during the latter part of 2014 were smokers. In December 2014 over 34% of women who had delivered smoked. The healthy lifestyle specialist midwife had involvement with women who were smokers.
- In March 2015, the EPAU was closed for five days due to staffing problems. When it was closed women were sent to Bassetlaw Hospital on the hospital shuttle if they needed a scan. Those women, who presented in the emergency department, were assessed by a specialist gynaecology registrar. Nurses told us if the EPAU was closed a GP could ring the gynaecology ward to discuss a woman's early pregnancy problems with a doctor.

Access and flow

- 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 triage system.
- There was a triage assessment area which was staffed by a midwife 24 hours a day, seven days a week, for pregnant women over 20 weeks of gestation and who required further care or assessment that could not be provided by the routine community midwifery service or GPs. 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. There was a specialist registrar and consultant on call. 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 high dependency area within central delivery suite. We found this was underutilised and mostly used as a 'general' birthing area.
- Nurses on the gynaecology ward told us that elective patients waited in a bay on the ward used as the theatre admissions unit. from 8am to 2pm for a bed to become available. Patients were taken to theatre when there was a bed allocated for their return post operatively. We

observed a female patient waiting; she told us she had been asked to attend for 12.30pm. When she spoke with us it was 2.10 pm and she had not received an explanation about a delay for a bed.

- The maternity unit closed on eight occasions between July 2013 and December 2014. This ranged from one hour to a maximum of 28 hours, with average closure time of 10 hours. During this time diversion to Bassetlaw site was activated and access to trust maternity services was maintained as part of the escalations plans.
- There was no transitional care facility at the hospital. The trust had pathways for midwifery led transitional care, managed through the postnatal maternity ward.
- Midwives told us the high rate of induction of labour in the unit (up to 30% of births) meant that rooms on the labour suite were occupied for longer periods of time, thus reducing capacity and flow through the unit. The hospital uses a red, amber green (RAG) rating on its Maternity quality dashboard. 'Green' rates for induction of labour are rated at less than 22.5 %. The red indicator relates to those over 28%.
- At times, women in active labour had been cared for on the antenatal ward, while women undergoing induction had been on the central delivery suite, despite the use of a RAG system. Staff told us this was being reviewed.
- The gynaecology ward took a high number of outlier patients from other specialities such as medicine, elderly care and surgery. Staff told us as a result of this there could be 10 ward rounds a day involving different consultants. There were not enough nurses to accompany each ward round, and nurses had to look in the patient notes to check for updates to care or discharge plans. This resulted in delays for patients. The hospital board papers in March 2015 noted that progress had been made in reducing the number of outliers.
- The gynaecology ward also cared for women who had mastectomy or other breast surgery. Nurses told us some women were discharged the same day after a mastectomy.
- There were plans to open a gynaecology assessment unit soon after our inspection. This meant that rapid assessment and diagnosis could take place and would prevent women having to wait in the main emergency department of the hospital.
- There was a comprehensive escalation procedure. The deputy matron completed a bed state every four hours. This was shared with the bed management team and was used to monitor capacity and demand for maternity and gynaecology bed availability.

Meeting people's individual needs

- 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, teenage pregnancy, substance misuse, patient safety, healthy lifestyle, breast feeding and safeguarding.
- There were specialist breast care nurses in post who were available for women undergoing mastectomy.
- Women could access their personal electronic maternity records at home.
- Postnatal visits were carried out according to a woman's individual needs. Midwifery staff told us women could be seen three times by a community midwife, and then given further support by a midwifery support worker.
- If a postnatal woman was well, she could be seen at a children's centre if preferred, this meant she did not need to wait at home for a visit.
- Women who had a caesarean section were cared for in a separate bay, to reduce the risk of healthcare acquired infections.
- Access to translation and interpreter services was apparent. We saw booked appointments in ward diaries. Staff told us they used telephone interpreters for 'basic' needs, but booked face to face interpreters for complex discussions or to break bad news.
- We were shown personalised folders which were given to women in the antenatal period of care. The maternity unit worked with a charity, the MAMA (Mama and Midwives Awareness Academy) who provided these. The folders were attractive and colourful and contained useful advice and information such as when to call the midwife, how to monitor baby movements, and which foodstuffs to avoid in pregnancy. Women could record the mobile number of their midwife on the folder so they had it to hand if needed.
- Women who spoke with us in the maternity unit told us they were very happy with their care, that their individual needs had been well met.
- Women also told us their partners were able to stay during induction of labour.

- Staff on the gynaecology ward told us it could be difficult to fulfil individual patient needs due to the diversity of patients on the ward. They cared for women with a variety of conditions. This included breast cancer, urology problems, early pregnancy problems, and gynaecology illnesses. Staff also cared for patients living with dementia, delirium, those with a learning disability, a wide range of medical conditions and sometimes other general surgical or orthopaedic conditions.
- We saw one patient on the gynaecology ward who had been on three different wards during this episode of care which she found upsetting.
- The EPAU saw between 16 and 18 women a day. If a woman needed an urgent scan on a weekend they could be seen on the gynaecology ward by a doctor.
- Senior maternity staff told us as a consequence of Child Sexual Exploitation (CSE) cases in the surrounding areas extra training had been arranged within the maternity unit to make staff aware of potential risks to young females.
- There were a range of information leaflets in clinic and ward areas, including information about tests and screening, breastfeeding and other sources of support.
- The hospital was due to revise the Health and Wellbeing strategy to include a specific section on health inequalities.
- Women who were at risk of suffering early pregnancy loss needed to attend the ultrasound department on the ground floor of the women's hospital, for example if they had an ectopic pregnancy, they had to go to a different floor level to have a scan. Senior staff told us concerns had already been raised about the environment and that a different location such as EPAU would be more appropriate; trust managers also advised that patient experience surveys did not illustrate any concerns about the location There was a small seating area for women who have had bad news; there was a small screen separating it from the main waiting area. There was a busy triage area where women could self-refer. Staff told us this service would be better if it was merged with the antenatal ward.

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.
- We were told that 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. Maximum learning from incident investigation may not have been achieved at the unit.

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 are 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 staff were not familiar with key objectives.

Maternity and gynaecology

We found there was disconnection between ward staff and the board. Most staff were unaware of the vision for the service. In some areas there were barriers to providing optimum care such as limited time and staffing resources and some acceptance of less than optimum care.

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. We were told the overall sickness and absence rate was low at less than 3.5%.

Vision and strategy for this service

- There was a 'Children and Families Care Group Operational Plan' in place for 2015-2017. The management team and the Head of Midwifery, provided a cascade communication of key priorities, objectives and the minutes of key meetings with their team, to disseminate the principles set out in the operational plan. However, we found that ward staff were not familiar key objectives.
- The senior management team were able to describe their vision for maternity and gynaecology services. Their aim was to develop a midwife led unit at Doncaster.

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. It was not clear if specific action was due to be taken in order to increase the rate of one to one care during labour.
- There had been 19 stillbirths between January 2014 and January 2015 at Doncaster Royal Infirmary. 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 four cases, different management may have changed the outcome. The review also found in six 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. We looked at RCA's of still births and a review from a never event. 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. This was reflected in the low numbers of front line staff attending mandatory resuscitation training. An action plan had been put in place which included specific training for staff that deviated from guidelines. The guidelines were also to be reviewed and cascaded to all staff.
- 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.

Leadership of service

- The leadership structure in women's services was a care group director, a clinical governance lead, heads 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.
- We found some evidence of goals and standards for improving quality. There were examples of investment, such as the project managed implementation of K2, an electronic record for maternity services. There were some barriers such as limited time, staffing resources and some acceptance of less than optimum care, 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 told us they were used as part of the escalation process in the absence of a manager. This means that a band 6 SOM could be used to make management decisions. SOM's told us they had escalated this and there had been some improvement. However, the trust informed us that the final decision would be made by the Executive Director on call.
- SOM's were meant to use two days a month to carry out their supervisory role, they told us it was a challenge to do this due to other demands on their time.
- The care group leaders 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 do 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 board and the wards.
- It was generally felt that maternity leadership and morale had improved in recent months at Doncaster.

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 the unit was a 'good place to work'. Most staff we spoke with were positive and enthusiastic.
- Staff told us managers operated 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.
- Trust papers for May 2015 showed a staff review found that certain groups of staff were particularly vulnerable when raising concerns because of the nature of their term of employment, for example locums, agency, bank workers or students and volunteers. The recommendations were the board should also be aware of any black and minority ethnic (BME) issues and consider whether they need to take action over and above what is recommended in the 'Freedom to Speak Up report.'
- We were told staff sickness was lower than the trust average at less than 3.5 %. We saw some evidence of long term sickness on staffing rotas. We were told that human resources supported ward managers on managing sickness and absence.
- We saw a clear commitment to care and that team's work constructively together to deliver good quality care.
- There was a transparent philosophy of reporting incidents when things went wrong.
- Midwives in the central delivery suite told us if they felt the unit was unsafe due to high levels of activity, or reduced staffing, they felt confident managers would listen to them.
- Staff told us there was an open culture. One midwife said she had emailed the chief executive about staffing concerns and got a reply.

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, improvements to the assessment areas on the gynaecology ward.
- Previous staff surveys showed around 78% of staff would recommend the unit as a place to work; a more recent survey was due to be published after our inspection.
- 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.

