Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Bassetlaw District General Hospital

Quality Report

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Date of inspection visit: 27 to 29 November 2018
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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

Urgent and emergency services	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a focussed unannounced inspection of the urgent and emergency care services at Bassetlaw District General Hospital on 27-29 November 2018. This inspection was to follow up concerns identified at our previous inspection in December 2017. In December 2017, we had concerns around the initial assessment process, paediatric nurse staffing levels, paediatric advanced warning scores (PAWS) were not always completed, compliance with mandatory training, including adult and paediatric life support was low, and there was a significant backlog of incidents that needed reviewing.

We inspected all five domains - safe, effective, caring, responsive and well led. At our previous inspection, safe, effective, responsive and well led had been rated as requires improvement. Caring was rated as good. This inspection was to see whether the required improvements had been made.

Following the inspection, we told the trust it must provide assurance that risks to patients were being addressed. The trust provided an initial action plan detailing actions to be taken to address the risks to patients. Further assurance was provided to us through regular updates and the trust established a working group to address the concerns we raised.

Our rating of this service stayed the same. We rated it as **Requires improvement** overall. Safe, effective and well led were rated as requires improvement. Caring and responsive were rated as good.

- Concerns identified at the previous inspection had not been fully addressed. We still had concerns about the risks posed to patients and the potential to cause harm.
- At our last inspection in December 2017, paediatric nurse staffing had been identified as an issue. Although service leads told us they had improved paediatric nurse staffing, since our previous visit there had not been recognition that there were insufficient paediatric nurses to provide safe and high quality care. In addition, the paediatric training for adult trained nurses did not appear to have been addressed.
- Paediatric nurse staffing and medical staffing was not meeting national guidance. Not all staff had the correct skills and competencies to support paediatric patients, including paediatric life support.
- There were no substantive full time consultants in post at Bassetlaw District General Hospital, cover was provided by locum consultants and six substantive consultants who worked across both sites. Around 85% of the middle grade rota was covered by locum staff.
- Adults and children safeguarding training compliance for medical and nursing staff was low. Additionally, the safeguarding level three training did not comply with national guidance, as it was completed online.
- The room used for patients with mental health needs was not in line with national standards. Although staff had completed a risk assessment and there were plans for changes to the room, this had not been identified on the risk register as a risk.
- Other risks identified at the inspection had not been identified on the risk register, or where they had been identified they had not been flagged as a significant risk.
- Not all medicines were stored securely and fridge temperatures were not monitored in line with trust guidance.
- The trust was failing to meet most of the standards in the Royal College of Emergency Medicine (RCEM) audits.
- The trust's unplanned re-attendance rate to ED within seven days was worse than the national standard.
- The service did not meet the trust target for completion of appraisals.

  However:

Summary of findings

- There had been some improvements since our last inspection.
- The initial assessment had been changed at Bassetlaw District General Hospital, which had reduced the risk to patients waiting in the queue and had improved the assessment process.
- More staff had been recruited to investigate incidents to help reduce the backlog that had been identified at our last inspection.
- Staff's understanding of the mental capacity act had improved since our last inspection.
- There was evidence of effective multidisciplinary working.
- Staff were caring and compassionate. We received positive feedback from patients.
- Managers worked closely with the clinical commissioning group and other stakeholders to try to provide appropriate services for patients.
- From November 2017 to October 2018 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was better than the England average.
- From November 2017 to October 2018 the trust's monthly median total time in A&E for all patients was similar to the England average.
- Staff spoke positively about their leaders and morale was generally good.
- There were governance structures and processes in place.

  Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with three requirement notices. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North)

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 	We rated this service as requires improvement. Safe, effective and well led were rated as requires improvement. Caring and responsive were rated as good.

Bassetlaw District General Hospital

Detailed findings

Services we looked at
Urgent and emergency services

Detailed findings

Contents

Background to Bassetlaw District General Hospital

Bassetlaw District General hospital (BDGH) is an acute hospital with over 170 beds. BDGH has inpatient, day case and outpatient facilities. It provides a full range of acute clinical services to the local population including:

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

We inspected urgent and emergency care services to follow up concerns raised at our previous inspection. We carried out an unannounced inspection between 27-29 November 2018.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, the CQC national professional advisor for urgent and emergency care and a specialist advisor with expertise in urgent and emergency nursing. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Facts and data about Bassetlaw District General Hospital

From August 2017 to July 2018 there were 167,240 attendances at the trust's urgent and emergency care services.