Innovation, improvement and sustainability

- Staff told us maternity services at Doncaster were going to be an 'early implementer' for a Royal College of

Maternity and gynaecology

Obstetricians and Gynaecologists (RCOG) initiative. The RCOG have committed to reducing avoidable incidents during labour which can result in stillbirth, early neonatal death or severe brain injury.

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. Inpatient services at Doncaster Royal Infirmary included a children's ward (a 20 bed medicine ward), a children's observation unit (COU), with 21 short-stay beds and a neonatal unit (NNU). The NNU had 18 cots, three of which were classified as intensive treatment/care, three as high dependency and the remaining 12 were Level 1. There was also a children's outpatient department (COPD) on site, which managed approximately 400 appointments a day, and a children's surgical unit (CSU) with seven beds. The CSU was managed by the surgical directorate with input from nurses and play specialists from the children's service.

There were 5663 children's admissions between July 2013 and June 2014. Of these 98% of which were emergencies, 1% were day cases and 1% were elective. There were 9227 outpatient admissions between January and December 2014.

During our inspection we visited all clinical areas where children were either admitted or which they attended on an outpatient basis, including the children's ward, COU, NNU, COPD and CSU. We talked with six medical staff, 20 nursing staff, 11 support workers and the management team. We also examined five sets of medical nursing records and spoke with 19 parents, family members and children/young people.

Summary of findings

We rated effective, caring, responsive and well-led as good. We rated safe as required 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. There were not always adequate numbers of registered children's nurses available at all times to meet the needs of children, young people and parent's within the inpatient and outpatient areas. Nursing staff were regularly moved between wards,

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units and sites in order to try and meet the needs of the children and young people using the service. Nurse staffing levels on the children's wards did not meet current national guidelines.

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. Complaints management required improvement.

Are services for children and young people safe?

Requires improvement

The levels of nursing staff within the children's clinical areas did not meet nationally recognised guidelines. 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. Staffing levels on the neonatal unit (NNU) were compliant with current requirements for units in hospitals providing neonatal care.

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 clean and there were effective 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

- Staff in clinical areas used the trust's electronic reporting system to report incidents. The service also had a patient safety database, which was managed by the band 7 sisters in each ward or department.

Services for children and young people

- The lead nurse (Head of nursing and quality) and matron (for paediatrics) told us most incidents were categorised as 'no harm' or near misses. They said the service's last serious incident was in March 2013.
- Incident data was collected and analysed jointly for the Doncaster and Bassetlaw sites. Information showed there had been 56 incidents reported in the four month period from September to December 2014; all of which were for the Doncaster site.
- Medication errors were the most commonly reported incident. In response, the service had introduced reflective practice and support for staff. We saw that incidents had been investigated and, where appropriate, lessons learned were shared at staff meetings. For example, staff on the NNU told us they would get feedback about any serious incidents and these would be discussed within the team.
- We attended part of the monthly clinical governance meeting for children's services during the inspection, where we heard incidents discussed and lessons learned were shared.
- 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

- There were effective systems in place to reduce the risk and spread of infection.
- All of the areas we visited were visibly clean, including the communal areas, toilets and bathrooms. The children's ward had two isolation rooms with en-suite facilities. The sister explained these rooms had filtered air to ensure the risk of cross-infection was minimised.
- We saw personal protective equipment, such as gloves and aprons, was readily available for staff to use when delivering care to patients. There were no wall-mounted alcohol hand gel dispensers in the ward areas. When we asked the lead nurse and matron about this, they told us this was as a result of a risk assessment which had showed there was a risk of ingestion and alcohol gel dripping onto the floor could be a slip hazard. Hand basins were available in patient areas for children and families.
- We observed that staff carried alcohol gel dispensers on their belts. We also observed staff washing their hands between patients.
- Staff told us the ward environment was audited regularly as part of the infection control audit programme. However, records submitted by the trust showed the last environmental audit on the children's ward was carried out on 29 July 2014 and the last audit on the COU was on 28 July 2014. There were no dates listed for environmental audits on the NNU. This meant there was no information to indicate the inpatient wards had undertaken an environmental audit for over eight months.
- Staff told us hand hygiene audits were carried out every month. 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. For example, the data provided showed hand hygiene observations were outstanding for 20 out of 30 staff on the children's ward, 20 out of 40 staff on the NNU and 20 out of 40 staff on the COU. We asked to look at the records of hand hygiene audits during the visit. However, these were not available.
- 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 all of the areas where children and young people were cared for in the trust; this included the two children's wards, the NNU, the CSU and the COPD.
- All of the areas we visited were suitably designed and well-maintained with child friendly décor, providing excellent facilities for children, young people and their parents. We were told the two inpatient wards had been refurbished when the wards had been relocated five years previously. The children's wards had been relocated to be closer to the maternity wards.
- Play areas had a good selection of toys available. There was also an area for adolescents on the children's ward and the dining area was decorated in the style of an American diner. Most of the beds on the children's wards were in individual rooms, some of which had en-suite facilities.
- Equipment on the wards was appropriately stored and sufficient. We found all of the storage areas were well-stocked and organised. Staff told us there were no problems acquiring and maintaining equipment; for example the trust had recently purchased 17 new infusion pumps for the children's wards.

- The service had a budget for environment and trust funds were also available which could be used to purchase equipment.
- When we visited the COPD staff told us building work was due to start next year. The management team meeting confirmed this and explained that the COPD would eventually be co-located next to the children's inpatient wards.
- We saw appropriate resuscitation equipment was readily available in all areas where children were seen in the trust. Resuscitation trolleys were in sealed units. Records confirmed other resuscitation equipment, such as defibrillators, were checked daily.
- New profiling beds specifically designed to reduce the risk of entrapment had recently been acquired for the children's wards.
- There was no segregation of children from adults in the recovery areas of the theatres. At the time of our visit to the main theatres' recovery there were three children in the area, although there was only designated space for two. We found that the children were directly opposite adult post-operation patients.

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 NNU, and observed administration of medications on the NNU; this included the safe administration of intravenous drugs.
- The children's wards had a named pharmacist who visited the ward on Monday to Friday. The pharmacist provided support and advice to staff. Staff told us the pharmacist checked the stocks of controlled drugs held on the ward every week.
- When we looked at incidents reported by the service for the four month period from September to December 2014; we saw 11 out of 56 incidents were medication errors.
- 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 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.
- All care records viewed on the children's wards and NNU 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

- 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.
- Senior staff told us the service carried out audits of staff awareness, for example to assess staff knowledge of child sexual exploitation.
- Staff said the service was 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.

There was a dedicated child protection clinic in COPD.

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.
- Records held with the department showed the majority of staff were up to date with their mandatory training; staff we spoke with confirmed this.
- However, trust data showed low percentages of completed training. For example, on the COU trust records showed only 9% of nursing staff had completed equality and diversity training, compared to the trust target of 85%. Trust records also showed only 58% of nursing staff on the NNU had completed fire safety training and 0% had completed neonatal resuscitation.
- Senior nursing staff told us they were aware that trust records for mandatory training were not accurate; this was the reason they kept local records. Data provided following the inspection showed 100% of staff on the NNU had completed basic neonatal resuscitation and advanced neonatal life support (NALS). The target was above 90%.
- One of the clinical educators told us training dates were booked for the following 12 months. This meant the service planned training to ensure all staff kept up to date.
- The trust ran mandatory training days and half days. Staff, including medical staff, felt this was a convenient and efficient use of time. We were told, and rotas confirmed, that study time was accounted for and protected on the staff rotas.
- Senior nursing staff told us the trust had recently taken a subscription to a national nursing journal which meant staff could access accompanying 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 sister in COPD told us staff development and training was run by the clinical educators and was the same as on the acute wards. Nursing staff in COPD were all trained in paediatric intermediate life support (PILS).

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 nursing staff told us they did not currently use a specific moving and handling tool or nutritional screening tool where risks had been identified. They told us any patients that needed nutritional support would be referred to a dietician.
- However, other staff told us there were currently problems with dietician availability for the children's service. One person said they had been unable to contact a dietician when support was needed. This meant children and young people who required additional support with nutrition and hydration may not have had their nutritional risks adequately assessed and followed up.
- The children's wards and COU 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. We found PAWS assessments were completed appropriately.
- The children's ward had two high dependency cubicles next to the nurse's station which were used to stabilise children. We saw these rooms had appropriate additional equipment.
- There were arrangements in place to ensure checks were made prior to, during and after surgical

procedures in children and young people, in accordance with best practice principles. This included completion of the World Health Organization's 'Five Steps to Safer Surgery' checklist.
- The trust 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 children's ward had 18 beds and two additional cubicles designated as high dependency; these were used for the stabilisation of critically ill children.
- The lead nurse and matron explained that expected minimum staffing for this ward was three registered nurses (RNs) plus two support workers for day time shifts and three RNs plus one support worker for night time duties. These staffing numbers gave a daytime ratio of one registered nurse to six patients during the day and night.
- Staff told us the high dependency cubicles were staffed by one RN for the two cubicles, when they were occupied. This meant the staffing ratio of one registered nurse to six patients did not take account staffing these cubicles; when these cubicles were occupied, there were fewer RNs available for meeting the needs of the other children on the ward.
- When we visited the children's wards we found they were very busy and nursing staff did not have time to talk to us.
- When we looked at duty rotas for the four week period of 2-29 March 2015 (28 days) we found nine daytime shifts and four night-time shifts where there were only two registered nurses on duty.
- 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 recommended minimum. Medical staff we spoke with also told us there were significant pressures on nurse staffing within the children's service.
- The COU had 21 beds. Staffing was four RNs plus two support workers for day time shifts and two RNs plus two support workers for night shifts.
- The CSU had seven beds and was staffed by two RNs plus two support workers on the days when surgery was taking place. The sister on COU explained that the CSU was supplied with staff from the COU. We looked at the duty rotas for the 2-29 March 2015 for COU and saw these included staff for CSU. We saw that the surgical unit was open on every Monday during March 2015 and the number of RNs on duty for the COU and CSU combined ranged from four RNs to seven RNs. This meant we were unable to confirm whether minimum staffing levels were being maintained on the COU.
- We observed the shortage of qualified nurses on the COU. This meant a healthcare assistant (rather than a qualified nurse) or a student nurse may greet families onto the unit and carry out their initial observations, prior to their assessment by a RN.
- Senior nursing staff said they felt staffing was "tight." This was confirmed when we spoke with nursing staff on the wards. They told us they were frequently moved between wards and sites to cover for staff shortages. They accepted this was to meet the needs of the service.
- The trust was currently recruiting to various nurse positions. For example, they were advertising for three band 6 posts, which would provide an extra sister at Bassetlaw and two extra sisters at Doncaster. Three band 5 posts had been appointed to, and the staff were waiting to take up their positions, and three band 5 posts were vacant and due to be advertised.
- Senior nursing staff told us sickness levels were in line with the trust target and staff turnover within the children's service was low.
- The trust had recently invested in the 'PANDA' (paediatric acuity and nurse dependency assessment) staffing acuity tool, and had started using it on 1 April 2015. PANDA is a tool which assesses the nursing dependency needs for children and calculates safe nurse staffing requirements. The management team explained that the results of this tool would be used to inform the nurse staffing establishment for the inpatient wards in the future.
- The NNU had 18 cots, three of which were for intensive care and three were for high dependency. We were told the NNU used a 'BadgerNET' neonatal network system. This system was used to monitor and record staffing levels to ensure there were adequate numbers of 'qualified in speciality' (QIS) neonatal trained staff available as per the British Association of Perinatal Medicine (BAPM) staffing standards.

- We found staffing levels on the NNU were seven RNs per shift, of which a minimum of three were QIS trained. This complied with the BAPM staffing standards.
- The service had tried to recruit, train and retain advanced neonatal nurse practitioners (ANNP), but with little success. The NNU had one registrar grade ANNP, who told us they had been in post for five years.
- Senior staff in COPD told us the unit was "busy"; they said the department currently had several vacancies including one full-time band 5, a temporary full-time healthcare assistant (HCA) position for maternity cover and a permanent part-time HCA. Staff in the department were regularly required to cover outpatient clinics at other sites.
- We were told the COPD was staffed separately to the paediatric inpatient wards; however, staff we spoke with in COPD told us they were regularly asked to cover shifts on these wards.

Medical staffing

- At Doncaster we spoke with medical staff of all grades, including consultant paediatricians, registrars and trainee doctors. Medical staff told there was a high use of locum medical staff; this was confirmed when we looked at the cross site on call rotas for January 2015. These showed locum consultants had been used on the paediatric 'consultant of the week' daytime rota for two weeks out of four (between 4 January 2015 and 1 February 2015).
- Data submitted by the trust also demonstrated that medical agency locum use within the children's service was 19% in November and December 2014.
- Consultant staff told us that they were concerned about the high use of medical locum staff, as this did not provide safety and continuity. Senior nursing staff told us medical staffing could have an impact on patient care. Other nurses told us they had concerns about continuity of patient care, as a result of locum medical staff usage.
- 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 every five and a half weeks; this was confirmed to us by the clinical lead. There were currently nine consultant staff participating in the on call rota. Consultant staff told us they felt this placed them under increased pressure.
- During the inspection we found there were vacancies in the medical staffing establishment. When we asked the management team about this they told us there was a 0.4 whole time equivalent (WTE) at tier 1 (foundation trainee) and 1.4 whole time equivalent (WTE) at tier 2 (speciality trainee). They told us they were advertising for two fixed term locum medical staff.
- The shortage of medical staff was also affecting appointments for children and young people in outpatients, where there was a lack of slots for new appointments. We found there were three vacancies for medical staff in outpatients. The children's and families care group operational plan document for 2015-2017 stated these posts would be advertised in Quarter 4 of 2015/2016 (between January and March 2016).
- We attended a morning paediatric medical handover which was attended by 14 medical staff of all grades and an ANNP) No other nursing staff attended the handover, although we were told they normally did. The handover was focussed and discussed the child's clinical presentation, agreeing a plan of treatment and care for each child. We also attended the consultant-led ward round which followed the handover, on the COU.
- Clinical staff told us IT facilities were available for handover meetings and were used when needed. For example if a patient's radiology results needed to be viewed.

Major incident awareness and training

- Staff had been trained to deal with major incidents. Senior nursing staff told us the children's service had been part of an evacuation scenario about 18 months ago and staff had undertaken ward based training in 2014.
- The senior sisters explained that the ward based awareness sessions had included a DVD and all ward staff had taken part, including the ward housekeepers. Staff we spoke with confirmed this. We found this training included awareness of the business continuity plan and risk assessments, including the control of substances hazardous to health (COSHH).

Services for children and young people

- The senior sisters on the children's wards told us staff kept up to date about major incident procedures through monthly training and this was a rolling programme.
- We were told by senior nursing staff that laminated action cards were readily available at the nurse's stations, these covered different major incident scenarios.

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. We also found there were problems with access and availability of dieticians within the trust to support the children's service.

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 followed.

Evidence-based care and treatment

- The trust had systems and processes in place to review and implement 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 was involved in various local and national research and innovation development projects. These included:-
  - A follow-up study examining the health of children with Down's syndrome
  - A randomised controlled trial of iodine supplementation in preterm infants
  - Yorkshire Specialist Register of Cancer in Children and Young People
  - UK paediatric chronic idiopathic thrombocytopenia (ITP) registry
- 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. The general manager told us the service had between 150 and 180 policies; they said 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.
- When we visited the NNU staff told us the unit used policies and procedures from the neonatal network.
- The 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; 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 nursing 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.

- Ward sisters carried out assurance rounds and had found that feedback about pain relief had improved since the PAWS tool had been introduced. The PAWS tool includes an assessment of the impact of pain and monitors it on an ongoing basis.
- The NNU was following new guidance about the use of sucrose in babies when carrying out procedures such as cannula insertion and venepuncture. Sucrose has been shown to provide pain relief for new-born babies having painful procedures, such as heel pricks or needles.
- Some inpatient wards used patient-controlled analgesia; this was supported and managed by anaesthetists. When we looked at the PAWS documentation in a selection of care records on the inpatient wards we found these had all been completed as required. The PAWS assessment includes an assessment of pain level.
- We were told that nurses could give certain analgesics to children and young people prior to them seeing a doctor.
- Parents we spoke with on the surgical unit and in the COU waiting area confirmed their children had received appropriate pain relief.

Nutrition and hydration

- Children and young people on the children's wards could choose from the children's menu provided or from the adults menu if they preferred. Breastfeeding mothers on the NNU could also choose meals from the menu and other resident parents were provided with tea and toast for breakfast. Parents on the inpatient wards had access to kitchen areas where they could make hot drinks and snacks.
- A tea trolley service was used on the inpatient wards between 2pm and 4pm in the afternoon. Drinks were offered to relatives as well as patients.
- Senior nursing staff told us the play team were important, as play leaders often helped with breastfeeding or at mealtimes.
- When we visited the NNU we saw there was a total parenteral nutrition (TPN) protocol for neonates. TPN is used for patients who cannot or should not get their nutrition through eating.
- We found the service did not use a nutritional risk screening tool. When we asked senior nurses about this they explained that the adult nutritional assessment tools were not suitable for use in children. The service used dieticians to support children and young people with nutrition; however, the system to identify those children and young people who need this additional support was not clear.

Patient outcomes

- Senior nursing staff were aware there was a high level of deprivation in the area. They said they were proud of the fact that breastfeeding rates on discharge from the NNU were currently 43%, and that this figure had been steadily increasing. They explained that all nurses were trained in breastfeeding techniques and that the infant feeding co-ordinator analysed the feeding on discharge rates every month.
- The service had previously had high neonatal readmission rates for jaundice. The staff had addressed 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 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 Doncaster Royal Infirmary was 65 mmol/l, compared with an England average of 69 mmol/l.
- 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 of the

training they needed to carry out their role safely and competently. The service's clinical educators told us that all staff working in the service were given the same opportunities for training and personal development.

- The clinical educators ran a staff development day and this was linked to patient safety. We found the service was running one of these days during our visit and medical staff were contributing. We were told this training would cover unexpected deterioration of the child, consideration of human factors, case discussions and lessons learnt, both positive and negative.
- Paediatric nurses in the emergency department attended the study days run by the children's service. We were provided with examples of what was included in these study days, such as information governance and breastfeeding.
- The clinical educators told us the service ran bespoke induction programmes, as there was nothing available nationally. 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. The service also ran student nurse induction days.
- The service had also developed a range of bespoke clinical skills packages for staff. 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.
- Nursing staff including clinical educators confirmed staff had regular supervision sessions, either individually or in groups.
- 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.
- The majority of the staff we spoke with told us they had had an appraisal in the past 12 months. However, data submitted by the trust showed that the percentage of nursing staff that had had an appraisal between April and December 2014 was well below the trust target. For example, appraisal rates on the inpatient wards were 36% on the NNU, 9% on the COU and 32% on the children's ward.
- 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.
- Medical and nursing staff from the paediatric service had monthly meetings with medical and nursing staff from the hospital's emergency department and the liaison health visitor regularly visited the emergency department and children's wards.
- We spoke with the ANNP on the NNU during our visit; they told us they attended the regional ANNP group.
- The neonatal lead consultant, lead nurse and sister from the NNU represented the trust at the Yorkshire and Humber paediatric operational delivery meeting.
- 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 had checked their practices with Asthma UK and the British Thoracic Society and identified 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.