The percentage of A&E attendances at this trust that resulted in an admission was 14.6% compared to the national figure of 19.3%

From December 2017 to November 2018 there were 9,547 paediatric attendances.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Urgent and emergency services

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

Information about the service

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Urgent and emergency services

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- Paediatric nurse staffing and medical staffing was not meeting national guidance. Not all staff had the correct skills and competencies to support paediatric patients, including paediatric life support.
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Urgent and emergency services

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  Ellen Armistead

  Deputy Chief Inspector of Hospitals (North)

Are urgent and emergency services safe?

Requires improvement

Our rating of safe stayed the same. We rated it as **Requires improvement** because:

- Paediatric nurse staffing was not in line with national guidance. Not every shift had paediatric nurse cover and when a paediatric nurse was working there was only one in the department. Adult trained staff did not have the required paediatric competencies.
- There were no substantive full time consultants in post at Bassetlaw District General Hospital, cover was provided by locum consultants and six substantive consultants who worked across both sites. Around 85% of the middle grade rota was covered by locum staff.
- Safeguarding training compliance remained low. Only 49% of nursing staff and 44% of medical staff had completed safeguarding children level three training.
- Staff told us they could complete their safeguarding training online. However, this does not comply with intercollegiate guidance for level three safeguarding training.
- There was no consultant with a paediatric emergency medicine (PEM) qualification. Although, there was a paediatric lead they had not fully completed the PEM training.
- Infection control policies were not always complied with.
- The room used for patients with mental health needs was not in line with national standards for liaison psychiatry services.
- Fridge temperatures were not recorded in line with the trust guidance. Not all medicines were stored in locked cupboards.

However:

- The initial assessment process had improved since our last inspection and we did not have the same concerns about patient safety as at Doncaster Royal Infirmary. Patients were booked in quicker and any serious issues would be flagged to the triage nurse to ensure they were seen first.

Urgent and emergency services

- At our last inspection, there had been a backlog of incidents that had not been reviewed. At this inspection, they had recruited more staff who were qualified to investigate incidents and they were in the process of catching up with the backlog.
- The environment had improved following building works and the department now had its own sluice room, rather than having to use the sluice in the clinical decisions unit (CDU).

Mandatory training

- There was a clinical educator in post who supported staff's training needs. New staff attended a corporate induction day and completed a preceptorship course, which included mandatory training.
- At our last inspection, mandatory training compliance rates were low. Staff told us at this inspection that they had completed their mandatory training. The clinical educator told us that staff had some allocated time now to complete training.
- Data provided by the trust showed that mandatory training compliance rates at the end of March 2018 were 60.93%, against a target of 90%. Compliance rates for the current year showed that at December 2018, compliance was 69.43%. However, these were not broken down by subjects or between nursing and medical staff, we are therefore unable to compare them with the mandatory training compliance rates reported on at our last inspection.

Safeguarding

- We saw up to date safeguarding adults and safeguarding children policies.
- Staff were aware of their responsibilities with regards to safeguarding. There were processes in place for the identification and management of adults and children at risk. We reviewed four paediatric records and found safeguarding information had been completed appropriately.
- Staff we spoke with told us that the mental capacity act (MCA) and deprivation of liberties safeguards had now been incorporated in to the safeguarding training.
- At our last inspection, compliance with safeguarding training was low. At this inspection, we were told that there was increased compliance as there had been a focus on ensuring staff completed the training. However, we were told that staff could complete the training online, which may not meet the intercollegiate guidelines for level three training. The Royal College of Paediatrics and Child Health (RCPCH) intercollegiate guidelines (2014) say that E-learning can be used at level three as preparation for reflective team based learning. Level three training should be multi-disciplinary and inter-agency, and delivered internally and externally.
- Data provided by the trust showed that at August 2018 nursing staff compliance for level two safeguarding adults was 67%, safeguarding children level two was 63% and safeguarding children level three was 49%. Compliance by medical staff was 44% for safeguarding adults level two and 44% for safeguarding children level three. This data showed that there had been a slight increase in training compliance but staff were still not meeting the trust target of 90%.

Cleanliness, infection control and hygiene

- All areas looked visibly clean and we observed cleaning staff cleaning cubicles after patient use. We saw staff cleaning mattresses after use. The department did not complete a matron assurance ward round as they did at Doncaster Royal Infirmary which captured environmental observations. Staff told us that they reviewed and cleaned all the mattresses not in use as they commenced the morning shift.
- At our last inspection, we found most mattresses were damaged, this posed an infection risk. At this inspection, we saw that there was one mattress that had a small tear. Two mattresses were waiting to be sent for repair or condemned and two mattresses we looked at were in good condition. Staff told us a mattress audit had recently been completed. Following our inspection, we asked the trust to provide results of a mattress audit, however, we were told that there was no formal report.
- Infection prevention and control audits completed by the trust showed an overall score of 91.9% in August 2018 and 95.9% in November 2018.