Seven-day services

Services for children and young people

- The service was working towards seven day working in paediatrics.
- There were consultant ward rounds at the weekend and patients were discharged from the inpatient wards seven days a week.
- Play team did not work at the weekends and this was confirmed by staff and play leaders we spoke with.
- Senior nursing 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.
- They also told us there was a trust escalation policy which staff could follow if there was an issue which the site manager could not deal with. This meant nursing staff could contact a manager at home for advice out of hours.
- Staff told us diagnostic services were available at the weekend. The ward pharmacist worked Monday to Friday; there was access to on-call pharmacist support at the weekend.
- There was an out of hour's rota for consultants, which covered both Doncaster Royal Infirmary and Bassetlaw District General Hospital sites.

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 all of the areas 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.
- Admission and discharge packs were available for parents on the NNU and we saw these included a wide range of information and support.
- When we looked at care records on the CSU we saw the discharge letters for dental patients included an information sheet with contact telephone numbers.
- We were told that the service was working on an electronic handbook which would include access to all of the service's policies and procedures on one screen.

Consent

- Families we spoke with were happy with the consent procedures which had been followed.
- 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.
- We found there was no pre-admission assessment and staff we spoke with confirmed this.
- We looked two sets of care records and found the documentation to be well-organised and completed appropriately. One consent form had been signed in the outpatients department.
- Consent documentation was audited by nursing staff every six months. Senior nursing staff said the results of these audits did not raise any concerns and consent processes within the service.
- They explained that consent forms were not only used for elective surgery. They said consent forms would also be used for BCG immunisations given in COPD and for any 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 emergency procedures.

Are services for children and young people caring?

Good

We spoke with 19 parents, family members and children/ young people during our visits to the different areas of the trust where children and young people were seen. The majority 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 by the service was generally positive. However, some of the systems used for gaining feedback from children and young people required further development, as only small numbers of patients had been asked for their opinions.

Compassionate care

Services for children and young people

- The majority of the families we spoke with were pleased with the facilities and happy with the care they had received.
- Families told us staff were caring, compassionate and organised; this was confirmed by our observations. We found staff to be caring, well-organised and motivated. In all of the areas visited we observed staff worked well as a team. However, some families did comment on the lack on staff continuity.
- When we visited the NNU we saw a patient experience board with results displayed from the monthly patient experience surveys. We noted the feedback was positive.
- When we visited the COPD we found there had been several positive changes made as a result of feedback from a 'Friends and Family' survey. For example:-
  - The reception area had been relocated, as there had been negative comments about the lack of privacy when booking in
  - Smaller chairs had been installed in the waiting room so that more seats could be accommodated, following comments that there was often "nowhere to sit"
- As a result of feedback on the children's ward, via patient experience forms, we found the adolescent room and play area had been redesigned. The adolescent room had been made smaller, the music on the juke box had been changed and a games station added. The play room had also been made bigger and a dressing up corner added.
- We looked at the commissioning for quality and innovation (CQUIN) young child experience survey for Doncaster and Bassetlaw hospitals in 2014. There had been 3 responses in quarter 1, 18 responses in quarter 2 and 2 responses in quarter 3. The results were positive in quarter 3 but the sample size was too small to draw any conclusions and the children who completed the survey in quarter 3 did not add any comments. The service planned to increase the sample size to 60 for quarter 4.

Understanding and involvement of patients and those close to them

- We observed members of staff talking with children and young people. We heard them using language appropriate to their age and level of understanding.
- Families told us they were always kept informed and that the information was clear and concise. One family, who were very happy with the care on the children's ward, told us they received good explanations and the doctors explained everything in language they could understand.
- When we spoke with parents on CSU they told us they had received relevant and useful information sheets.
- The NNU had produced DVDs about breastfeeding and other information for parents; staff told us this had been produced in consultation with parents who had used the facilities. Parents on the neonatal unit had access to a parents support group once a month and the parents were encouraged to make suggestions as to how the service could be improved.
- We looked at the CQUIN young child experience survey for the COU in quarter 3 of 2014. We saw eight people had completed the question "If you had to wait a long period of time (e.g. over an hour) to: see a doctor, have tests performed, await test results/medication, did you feel staff kept you informed of the reason for the delay and an indication of how long this was expected to be?" Four people (50%) said 'yes always', three people (37.5%) said 'yes mostly' and one person (12.5%) said mostly not. Six parents made comments; two of these were about the length of time they had waited to be seen in the emergency department and one was about delays in medication administration on the ward. One commented about the lack of information about mealtimes. Three people made positive comments about the staff and service.

Emotional support

- Parents and children told us they had been well supported during their visits or stays on the children's wards, NNU, CSU and COPD.
- We saw and heard staff supporting children who were upset or frightened. For example, the play leaders played with children on the CSU while they were awaiting surgery and accompanied them to the theatre for their operations. Play leaders also distracted children while they were having procedures carried out, such as having blood samples taken.
- Parents we talked with gave examples of how the service overall and staff supported their children and themselves.

Services for children and young people

- We observed some excellent examples of caring emotional support for families during our time spent on the inpatient wards and in the school room.
- The children's ward had a quiet room. We were informed this was used for breaking bad news when needed.
- On the NNU we found there were memory boxes and a cold cot for parents to use following bereavement; these parents also received community visits after they had left the unit. The NNU was also designing a bereavement suite for families to use.
- Senior sisters on the ward told us they held debrief sessions for staff following the death or serious injury of a child. They told us staff at the trust had direct access to a staff support service, run by an external company. Services offered included confidential counselling.

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. However, there was no segregation of children from adults in the recovery areas of the theatres.

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 timescales.

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.
- 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.

Access and flow

- Access and flow was well-established within children's services. The emergency department facilities for children were limited and were part of the adult service. The children's and families care group had no direct influence over the provision of emergency services within the emergency department.
- The COU had 21 beds and was immediately adjacent to the children's ward which had 18 beds. Children and young people (age 0-16 years) were admitted to the COU either via the emergency department or following referral by their GP. Here they received an initial assessment, and treatment if required. Staff told us patients on the COU would remain on the unit for a maximum of 24 hours, when they would either go home or be transferred to the children's ward. The COU also booked appointments for children and young people to have procedures such as blood tests.
- The COU had short term open access for patients for 48 hours following discharge; this could be adjusted for individual patients if clinically indicated. We found one patient who was being discharged during our visit was given 72 hours open access to the COU; this decision was made by their doctor.
- Day case surgery for children was provided within the seven bedded CSU, which was open from 7.30am. The CSU cared for children and young people undergoing elective dental, ophthalmic and ear, nose and throat surgery. Children requiring a period of observation post operatively, who were unable to be discharged home from the surgical unit, would be transferred to the COU.
- The children's ward provided care for children and young people with a predicted stay of more than 24 hours. The ward had two stabilisation rooms, located directly next to the nurse's station. These rooms were equipped with appropriate monitoring and stabilisation equipment.
- Staff used a PAWS monitoring chart to help them identify whether children and young people required transfer to a tertiary centre, such as Sheffield.

- The NNU had appropriate facilities and staff to stabilise babies prior to transfer to other units, if required. Staff told us they used the EMBRACE service when transfers to other centres were needed.
- The ward staff, including domestic staff, had a tracker system. This meant staff could be bleeped to assist with duties such as collecting samples or taking a patient to the X-ray department.
- When we looked at the children's and families care group operational plan document for 2015-2017 we saw 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.

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 than the national average of 33%. As a result of this feedback all 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 was getting feedback from parents about the new beds before deciding which ones to purchase.
- When we visited the CSU we saw there was a play leader available. We saw they were proactive with activities and accompanied children to theatre.
- Two staff in COPD were trained to show parents how to use an EpiPen®. EpiPen® is an auto-injector for the emergency treatment of people at increased risk for life-threatening allergic reactions (anaphylaxis).
- We saw there were good facilities for older children in the COPD, including computer tablets and PCs for internet access and games suitable for all ages. We were told these had been purchased as a response to feedback from families using the department in a 'friends and family survey.'
- In the COPD one of the play leaders told us they were taking a group of children with special needs to visit a farm on the week following our visit.
- We found the COPD had good services for children with special needs; for example, visually impaired children attended group activity sessions and there were facilities for assessing children and young people on the autism spectrum. The department also had clinics for children with long term medical conditions such as epilepsy and Down's syndrome.
- The COPD had a designated room for breastfeeding mothers. The sister explained that this was also useful for when new-born babies needed blood samples taking for screening tests, as these were easier to obtain if the baby was asleep.
- Phlebotomy services for children were provided on the children's wards and in the COPD. This meant children did not have to attend adult clinics to have blood samples taken.
- Senior nursing staff had recently asked parents and children to provide feedback about 3D distraction glasses. The feedback had been positive so these had been purchased and were available for use by children using the service.
- An education service was provided in the schoolroom on the children's ward for patients staying longer than 48 hours. We were informed this met the "legal requirement for education." We were told there had been a recent Ofsted inspection report and that the result was 'good with outstanding areas.'
- Staff told us there were no problems accessing translation services for black and minority ethnic (BME) families that required them. Staff were aware there was a population of people from Eastern Europe who accessed services. 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 needed.

Learning from complaints and concerns

- Data submitted following the inspection showed paediatrics had received 28 complaints in the 12 months from April 2014 to March 2015 across both sites.
- Staff on the NNU told us there had been no formal complaints about the unit for the previous four years.
- 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 only 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 need 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 timescales. Managers told us some of the delays were due to waiting for responses from families about how they preferred 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 required improvement. 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.

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 trust's emergency department and COU.
- 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 systems and processes in place to manage risk. Issues relating to nursing and medical staffing over the last three years had been identified on the risk register and remained under regular review.
- 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.
- The operational plan, which was written in December 2014, identified the inability to recruit paediatric nurses and identified that consideration, should be given to reducing bed numbers. However, during our inspection we found that no beds had been closed and there had been no significant increase in nurse staffing numbers. This meant the service was unable to meet current best practice guidelines for staffing in paediatrics.
- 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.

Leadership of service

- During our interview with the management team (clinical director, neonatal lead consultant, lead nurse, matron and general manager) 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 identified 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.
- The lead nurse and matron led the nursing team and were supported by band 7 ward managers in each of the inpatient wards and in the COPD. The band 7 ward managers told us they felt well-supported by the management team.
- We saw from the minutes, and from attending part of the monthly clinical governance meeting, that this meeting was well-attended by nursing and medical staff, including the clinical educators and the service's patient safety lead.
- However, some medical staff told us they felt they could not influence change and that when concerns were raised they did not 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 all told us the culture within the service and the teamwork was good. Staff spoke positively about the care they provided for children, young people and families.
- We observed that staff worked well together during our visits to the various wards and departments. They also worked well with multidisciplinary teams within the hospital and with other outside services in order to provide the best care possible for their children and young people.
- Staff told us they felt well-supported by their line managers and the management team, they said their managers were approachable. Several staff commented on the quality and value of the training provided.
- 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.
- The management team told us the diabetes team and the cystic fibrosis team had parent's liaison groups. They said a young person living with cystic fibrosis was a member of the group. They also told us they frequently involved children and young people in planning any changes services.
- When we visited the NNU staff told us there was a monthly parent's support group which was held in the antenatal unit. We also saw a 'Bliss' noticeboard; Bliss is a voluntary organisation which offers support to parents of babies born 'too soon, too small, too sick.'
- Staff told us they were kept informed about changes within the service and that they felt well-supported by their line managers and the management team, who were visible and approachable.

Innovation, improvement and sustainability

- The management team told 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

Doncaster Royal Infirmary forms part of the Doncaster and Bassetlaw Hospitals NHS Foundation Trust and provides end of life care services on site and in partnership with Bassetlaw District General Hospital, 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 Doncaster and Bassetlaw hospitals. A WTE (whole time equivalent) end of life care coordinator was based on site at Doncaster Royal Infirmary. 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). We saw that referrals to the integrated service from April to December 2014 totalled 906, 82% of whom were patients with cancer. 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 34 staff. We visited a number of wards and clinical areas across the hospital including general medicine, cardiology, critical care medicine, oncology, haematology, gynaecology, general surgery, stroke medicine, respiratory medicine, gastroenterology, and the Intensive Therapy Unit. We also visited the bereavement office, the chapel and the mortuary. We reviewed the records of 11 patients at the end of life and reviewed 16 Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders. We spoke with two patients and three 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. Hotel services staff were not adequately trained or supported in the receipt of bodies to the mortuary and we were not assured by the trust's arrangements for the storage of bodies in the mortuary in a way that respected the dignity of patient's after death. 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 seven day face to face assessment service. 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. The development of an electronic referral/alert system had seen an increase in referrals to the end of life care team in a timely manner. A business case had been developed as a result and the trust board had committed investment in expanding the end of life 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.

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 75% 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 reporting system and we saw evidence of this relating to end of life care. A specific example was the use of incident reporting when a patient, who was considered to be at the end of life, had not been recorded in the alert system that notified specialist staff of their admission.
- We were told that all end of life care incidents would then go to the end of life care lead nurse who was responsible for ensuring incidents were investigated.
- There were 8 incidents relating to end of life care recorded between December 2014 and January 2015. We saw one incident where a patient had not been

prescribed anticipatory medicines for end of life care. Action taken included the input of a palliative care pharmacist into pre-emptive prescribing training for medical staff.
- 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. Staff told us that the equipment available for the transfer of the deceased was generally adequate and we viewed manual handling training records that showed staff had been appropriately trained in its use.
- There was no specialist bariatric concealment trolley available for transferring deceased bariatric patients, however the Director of Nursing assured us this was being rectified and the equipment 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.
- 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 supported and guided 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 4 hours. The assessment included checking the site of the infusion, the volume, rate and time remaining.
- We reviewed 11 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 team 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 diabetes management and pressure ulcer prevention in the last few days of life.

End of life care

- We viewed the records of 11 patients who were at the end of life and of these we saw four patients who were being cared for using the IPOC for the last days of life. Of these were saw that one patient had just been commenced on the IPOC at the time of our inspection and another three had been established on the IPOC over hours or a few days. Of these three, we saw that initial assessments were generally completed appropriately and accurately by nursing staff with four hourly nursing entries generally recorded. However, medical assessments were not consistently or fully completed.
- The end of life care coordinator was aware of the 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 their life was admitted or identified. This meant that through a process of record management, the End of Life team were alerted to patients who were at the end of their life and who may require specialist input. We reviewed 16 Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms. The majority of these (75%) were completed accurately. In all cases we saw that decisions were dated and kept at the front of the patient's file. Four DNACPR decisions had not been approved by a consultant and two included 'frailty of old age' 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 45-55% of specialist palliative care staff had attended safeguarding training at level 1, 2 or 3.
- 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 was 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 includes 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 two Doncaster and Bassetlaw hospital sites and one end of life care coordinator based at Doncaster Royal Infirmary. The specialist palliative care nursing team were managed by a lead nurse who also covered cancer, chemotherapy and acute oncology services.
- The lead cancer nurse for end of life care had successfully developed a business case to increase the number of end of life care nurses by two across the trust, enhancing the staffing infrastructure for the end of life service. We were told these posts were due to be recruited to imminently.

End of life care

- Specialist palliative care nurses were available from 8.30 – 4.30 seven days a week and they were able to conduct face to face assessments during this time.
- 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 confirmed they had attended an end of life care training session as part of their induction into the trust. They also told us the specialist palliative care nurses would contact the wards every day.
- 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 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. However, there was evidence that hotel services staff did not have the training or support to properly deal with the receipt of bodies to the mortuary, particularly around the psychological impact of the role. 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.

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. 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. We saw some evidence that mental capacity assessments were recorded in relation to DNACPR decisions although this was not always done consistently.

Evidence-based care and treatment

- The Liverpool Care Pathway (LCP) had been phased out nationally by July 2014 and staff we spoke with at Doncaster Royal Infirmary 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 amber care bundle had been implemented in two wards at Doncaster and we were told that this would be expanded to other wards once the trust had appointed the new end of life clinical nurse specialist posts. In preparation, the specialist palliative care team had trained a number of consultants and nurses within the trust in the use of the amber tool. 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 Clinical Commissioning Group (CCG) and other organisations where ACP was discussed within the context.
- We viewed plans to pilot the Gold Standards Framework (GSF) on three wards in 2015 at Doncaster Royal Infirmary.

Pain relief

- There were 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.
- 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. We saw an example of a patient who was no longer being monitored using the early warning score following a decision that their care be focused on symptom control and comfort but had yet to be commenced on the last days of life IPOC. As a result their level of pain was not being regularly recorded although staff told us it was being assessed.
- 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 living 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.

Facilities

- We viewed the mortuary and a related entry onto the trust's risk register. We saw from a mortuary overview document that mortuary storage had been increased to 101 spaces in June 2014. However, we were told that during the winter months (2014/15) capacity had exceeded this (120). Staff told us that temporary trolleys were used within the cold storage room and that bariatric spaces had been used, with smaller bodies stored next to each other.
- We saw from a mortuary body storage and notification action plan (June 2014) document that a RAG (red, amber, green) traffic light system was in use and that this was used to alert relevant agencies when capacity was close to being reached. It was unclear what additional action was taken by the trust following the capacity issues in the winter of 2014/15.
- Members of the executive team we spoke with told us the capacity issues had been prompted by the closure of local crematoriums in the region over the Christmas period and that it had been reported and addressed within 48 hours.

Nutrition and hydration

- A Nutritional Screening and Assessment Tool was in use for all patients on admission to Doncaster Royal Infirmary.
- 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.
- We observed a red tray system in use on the wards to alert staff to patients who required assistance and we also saw information and guidance about textured diets and the availability of snack boxes and finger food.
- Staff we spoke with told us they were led by patient wishes in relation to oral intake of food and fluids.