- At our last inspection, the only sluice available was in the clinical decisions unit, this therefore posed a potential infection risk. At this inspection, a new sluice had been created in the main department. We saw that this was clean and tidy.
- Staff did not always comply with the trust hand hygiene policy and the bare below the elbows initiative. We observed three patients triaged by the delegated nurse and saw that they did not wash their hands between patients.
- Personal protective equipment, such as gloves and aprons, were available and we saw staff using them appropriately.

Environment and equipment

- Since our last inspection, there had been a new reception area and streaming room built. Patients sat in the waiting area could be viewed by reception staff and the streaming nurse.
- Equipment that we looked at, had been electrical safety tested.
- We saw up to date checklists for checking of resuscitation equipment. There were only a few days when this had not been completed. However, we saw that the neonatal resuscitation trolley was not sealed.
- The resuscitation room had three bays, one of which was equipped for children. However, we saw that this room was small and equipment was not properly organised.
- The clinical decisions unit had four beds, consisting of a two bedded bay and two single rooms. There was also space for four chairs.
- In the main department there were eight cubicles, one cubicle had a door and could be used for any patient that was an infection risk or for privacy when a patient had died. The early assessment room could accommodate up to two patients, separated by a screen.
- There were three paediatric cubicles and a separate paediatric waiting area. At our last inspection, there were concerns that children waiting in this area could not be seen. At this inspection, we noted that there was now a viewing window from the triage room to the waiting room and CCTV had been installed so that the receptionists could see in to the waiting room. However, we saw that on our arrival in the department the blind at the triage window was closed.
- At our last inspection, we noted that the room used for patients with mental health needs was not in line with the quality standards for liaison psychiatry services. At this inspection, we saw that the room still did not comply with standards. Staff told us that a risk assessment had been undertaken and they were waiting for the estates department to undertake improvements. The risk assessment had identified several actions to be taken including changing doors and removing furniture.

Assessing and responding to patient risk

- At our last inspection, we had concerns about the initial assessment of patients. This included the wait for initial assessment and the initial assessment process. At this inspection, we saw that this had improved.
- At our last inspection, we witnessed patients arriving by ambulance that were not booked in until after handover took place. Patients waited in the corridor if the ambulance assessment area was full. At this inspection, we did not see any patients waiting in the corridor for an initial assessment.
- At our last inspection, we had concerns about walk in patients waiting in long queues for an initial assessment. The initial assessment did not include any clinical observations. At this inspection, we saw that a new model had been introduced where a receptionist booked the patient in and then they were seen by a triage nurse for an initial assessment. A health care assistant performed observations and any required tests. When a patient booked in with a serious complaint, such as chest pain, the receptionist could add this on to the system and the triage nurse prioritised those patients. The triage nurse streamed patients to the emergency nurse practitioner and urgent care centre if appropriate.
- The median time from arrival to initial assessment, for emergency ambulance cases only, was better than the overall England median from October 2017 to

September 2018. In the most recent month, September 2018, the median time to initial assessment was 5 minutes compared to the England average of 8 minutes.

- From November 2017 to October 2018 there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Bassetlaw District General Hospital. The overall performance was between 50-60%.
- The Royal College of Paediatrics and Child Health (RCPCH) (2018) recommends that all children attending emergency care settings are visually assessed by a doctor or nurse immediately upon arrival with clinical assessment undertaken within 15 minutes to determine priority category, supplemented with a pain score and a full record of vital signs. Any child with abnormal vital signs identified at triage should have observations repeated within 60 minutes or earlier for serious conditions. A full assessment should be completed by a decision maker with paediatric competence within 60 minutes or earlier according to clinical urgency as identified at triage. During our inspection there was a paediatric nurse on duty. All paediatric patients were booked in and had their initial assessment completed by the paediatric nurse. We saw four paediatric patients and all had been seen within 15 minutes and had paediatric advanced warning scores (PAWS) completed. When a paediatric nurse was not on duty we were told that they would be seen by the triage nurse.
- We reviewed 23 sets of patient records, nine adult records and 14 paediatric records, and found that 14 were triaged and reviewed within 15 minutes. Five were triaged within 20 minutes and four within 36 minutes.
- Staff had access to support from a mental health liaison team who were on site 24 hours a day, seven days a week. Staff had access to referral pathways for the mental health liaison team and child and adolescent mental health (CAMHS) team. There was a standard operating procedure for mental health streaming by the triage nurse. However, we saw that this had a review date of 2016, there was therefore a risk that staff may be working to out of date guidance.
- Bassetlaw District General Hospital did not have an inpatient paediatric ward or surgical admission ward. Patients requiring admission were therefore transferred to Doncaster Royal Infirmary.However, transport for these patients could be an issue and patients could be kept waiting in the department for long periods of time. There was a dedicated ambulance crew for paediatric patients between 4pm and 2am only. There was a paediatric registrar available on site at Bassetlaw if needed and a surgical registrar was available off site to review patients if needed. Service leads told us that they were in discussion with the local clinical commissioning group (CCG) and ambulance service as this had been identified as a problem. However, we noted that this had not been identified as a risk on the risk register.
- We reviewed information provided by the trust and there had been 46 incidents relating to delayed transfers between December 2017 and November 2018. The trust carried out an audit of transfers between 25 July and 30 August 2018 and found that 10 patients had waited over 12 hours for transport. One patient had an 18-19 hour wait for transfer.