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.
- The trust performed higher than the England average in seven 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, a review of interventions during the dying phase and a review of the number of assessments undertaken in the patient's last 24 hours of life.
- 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, the development of bereavement support training, and the implementation of seven day face to face nursing assessments.
- 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 2 new posts being recruited to. An end of life care coordinator was based at Doncaster Royal Infirmary.
- 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 was alerted of all patients at the end of life via and electronic alert system. Staff on the wards also told us they received daily phone calls from the end of life care coordinator to ask if there were end of life care patients or 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 ward manager told us that due to staffing shortages it was difficult for nursing staff to access mandatory training or end of life care training. They 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 all 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.
- We were told that hotel services staff dealt with the receipt of bodies into the mortuary, including those who came to the hospital brought in following death. Services staff told us they would visit the mortuary as part of their induction where they would be shown what to do by the mortuary technician but that they did not have further training in this. They would then be allocated to hotel services jobs via a tracking system but that this allocated jobs in a random way. This meant that hotel services staff could be expected to receive bodies into the mortuary as soon as they had completed their induction and with minimal preparation or support.
- We viewed a policy that stated a mortuary technician on-call was available to receive bodies where it was deemed to be distressing for hotel services staff; however staff told us it was difficult to assess this and that it was common practice not to call the on call mortuary technician.
- Hotel services supervisors confirmed that hotel services staff would receive bodies into the mortuary out of hours and that these would include those bodies brought in from the community.
- Hotel services and mortuary staff told us they felt that hotel services staff should not be receiving bodies into the mortuary without additional training or support and that there was a gap in the support available to them. Staff acknowledged there was a 24 hour psychological support telephone line available but they said they were unlikely to use it due to the specialist nature of the work they undertook.

- Members of the executive team told us that bodies brought in to the hospital should be received by the mortuary technician, but this was not in line with mortuary overview standard operating procedure and was not what was happening in practice.

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 sought 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.
- We observed the specialist palliative care nurses and end of life care coordinator meeting for a daily discussion of patients and workloads and during this we saw that patient care was prioritised and well-coordinated by the team.
- The end of life care coordinator was alerted to all patients identified as being at the end of life via an electronic alert system for end of life patients. All patients who were commenced on the individualised plan of care for the last hours/days of life are 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. The aim was for the End of Life Care Coordinator to review 90% of patients within 4 hours and 100% within 24 hours.

Seven-day services

- The specialist palliative care team provide a seven day 8.30 – 4.30 face to face service where patients would be assessed in relation to their palliative and end of life care needs.
- 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 16 DNACPR forms we viewed across a variety of wards and clinical areas in the hospital we saw that five included confirmation that the decision had been discussed directly with the patient. Of the other 11 we

saw that two patients had DNACPR decisions made in the community prior to admission. For the other nine patients we saw recorded that they weren't able to be involved in discussions for a variety of reasons, including their unconscious state (2), dementia (2), and confusion (2) and may cause distress (2). We did not see formal mental capacity assessments being undertaken as part of a DNACPR decision; however we did see an example of a record of one patient's inability to recall information and a lack of understanding or insight. We also saw that one patient who had regained capacity, was later involved in discussions about resuscitation when able. This demonstrated an understanding of the process of assessing mental capacity, although we did not see a consistent, uniform approach to this across the trust.

- In all cases where a patient was not involved in discussions, we saw that DNACPR decisions were discussed with the patient's family in order to make a decision that was in the person's best interest.
- 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.
- Patients we spoke with told us they were happy with the quality of care and they felt well looked after. One patient we spoke with told us the nurses on the wards were very kind and took the time to make sure they were comfortable and that the specialist palliative care nurses had visited them often to provide support.
- A relative we spoke with told us they were happy with the quality of care and that they felt well supported by staff, that there was good communication and they were involved in decision making.
- A bereavement advice service was in place between 8 and 4, Monday to Friday. Bereavement officers and volunteers provided support to relatives 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.
- 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. When this was not possible 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

- Patients and family members we spoke with told us they felt involved the care delivered.

End of life care

- 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 confirmed that staff had asked them where the patient would have preferred to be cared for in their last days of life and that they had been made aware of the option to get the patient home if that was what they wanted.
- 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 had been given by relatives. One example of this was that free parking for relatives of patients at the end of life had been reinstated.
- Staff told us of examples where they had supported patients to achieve their wishes at the end of life. For example a junior doctor told us of a patient who had been married at the hospital and how staff had worked together with the patient and their family for this to happen.
- 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.
- 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, via a voucher system from the end of life care coordinator or specialist palliative care nurses. However, not all ward based staff were aware of this as it had previously stopped and then reinstated.
- Where possible, patients at the end of life were given the option to move to a side room to ensure their privacy and dignity and time with relatives.
- 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.

Are end of life care services responsive?

Good

All patients requiring end of life care had access to the specialist palliative care team and the end of life care coordinator. We saw that referrals to the end of life care coordinator in 2014 had totalled 608, an increase from the previous year following the implementation of an electronic referral/alert system. 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.

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 and the end of life care coordinator seeing patients immediately when required. 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 people living with 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 Doncaster the percentage of people dying at home was 22%.

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. Examples we saw were oncology and pain clinical nurse specialists who worked with ward staff to ensure appropriate care for patients in the last year of life.
- Patient's and family members we spoke with told us that their care was individualised and we observed discussions around care and treatment decisions that demonstrated this.
- There were plans to refurbish a room on a respiratory ward to be appropriate for patients receiving palliative care and who could not be discharged to die at home.
- 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

- All patients we saw 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 and that the team were responsive to the needs of patients. We saw referrals being made in timely and appropriate ways. The aim of the end of life care coordinator was to view patients identified as being in the last days/hours of life within 4 hours.
- The specialist palliative care team aimed to review urgent referrals within 24 hours and routine referrals within 48 hours. Staff we spoke with told us that the end of life care team would generally see patients straight away if they had problems with symptoms.
- We observed the end of life care coordinator attending the ward to visit a patient in the process of commencing on the last hours/days of life IPOC. The coordinator worked with the medical and nursing staff on the ward to discuss issues with the family, address symptom control and pain issues and plan the care for the forthcoming hours/days.
- Staff we spoke with told us the alert system used when a patient was commenced on the IPOC worked well and that in addition to this the end of life care team would generally phone the ward on a daily basis to identify if there were patients for them to see.
- The chaplaincy service was accessible 7 days a week via an on call system.
- The 7 day face to face assessment service at Doncaster meant that patients identified as being at the end of life or requiring support around symptom management issues could be seen on a daily basis depending on need.
- 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.
- We spoke with members of the IDT who told us the main barrier to rapid discharge was the variation in availability of care packages in the community. However, 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 example of a concern that we saw had been acted on related to a withdrawal of concessionary care parking for relatives of patients at the end of life. We saw that this concern had been addressed and that concessionary parking had been reinstated.

End of life 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 use of symbols on the wards to quickly alert all staff to them being at the end of life.

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 confidence 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 five to seven 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 reported 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 incident 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 7 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.

End of life care

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 end of life coordinator and 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 consistently told us they felt that the trust board had prioritised 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.

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

- 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 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.
- 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 one member of staff had developed a flower symbol to use to identify patients at the end of life by using the symbol on their records and patient lists so that all staff were aware of their condition. Staff told us this meant general staff who may not know details of patients' medical and nursing needs would be more aware and able to respond sensitively to the patient and family needs.

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 Doncaster Royal Infirmary covered a wide range of specialities including dermatology, trauma and orthopaedics, ophthalmology, respiratory, urology and general surgery.

The outpatient services were provided in several areas at the hospital including main outpatients 1 and 2, South block, eye clinic and other specialty departments such as urology. 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.

There were 296,282 outpatient attendances between January and December 2014 at Doncaster Royal Infirmary.

Doncaster Royal Infirmary (DRI) provided imaging services that included plain film x-rays, Fluoroscopy, which means the use of radiation with the images being viewed on a television monitor during the examination, Mammography, Dual Energy X-Ray Absorptiometry (DEXA) for measuring bone density, Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Ultrasound, Digital Subtraction Angiography (DSA), Interventional Radiological procedures and Nuclear Medicine.

Some diagnostic imaging services such as x-ray were available 24 hours a day, seven days a week. Other service such as CT and MRI scans were available seven days a week and other services were available during the working week.

During our inspection at Doncaster Royal Infirmary, we visited main outpatients 1 and 2, south block outpatients, fracture clinic, eye clinic, radiology suite, nuclear medicine and the MRI suite. We spoke with 14 patients and spoke with a range of over 20 staff including managers, radiographers, sonographers, nursing and administrative staff.

Outpatients and diagnostic imaging

Summary of findings

We rated outpatients and diagnostic and imaging as requires improvement. Safe and well-led required improvement; effective was inspected but not rated and caring and responsive were good.

There is a legal requirement to protect the public from unnecessary radiation exposure. We saw that there were 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. Not all areas had been addressed when we revisited as part of an unannounced inspection 10 days later. 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. Imaging and nursing staff reported that a safety handover of the patients from the wards did not occur. Inpatients were left waiting in beds on the main corridor of the department with no escort. This practice potentially created safety risks.

Records showed the number of staff that had received mandatory training and an annual appraisal was below the trust compliance target of 85%, particularly in outpatients. We saw patient personal information and medical records were mostly managed safely and securely. 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.

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. Most referral to treatment targets were met including all cancer related targets. There was no centrally held list of all patients requiring a review or follow-up appointment. Medical imaging was not meeting the six week target referral to treatment target; however improvements had been made.

Staff we spoke with were aware of the trust overall vision and strategy and were positive about the recent and future management of medical imaging and outpatients. An outpatient's services strategy had been drafted 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 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. Not all areas had been addressed when we revisited as part of an unannounced inspection 10 days later.