Nurse staffing

- Nurse staffing had been assessed using the Baseline Emergency Staffing Tool (BEST). The BEST tool is a nationally recognised workforce planning tool. A business case had been put forward for adjustments to the skill mix in response to the outcome of the BEST tool, as more senior nurses were required.
- Nursing staff were allocated to different areas for each shift. One nurse was in charge, one covered resus, one for streaming, one for the clinical decisions unit, one for the green area and one for the blue area in the main department and one nurse for paediatrics. However, staff we spoke with told us that if it was an adult trained member of staff covering paediatrics then they may also be covering resus and this could be difficult when the department was busy.
- Staff that we spoke with told us that there were staffing problems and there was not always enough staff on each shift to cover every area. We reviewed staffing rotas and found that there were frequently less than seven qualified nurses on a shift. This had also been identified at our last inspection.

- Band four associate nurse practitioners had been employed to provide extra cover.
- A band seven paediatric nurse worked across both hospital sites to provide paediatric leadership. There was one permanent paediatric nurse in the department who worked 30 hours a week. Two adult trained staff nurses had completed a paediatric masterclass. There was no paediatric nurse cover overnight. Guidance from the Royal College of Paediatrics and Child Health (RCPCH) (2018) says that there should be two paediatric nurses present on each shift. Adult nurses covering the department should have training to ensure they have the relevant skills and competencies to care for infants, children and young people. Following our inspection, we asked the trust to provide us with evidence of how they would achieve this going forward. The trust told us that following our inspection they were actively recruiting more paediatric nurses.
- We reviewed nurse staffing rotas for October and November 2018 and found that 27 days out of 61 did not have any paediatric nurse cover for the duration of the day.

Medical staffing

- Consultant cover in the department was from 8am until midnight, including weekends. The Royal College of Emergency Medicine (RCEM) guidance recommends 16 hours a day of consultant presence. The consultant presence had increased since our last inspection.
- At our last inspection, we found there were no full time substantive consultants in post at Bassetlaw District General Hospital. This remained the same at our inspection. There were six whole time equivalent consultants, four of which worked full time. However, these were locum consultants. Six substantive consultants worked cross site between Doncaster Royal Infirmary and Bassetlaw District General Hospital.
- A tier four middle grade covered overnight. There were two permanent middle grade staff, 85% of the middle grade rota was covered by locum staff.
- RCPCH guidance says that every emergency department treating children should be staffed with a paediatric emergency medicine (PEM) consultant with dedicated session time allocated to paediatrics. The department did not have a PEM consultant.
- Fourth year certificate of eligibility for specialist registration (CESR) trainees were to start rotating to the department.

Records

- Paper records and electronic records were used. Any paper records were scanned on to the electronic system following discharge or transfer from the department.
- Discharge summaries were generated and posted to GP's.
- Records we reviewed contained appropriately completed documentation. However, it had been highlighted in the September/October 2018 emergency department newsletter, that there were ongoing problems with lack of documentation. Staff had timely access to records.

Medicines

- At our last inspection, we found that controlled drug (CD) balance checks were not always carried out. At this inspection, we found that all checks had been completed.
- We looked at fridge temperature checklists and saw that they had been completed for the day of inspection 28 November, but we saw that they had not been completed regularly and had not been done before then since 18 November 2018. We saw that fridge temperature checks only recorded the current temperature and not the minimum and maximum temperature. This was not in line with the trust guidance which said that a record should be made of minimum and maximum temperatures and any action taken where temperatures fall out of the accepted range should be recorded.
- Medicines were not always locked away, for example we saw that medicines were dispensed from bowls

kept in the triage area. This meant that there was access to the medicines by anyone using the area. We saw that the fridge was unlocked, however the room it was in was locked.

- At our last inspection intravenous infusions containing potassium were not stored separately. At this inspection we saw that intravenous fluids containing potassium were stored separately.
- Patient group directions (PGD's) were used for nursing staff at initial assessment to be able to administer medicine. We saw completed PGD's that were up to date.

Incidents

- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From October 2017 to September 2018, the trust reported no incidents classified as never events for urgent and emergency care.
- In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from October 2017 to September 2018.
- Staff were aware of the duty of candour and patients were informed when something went wrong, given an apology and told of the actions taken as a result.
- Staff knew how to use the electronic system to report incidents and received feedback about incidents.
- At our last inspection, we saw that there was a backlog of incidents that had not been reviewed. At this inspection, we spoke with the clinical director who told us that they had recruited more people qualified to investigate incidents, to catch up with the backlog.
- The emergency department did not have separate morbidity and mortality meetings but attended a trust wide meeting. Any unexpected deaths or potentially avoidable deaths were reviewed in the department and discussed at clinical governance meetings. We saw from clinical governance meeting minutes that mortality and morbidity was a standing agenda item.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

Our rating of effective stayed the same. We rated it as **Requires improvement** because:

- Not all staff had the correct skills and competencies to support paediatric patients. This included additional training for paediatric resuscitation. Only 33% of medical staff had completed advanced paediatric life support (APLS) training. This had been identified at our last inspection.
- The RCEM audit results remained the same as at our last inspection in December 2017. The trust was failing to meet many of the standards, implementation of evidence based practice was variable.
- Appraisal rates did not meet the trust's set standard of 90%.
- The trust's unplanned re-attendance rate to A&E within seven days remained worse than the national standard of 5%. In the most recent month, September 2018, trust performance was 8% compared to an England average of 8.5%, this had increased from the previous year where it was 7.6%.

However:

- There had been improvements since our last inspection in December 2017 in relation to staff's knowledge and understanding of the Mental Capacity Act.
- There was evidence of good multidisciplinary working. A rapid assessment programme team was in place to review patients to enable them to return home with additional help. This helped prevent admission to a hospital ward.
- Patients were regularly offered food and drink and this was documented within patient records.

Evidence-based care and treatment

- Department policies were based on National Institute for Health and Clinical Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines. Up to date NICE guidance was displayed in the department for staff to review.
- The trust participated in the national RCEM audits so it could benchmark its practice against other emergency departments. Action plans were in place to improve areas in the audit that were not at the required level.
- The department had created a computer programme named 'MY ED', this contained relevant pathways and protocols for staff to use which were up to date and relevant. We saw that staff used the programme as a point of reference and to ensure they were following current guidelines.
- We saw that management guidelines were in place for sepsis and fractured neck of femur.

Nutrition and hydration

- Water fountain and vending machines were accessible in the waiting area of the department.
- Patients were offered food and drinks. Tea and coffee facilities were available for patients and relatives in the main area of the department. For patients who were in the department for a period of time or within the clinical decision unit (CDU) meals could be provided. We saw on patients records that they had documented when the patients had been provided with food and drink.
- In the CQC Emergency Department Survey, the trust scored 6.4 for the question "Were you able to get suitable food or drinks when you were in the emergency department?" This was about the same as other trusts.

Pain relief

- We saw that patients were given analgesia at the point of triage to provide pain relief. Patients told us that staff responded promptly to administer pain relief medication.
- In the CQC Emergency Department Survey, the trust scored 4.3 for the question "How many minutes after you requested pain relief medication did it take before you got it?" This was worse than other trusts.
- The trust scored 7.2 for the question "Do you think the hospital staff did everything they could to help control your pain?" This was about the same as other trusts.

Patient outcomes

- The RCEM audit: moderate and acute severe asthma 2016/17 remains the same as reported in our previous report. The trust failed to meet any of the national standards. The department was in the lower UK quartile for standard four. The department's results for the remaining six standards were all between the upper and lower quartiles.
- The RCEM audit: consultant sign-off 2016/17 remains the same as reported in our previous report. The trust failed to meet any of the national standards. The department was in the upper quartile for two standards and lower quartile for one standard. The department's results for the remaining standard was not reported.
- The RCEM audit: remains the same as reported in our previous report. The trust failed to meet any of the national standards. The department was in the upper quartile for five standards. The department's results for the remaining three standards were all between the upper and lower quartiles.
- We observed action plans were in place from findings of the audits and actions to be taken to meet the recommendations.
- From October 2017 to September 2018, the trust's unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% but about the same as the England average. In the most recent month, September 2018, trust performance was 8% compared to an England average of 8.5%. This had been an increase from the previous year where it was 7.6%.

Competent staff

- Staff completed triage training to support and understand the needs of the patient when attending the department.
- Paediatric advanced warning scores (PAWS) training was available for staff to complete. Data provided by the trust showed that 65% of staff had completed the training.