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.

Imaging and nursing staff reported that a safety handover of the patients from the wards did not occur. Inpatients were left waiting in beds on the main corridor of the department with no escort. This practice potentially created safety risks.

Across the outpatients departments and diagnostic imaging, an average of 36.8% of staff had undertaken children's safeguarding training against a trust compliance target of 85%. Mandatory training figures across the outpatient departments varied. Many departments had not met the trust's target compliance rate of 85% with some recording no attendance. It was unclear if this was a recording issue, but meant the trust could not be assured staff had the necessary training.

Medicines in the medical imaging department were not stored at the appropriate temperature. Immediate action was taken to address this. We found some out of date medicines in one of the outpatient's clinics.

Emergency resuscitation equipment was available. Most was routinely checked daily with the exception of the main radiology department.

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

- Seventeen patient-related incidents regarding outpatients at the hospital had been reported between September and December 2014. All were reported as causing no harm.
- Ninety-two patient-related incidents had been reported for the same period regarding diagnostic related services. Three were recorded as causing moderate 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).
- We saw learning had occurred from a serious incident that had occurred in 2013. The patient was involved in ensuring learning and staff knew about 'Gina's story' which was shared and available on the internet.
- A root cause analysis (RCA) was completed on all serious incidents and these were documented onto the trusts electronic reporting systems. These were also monitored and reviewed at clinical governance meetings.
- Managers told us they encouraged an open culture of incident reporting and staff we spoke confirmed this.
- 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. Staff told us that incidents were discussed informally and at departmental meetings. We saw good examples of how information from incidents was shared in newsletters, such as in the fracture clinic. However, in some areas we were unable to identify clear systems and processes across the services to evidence post incident feedback, shared learning and changes in practice resulting from 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.
- The trust reported radiation incidents to the Care Quality Commission (CQC) under IR(ME)R and had responded to actions as determined by CQC. Staff

reported that the decision to report incidents to CQC was made at the clinical governance meeting and were supported with technical information from the medical physics team.
- Within diagnostic imaging, the managers we spoke with 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 'lean' learning company had been invited to support medical imaging.

Duty of Candour

- 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 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. We saw staff wearing protective clothing such as disposable gloves, aprons appropriately. 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 89%. This was lower than other care groups. Hand hygiene audits were submitted to the infection prevention and control team as part of the infection prevention and control accreditation scheme. We saw the results displayed in the clinic areas which showed high levels of compliance.
- Staff were aware of procedures to follow if patients were known to have a communicable infection.
- The imaging department including waiting areas and outpatient clinic rooms were visibly clean. We saw cleaning schedule records which showed clinic rooms and equipment were cleaned regularly.
- 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 signed and dated in accordance with trust policy. We saw in a number of outpatient areas that sharps bins were placed on the floor. This was not in accordance with the trust policy which stated ideally they must be secured off the ground, should be out of the reach of children and must be at a safe working height and secured so they cannot be tipped over.
- The appropriate containers for disposing of other clinical waste were available and in use across the departments.

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. 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.
- In addition, patients should not be able to physically enter a room from their cubicle. If patients are able to physically enter the room, then there should be adequate signage to warn patients not to go into the room. Within the main department, doors from the cubicle were accessible into the x-ray room and there was no warning signage displayed.
- The lack of signage contravened Health and Safety legislation and required urgent action. This information was shared with the senior managers of the trust and referred to the Health and Safety Executive (HSE) for further follow up. The senior managers took immediate action to start to address the safety issues identified. We reviewed the action taken when we revisited at the unannounced inspection and we found that most areas had been addressed however there were areas, such as the fracture clinic that had not been identified or addressed. This was raised with managers at the time of inspection.
- We saw there was correct signage within the Nuclear Medicine department.
- The diagnostic imaging departments were visibly clean, tidy and uncluttered. Patient waiting and private changing areas were clean and tidy. Single sex and disabled toilet facilities were available.
- The outpatient's clinics were provided across a range of department at Doncaster Royal Infirmary. Some areas, such as south side outpatients, was built for purpose and provided an appropriate environment. Other areas, notably the eye clinic (ophthalmology), were not fit for

purpose. There was insufficient space, patients were waiting sat in a narrow corridor which also contained equipment and we saw one patient being attended to in a non-patient environment due to lack of space. This was particularly an issue for patients who were more likely to have visual impairments. The trust has identified this and building work was due to commence with completion of the first phase by end of September 2015.

- Resuscitation equipment was readily available for staff to use if needed across outpatients and diagnostics departments. Equipment was checked daily with the exception of CT department.
- We saw that equipment was mostly serviced. For example, in the eye clinic this was done every six months. Some equipment was old and due to be replaced as part of the refurbishment programme. We saw other equipment, such as the oscillator saw in the plaster room, which had a record book to document checks, but these had not been completed regularly for three of the machines we looked at.
- The trust kept an inventory on all of the imaging equipment in use across all locations.
- 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.
- The manager told us that there were systems and processes in place to ensure the maintenance and servicing of imaging equipment.
- New fitted patient alarm pull cords had been installed in the imaging department. We saw that these cords were fitted too high off the ground for patients to reach if they were on the floor. We brought this to the attention of the manager who reported this issue at the time of our visit.
- There was no evidence available to demonstrate patient call alarms were checked on a regular basis.

Medicines

- Medicines including controlled drugs were stored correctly. Fridges were kept locked and daily temperature checks were mostly recorded. Within the imaging department, the drug fridge thermometer had recently broken and a new one had been ordered. This resulted in medicines not being stored at the appropriate temperature and we found medicine packaging and instruction leaflets were wet and damaged and therefore the quality of the drugs stored could not be accurately assured. This issue was raised with staff who agreed to contact the pharmacy immediately for further advice. We followed this up at the unannounced inspection and found that advice had been sought and medicines were appropriately stored pending the arrival of a new fridge.
- We looked at a random sample of the medicines stored, including controlled dugs, intravenous fluids and contrast medium across the departments. Most were in date although we found one batch of medicine in the fracture clinic to be out of date. We raised this with the manager at the time of inspection.
- We saw some medicines for external use were stored in the kitchen area of the pre-assessment clinic.
- Medicines management had undertaken an audit within pre-assessment clinic regarding dispensing of medicines. This demonstrated high compliance with trust procedures.

Records

- We saw patient personal information and medical records were mostly managed safely and securely. Within the outpatients departments we visited, records were stored in lockable covered trollies, however these were not kept locked and we saw them across the clinics located in corridors, so there was a risk they were accessible to the public.
- Staff reported that records were available in a timely manner for outpatient 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 four patients records and found these were appropriately completed and entries signed, dated and timed.
- Risk assessments for venous thrombo-emboli in patients with lower limb casts were recorded in patient's notes in the fracture clinic. This included the use of any prophylaxis.
- We visited the records/booking office in the fracture clinic. Although we were advised that notes were traceable and the room had restricted access, there was insufficient storage space with patient's notes being stored in piles on the floor.
- 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 was 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.

Safeguarding

- For the outpatients departments, we looked at data across a sample of clinics, including dermatology, ENT, fracture and orthopaedic clinics, general medicine and renal outpatients and found that 71% of staff had received adults safeguarding training.
- Within the medical imaging department, 81% of clinical staff had received adults safeguarding training.
- Across the outpatients departments and diagnostic imaging, an average of 36.8% of staff had undertaken children's safeguarding training at Level 1, 2 or 3.
- 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.
- We saw examples where, lead staff had been identified in the outpatient's clinics to provide safeguarding supervision for staff, such as in the fracture clinic. A newsletter to update staff was also produced and shared with all staff by email.
- Systems were in place to identify patterns for patients, particularly children, who did not attend appointments. For example, within the fracture clinic it was identified as a potential safeguarding concern if an appointment for a child was cancelled three times.

Mandatory training

- Mandatory training figures across the outpatient departments varied. For example, data showed that no nursing staff had received resuscitation training in the fracture and orthopaedic clinic and 82% had received training in general medicine outpatients. It was unclear if this was a recording issue. The trust target was 85%.
- Fire safety and health and safety training across outpatients ranged from 50 to 100%. However, mandatory training for moving and handling, infection control and conflict resolution was below the trust target in most areas.
- 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 at all of the hospital sites.

Assessing and responding to patient risk

- We found that local rules were available for staff to follow when undertaking radiation procedures involving the use of diagnostic X- rays.
- 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. There was a separate RPA for Nuclear Medicine who was employed by the trust.
- Both RPA's had produced an annual report in compliance with relevant legislation and actions from these inspections were monitored through the trusts Radiation Safety Committee.

- The principal function of the Radiation Safety Committee was 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 met twice each year and received reports from the appointed Radiation Protection Advisers, ensuring all recommendations were achieved.
- The manager told us that all modalities had appointed and trained Radiation Protection Supervisors (RPS), whose role was to ensure that equipment safety and quality checks and ionising radiation procedures were carried out in accordance with national guidance and local procedures.
- Imaging and nursing staff reported that a safety handover of the patients from the wards did not occur as patients were not escorted to the x-ray department by the ward staff. .During our visit we saw six inpatients left waiting in beds on the main corridor of the department as there was no dedicated inpatient waiting area available. This practice potentially created environmental health and safety risks. Managers were aware of the issues and there were plans to recruit departmental assistants to undertake escort duties and to manage the flow of inpatients. However, these plans do not resolve the immediate welfare and safety risks to inpatients attending the department for x-rays and diagnostic procedures.
- The diagnostic imaging 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.
- Staff told us that inpatients were sent for x-ray by the wards without escorts and they had no control on the arrival times of inpatients from the wards. This also meant that ward staff had no knowledge of the status of the imaging department at the time of transferring the patient for example, whether there was adequate staffing to accept the patient. This issue had been escalated by the radiography staff onto the departmental risk register.
- Within the outpatient's clinics, staff were able to describe action they would take if a patient's condition deteriorated. Nursing staff gave us examples of their roles and responsibilities when this happened.
- Systems were in place to contact an emergency response team when required.