- Vital signs training was competency and assessment based. To ensure that staff were competent, there were three levels to complete. Level two was completing the training and level three was being able to perform the observations independently. Staff were required to perform the procedure with an appropriate clinician who would provide an assessment of the procedure. Some staff we spoke with told us that they found it difficult to complete this due to time and staffing constraints. We saw on some staff records that they had completed the training but were not at level three where they could perform the paediatric observation independently. We were told that nine staff had completed the training and there were eight ongoing packages.
- There were two registered sick children's nurses (RSCN) staff working in the department. An extra two registered nurses had completed a six week university course for the care of children and young people. This meant that a proportion of staff did not have any extra skills specific for children.
- At our last inspection, compliance with adult and paediatric life support training was low. At this inspection, the clinical educator told us that the previous education lead had increased the numbers of staff who had completed the basic and advanced life support courses. There were plans in place to ensure staff were advanced life support or immediate life support trained. However, in data supplied by the trust we saw that 10 out of 28 (36%) adult trained nurses had up to date paediatric immediate life support course (PILS) and eight out of 12 (67%) had up to date advanced paediatric life support (APLS) training.
- Only three out of nine (33%) medical staff had completed APLS training. This meant that we were not assured that staff had the correct skills to manage life threatening situations for children. We saw evidence that more staff had been booked on to courses in 2019.
- Information provided by the trust showed that 47% of all staffing working in the department had received an appraisal. This was not meeting the trust standard of 90%.

Multidisciplinary working

- There were effective working relationships between medical and nursing staff in the department. Both the nurse in charge and emergency physician in charge worked closely together to support the department with staffing, patient capacity and demand.
- Within CDU, the consultant in charge would complete a ward round daily plus a huddle to review patients within the unit and their ongoing care.
- Other speciality teams would attend the department and review patients, however there were sometimes delays in this occurring to the demands in their own working area. We spoke with some doctors attending ED to review patients who confirmed this.
- We saw that patients in CDU received care from the rapid assessment pathway team (RAPT). This involved multi-disciplinary professionals reviewing patients prior to discharge to review their ability to manage at home.
- We saw the critical care outreach team attended the department. At the time of our inspection we saw the team reviewing a deteriorating patient that had been escalated appropriately.

Seven-day services

- There was access to facilities such as blood tests, X-rays and CT scans available within the hospital.
- Advanced nurse practitioners provided treatment to patients in the departments seven days a week.
- There was 24 hour access to adult mental health teams, who were on site to provide support. Staff were aware of how to contact the teams. Staff could also access drug and alcohol teams.

Health promotion

- National priorities to improve the population's health were supported such as smoking cessation and alcohol dependency. Health and condition specific advice was provided in leaflets and posters throughout the hospital and on the trust's website.
- Staff provided health promotion advice to both patients and families. They could access and provide details on other services to support the patients with

their lifestyle choices. Other agencies attended the department such as social workers and physiotherapists to support the patient to be more independent on their discharge.

- Information boards were in place to inform and support patients. These included providing information on infection control and influenza.
- The department provided patients with information leaflets about their condition and aftercare. Discharge advice was given to patients and carers to allow patients to safely manage their condition at home or where to seek advice if appropriate.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- At our inspection in December 2017 staff demonstrated little knowledge of the Mental Capacity Act. At this inspection, staff had knowledge of the Mental Capacity Act and were aware of implications and how to manage patients who did not have mental capacity.
- Patients told us that staff asked for consent prior to completing any care and procedures. We observed that staff would gain consent and discuss with the patient whilst completing the care. Medical staff would gain written consent for patients who required sedation.

Are urgent and emergency services caring?

Good

Our rating of caring stayed the same. We rated it as **Good** because:

- We observed staff interacting with patients in a caring way and polite manner.
- Patients received emotional support as part of their care.
- Staff involved patients and those close to them in decisions about their care and treatment and were kept informed about progress.
- Friends and Family Test data was better than the England average for the department.

However:

- There had been some complaints raised regarding staff's compassion when the department was busy.

Compassionate care

- We spoke with six patients and relatives and found that the majority told us that they found staff to be caring. We observed several interactions including the triaging of patients, we saw that staff responded in a caring manner.
- Staff responded compassionately to patient's pain, discomfort, and emotional distress in a timely and appropriate way.
- The trust's urgent and emergency care Friends and Family Test performance (% recommended) was better than the England average from October 2017 to September 2018. In the most recent month, September 2018, the trust scored 94.8% compared to an England average of 86.5%.
- We saw from complaint data and department newsletter in November 2018 that there had been some complaints raised from staff regarding lack of compassion and caring to patients.
- The area within CDU was open plan and the nurses station was based at the side of the bed area. As a result, conversations could be overheard by other patients, particularly patients sat in the chaired area.
- We saw that one patient was placed on the corridor for a short period of time. The patient told us that they had waited in the corridor during other attendances.

Emotional support

- Staff provided patients and relatives with emotional support. We saw that staff reassured patients and tried to put them at ease.
- Patient's families were supported in an appropriate place after a bereavement. There was a quiet room for relatives to use if needed. Chaplaincy services were available for multiple faiths.

Understanding and involvement of patients and those close to them

Urgent and emergency services

- Patients told us they felt involved in planning their care, making choices and informed decisions about their care and treatment. We observed staff communicating in a way that people could understand which was appropriate and respectful.
- We observed staff providing care to patients on arrival to the department. Patients were involved and asked information about their condition or illness.
- Patients and relatives told us they were kept informed of what was happening and understood what tests they were waiting for. We observed that patients were given a clear explanation at discharge and were advised what to do if symptoms re-occurred.
- We saw that staff discussed decision making with the patients and relatives. In times where emergency care was required to be given, staff explained the decisions needed. The information was given in a way that people could understand and without using complicated medical terminology.
- In the Emergency Department Survey, the trust scored about the same as other trusts for 21 out of 24 questions. The trust scored worse than other trusts for three questions, which were:

- Were you told how long you would have to wait to be examined?

- Did the doctors and nurses listen to what you had to say?

- Did a member of staff tell you about medication side effects to watch out for?

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Good

Are services responsive?

Our rating of responsive improved. We rated it as **Good** because:

- The department worked with commissioners and external providers to try to meet the needs of the local population. The initial assessment process had been changed since our last inspection and was more responsive to the needs of patients.
- From November 2017 to October 2018, the service performed better than the England average in relation to the Department of Health standards for patients admitted, transferred or discharged within four hours of arrival. This had improved since our last inspection.
- From October 2017 to September 2018, the service met the Royal College of Emergency Medicine (RCEM) standards for time of arrival to receiving treatment not exceeding one hour, in 10 months out of 12.
- Operational meetings took place four times a day to look at capacity and flow.
- A patient flow co-ordinator ensured speciality medical patients were seen in a timely manner and there was an escalation process in place.
- From November 2017 to October 2018 the percentage of patients waiting more than four hours from the decision to admit to admission was better than the England average. No patient waited more than 12 hours from the decision to admit.
- There were strong links with and support from the mental health liaison team.

However:

- At our last inspection, we found that the department was not following its own policy for the use of the clinical decisions unit (CDU). At this inspection, we found that this was still the case and that at times there was inappropriate use of the CDU.
- Patient information leaflets were only available in English.

Service delivery to meet the needs of local people

- The department worked with commissioners, local authorities and external providers to plan and deliver services to meet the needs of the local people. Local commissioners worked with staff in reviewing and changing the streaming model at the front door after feedback from staff and patients.
- The department liaised with services providing cover to the department such as NHS111.

- The department were working with ambulance providers to ensure that patients were transferred to alternative hospitals in an appropriate time.
- The service continued to offer 24 hour support patients suffering from mental health problems. This included access to the mental health liaison team who were on site and provided an assessment.
- There was a separate children's waiting area behind the reception and streaming area that now had CCTV in place. A window had also been inserted for the streaming nurse to visually check children waiting to be seen.
- Staff had visited other hospitals in advance of implementing the 'fit to sit' initiative. This was a NHS initiative which encouraged patients that were well enough to sit rather than lay on trolleys waiting to be seen.

Meeting people's individual needs

- The clinical decision unit (CDU) provided an overnight facility for patients with complex discharge needs and allowed a team to assess their social, physical and medical needs prior to discharge. The unit could also prevent admission into hospital.
- There were no changes since our last inspection in December 2017 regarding processes in place for learning disabilities, interpreters and patients living with dementia.
- The reception desk was at a low level for wheelchair users. The waiting area could accommodate wheelchairs and mobility aids and there were accessible disabled toilets.
- A range of information leaflets were available for patients to help them manage their condition, however, leaflets were only available in English. Staff could access interpreters if needed.
- A quiet relative's room was available to be used by staff as necessary.
- The trust scored about the same as other trusts for each of the three Emergency Department Survey questions relevant to the responsive domain. These included:
- Were you given enough privacy when discussing your condition with the receptionist?
- Overall, how long did your visit to the emergency department last?
- Were you given enough privacy when being examined or treated?