Radiology and Nursing staffing

- Staff informed us that there were usually sufficient numbers of staff deployed for the outpatients departments.
- Bank or agency staff were used to cover vacancies or sickness. We saw bank and agency usage varied across the clinics. For example an average of 6.5% bank or agency staff were used within the eye clinic between January 2014 and December 2014; 4.8% in urology outpatient and 2% in South block outpatients. Vacant post were being recruited to.
- There was a registered nurse in charge of each clinic we visited.
- Specialist nurses held a range of outpatient clinics.
- The medical imaging service was supported with agency staff and overtime to cover a short fall of one sonographer and nine radiographer vacancies. In addition, three sonographers were due to leave shortly. We saw contingency plans to cover these posts with agency sonographers were agreed. Nine radiographers had been recruited and were due to commence into post from June/July 2015.
- There were nine specialist nurses within medical imaging. There was currently one member of staff on extended leave, which was being covered by the remaining members of the team.
- Overall staffing and recruitment was escalated onto the departments risk register and staff sickness was on average below the trust target of 3.5%.

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 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.
- 'Battle boxes' were available in clinics which provided emergency equipment in case of incidents such as a loss of power.
- Staff we spoke with were aware of these plans and how to access them.

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.
- We saw that evidence-based guidance was used for example VTE risk assessments and prophylaxis for patients with lower limb casts.
- The trust had an Ionising and Non Ionising – Radiations Safety Policy issued October 2012 with a review date of August 2015. 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.
- There was some evidence of local audits within speciality clinics, such as in eye clinic therapy-led clinics and fracture clinic. For example, 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.
- 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 the trust; for Doncaster Royal Infirmary it was slightly below but close to the England average.

Outpatients and diagnostic imaging

- 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 across a sample of clinics, including dermatology, ENT, fracture and orthopaedic clinics, general medicine and renal outpatients and found that 39% of staff had received an appraisal between April 2013 and April 2014; 18% of staff had an appraisal between April 2014 and December 2014. The trust target was 85%.
- Within the 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.
- The outpatients departments used the Leicester clinical procedure assessment tool to assess staff competence. We saw examples of these such as for limb immobilisation and equipment training.
- 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

- 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 and we saw that therapy staff and radiology staff worked effectively within the fracture clinic.

Seven-day services

- The medical imaging services provided at DRI included plain film available 24 hours a day. CT scans were available 24 hours a day Monday to Friday and 9 – 5 at weekends with an additional on-call service. An MRI service was available 12 hours a day, 7 days a week.
- Outpatient clinics ran Monday to Friday with some clinics being held on Saturday mornings.

Access to information

- An outpatient experience survey undertaken between January and March 2015 showed 96% 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.
- Most staff we spoke with told us they were aware of the Mental Capacity Act and Deprivation of Liberty Safeguards, but they 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.

Outpatients and diagnostic imaging

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.

Within the medical imaging department, inpatients who attended the department were left unattended on the corridor whilst waiting to be x-rayed. We saw beds were left adjacent to the outpatient waiting areas and there was a lack of privacy or dignity.

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.
- Within the medical imaging department, inpatients who attended the department were left unattended on the corridor whilst waiting to be x-rayed. We saw beds were left adjacent to the outpatient waiting areas and there was a lack of privacy or dignity.
- The trust had used 'Your opinion counts' feedback forms. We saw these were mostly positive.
- 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. It was too early for the trust to have any meaningful results.

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.
- Within one of the clinics we visited, we saw there was a room designed and designated for breaking bad news to patients. This was designed to create a homely, non-clinical environment, leaflets were available but were discretely stored so they could be provided according to the patient's wishes and there was an external door so patients and their families did not have to walk through a busy clinic waiting area after receiving bad news. Staff said that they involved the multidisciplinary team when breaking bad news and specialist nurses were available to offer support.

Outpatients and diagnostic imaging

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 six 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 (where patients can select where and when they attend) was used in 50% of cases at Doncaster Royal Infirmary. This was less than other hospitals at the trust; the reasons were not yet fully understood.
- 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. The exception was the eye clinic; there were building plans in place to address these issues.
- 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 six week target referral to treatment target. Data showed that at March 2015, 96.7% of patients waited less than six weeks from referral for a diagnostics test against a target of 99%. This meant a total of 280 patients were waiting more than six 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 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 for Doncaster Royal Infirmary showed 76% of patients reported they were seen early or on time for their appointments; 4% reported waiting more than 30 minutes after their appointment time. 92% of patents said they were informed about the delay and 70% 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.
- Inpatient arrival was not under the control of the radiographers and at one time, we saw six patients waiting on beds left waiting on the main corridor.
- 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.

Outpatients and diagnostic imaging

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 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.

Outpatients and diagnostic imaging

- 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.
- 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.
- The Integrated Discharge Team was a beacon of good practice, as recognised by the 2015 National Award for Collaborative Leadership and was very active in providing a discharge planning service to all adult in-patients. The Frailty Assessment Unit was another example of effective collaborative working; the service enabled rapid assessment of elderly patients and person-centred care planning.
- Selected Serious Incidents were rerun in the Clinical Skills department with the team originally involved in the incident to identify learning points.

Areas for improvement

Action the hospital MUST take to improve

- The hospital must review arrangements for the initial assessment of patients, including the use of streaming and triage, and add streaming / triage to the risk register
- The hospital must ensure appropriate numbers of medical, nursing and support staff of the required skill mix are available in the emergency department
- The hospital must ensure patient waiting times are reduced to ensure the 95% target for patients seen within four hours is met and maintained
- The hospital must ensure patients' pain symptoms are assessed, and pain relief administered promptly for all groups of patients.
- 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, emergency department and critical care unit that facilitates the prevention and control of infection.

Action the hospital SHOULD take to improve

- The hospital should review how the privacy and dignity of patients is maintained, particularly in the central (overflow) area of the emergency department
- The hospital should review equipment in the emergency department to check appropriate and adequately serviced, working equipment is available.
- The hospital should take steps to support and develop working arrangements between the emergency department and other specialities within the trust
- The hospital should review arrangements for sharing with staff lessons learned from root cause analysis and investigation of incidents
- The hospital should consider reviewing its audit programme for evidenced based guidance to include the review of adherence to clinical guidance
- The hospital should record and monitor daily temperatures of fridges used for storage of medicines
- The hospital should review and complete actions identified in CQC's review of health services for children looked after and safeguarding, September 2014
- The trust should review the need for diabetes management to be included in the mandatory training programme for trained nurses.
- Medical services management should seek assurance that deprivation of liberty is being appropriately assessed and an order sought where required.
- The trust should review access to an emergency buzzer system on M1, M2 and G5.
- The trust should review the midwife to birth ratio.

Outstanding practice and areas for improvement

- The trust should review the rates of induction of labour and non-elective caesareans.
- The trust should consider employing a specialist diabetes midwife.
- The trust should review the management of medicines on the maternity unit, particularly the area the home birth trolley/ drugs are kept.
- The trust should consider having a designated bereavement area in maternity.
- The trust should review the domestic abuse policy to ensure it is consistent with NICE guidelines
- The trust should continue to manage patient flow to reduce the number of outliers in surgery and gynaecology.
- The trust should review the need for a standardised way of ensuring cleaning has taken place (environment and equipment).
- The trust should ensure that it has effective assessments and plans in place for any evacuation of the critical care unit.
- The trust should take action to improve the provision of storage facilities across the critical care unit.
- The trust should improve the standards of infection prevention practice on the critical care unit.
- The trust should as part of its overall patient pathway management ensure that patients on the critical care unit are discharged in a timely fashion to a more suitable environment.
- The trust should consider in its overall development strategy a more suitable location for its critical care unit.
- The trust should review segregation of children from adults in the recovery areas of the theatres.
- 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 review the system for recording mental capacity assessments for patient's unable to be involved in discussions about DNACPR decision
- The trust should support staff involved in receiving bodies into the mortuary with adequate training to carry out the role
- 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 to monitor the effectiveness of services within outpatients and diagnostic imaging.
- The trust should review actions to improve safety and privacy within the medical imaging department particularly for inpatients who attend the department on beds.
- 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.

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.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control 12(2) (h) The registered person must assess the risk of, and prevent, detect and control the spread of, infections. Parts of the theatre sterile supplies unit were not clean. In parts of the unit the flooring was patched up with sticky tape and trolleys and autoclaves were dirty, dusty and worn. In the emergency department the environment and some equipment was not clean.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care 9 (1) and (3)(a)&(b) The care and treatment must be appropriate and meet service users' needs. The registered person must carry out an assessment of the needs and preferences for care and treatment and design care or treatment to ensure their needs are met. The arrangements for the initial assessment of patients not entering the emergency department by ambulance did not ensure patient needs were met.

This section is primarily information for the provider

Requirement notices