Access and flow

- At our last inspection in December 2017 we saw that although there was adequate seating patients had to stand a considerable amount of time in the queue to see the streaming nurse before they could sit down and the time they had to stand depended on how busy the department was.
- At this inspection as the streaming process had changed, patients were booked in by a receptionist and sat down and then waited to see a streaming nurse. We saw no queues with this system and there were no queues waiting to see the receptionist.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. From November 2017 to October 2018 the trust met the standard in two months and performed better than the England average each month. The target fluctuates but has not fallen below 90% since February 2018.
- We reviewed 16 notes and found that 11 were seen with the Department of Health's standard. The remaining five were admitted or discharged between four hours and five hours 30 minutes. One child remained in the department for almost five hours, they were referred to paediatrics within one hour of triage however then were not seen and discharged for three and half hours.
- We saw there were patient flow co-ordinators in place. Their role was to review patients in the department and to identify if they would be able to see a speciality medical referral within one and half hour hours. An escalation process was in place from 30 minutes where there was no response from the required team.
- Many staff told us that they felt there was a pressure to meet the four hour target with the emphasis on this

rather than the care required. We heard conversations that supported this and heard staff say that patients were not near the target or questioning why they had gone over the target.

- An operational meeting was held four times a day which looked at capacity and patient flow.
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust met the standard for 10 months over the 12 month period from October 2017 to September 2018. In the most recent month, September 2018, the median time to treatment was 52 minutes compared to the England average of 61 minutes. This had improved from the previous year where the median time to treat was 58 minutes.
- From November 2017 to October 2018 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was better than the England average.
- At our last inspection in December 2017, the clinical decisions unit (CDU) had an operational policy in place to ensure that the unit was not used as an inappropriate place for patients to wait for an admission to a hospital ward. We were told that the unit was used for this purpose and to potentially prevent the department breaching the four hour target.
- At this inspection, staff told us that the unit was still used as an inappropriate place and a new standard operating procedure was to be completed to review the criteria. The criteria will identify if the patient is on a specific pathway relevant to be in the unit. Staff told us they felt pressured at times to admit patients onto the unit. The expectation was that if the patient remained in the unit after 24 hours they should be admitted to a ward environment. We saw that patients were admitted within the four hour target to CDU, on reviewing one patient record we saw that the patient was awaiting surgical assessment.
- Over the 12 months from November 2017 to October 2018, no patients waited more than 12 hours from the decision to admit until being admitted.
- From October 2017 to April 2018 the monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was similar to the England average. Since April 2018 however there has seemingly been a data issue and no data has been submitted for this metric.
- From November 2017 to October 2018 the trust's monthly median total time in A&E for all patients was similar to the England average. In the most recent month, September 2018, the trust's monthly median total time in A&E for all patients was 147 minutes compared to the England average of 154 minutes.

Learning from complaints and concerns

- There was no change to the complaints process we documented in our last report. Staff told us that there had been complaints regarding the previous waiting and triage system about the amount of time patients had to wait to book in.
- Ward managers in the department were aware of ongoing complaints and were working with staff to investigate the complaint.
- Information provided by the trust showed that there were 15 complaints over the last 12 months, four were regarding staff attitude.
- We saw that complaints and themes of complaints were discussed within the department's newsletter.

Are urgent and emergency services well-led?

Requires improvement

Our rating of well-led stayed the same. We rated it as **Requires improvement** because:

- There had been lack of oversight and action in responding to concerns identified at our last inspection in December 2017. Senior and executive leaders had failed to identify the risk to patients.
- Governance arrangements were in place. However, they had failed to identify concerns, such as paediatric nurse staffing

- There was a system for identifying, capturing and managing issues and risks, however, the risk register we saw did not fully capture the risks we saw throughout the inspection.
- Regular team meetings and operational meetings were not taking place.

However:

- Staff spoke positively about their leaders.
- Morale was good and staff worked well together as a team.

Leadership

- There had been a change in care group structures since our last inspection. The emergency department (ED) was part of the division of medicine. The division had a divisional director, an associate director of nursing, a deputy chief operating officer and a general manager for emergency medicine. A clinical director for emergency medicine and two heads of service had been appointed in October 2018.
- Staff we spoke with spoke positively about their leaders. Staff told us that the department manager and matron were supportive and they felt listened to.

Vision and strategy

- We spoke with one of the new service leads and the new clinical director. Both told us about their vision for the service and what they hoped to achieve.
- At our previous inspection, funding had been agreed for improvements to the front door and streaming environment. At this inspection, we saw that these improvements had been put in place.

Culture

- Staff we spoke with told us they worked well as a team and supported each other. There was a desire from staff to provide effective care and treatment to patients.
- We found that morale was generally good. Staff we spoke with told us that morale was occasionally affected by poor staffing levels.
- Staff were involved in improvement work and were trying to standardise cross site working. Staff told us they were also involved in the changes to the department and felt listened to.

Governance

- There were governance structures and processes in place. A governance lead for the department had two hours a week dedicated to the governance role, supported by administrative staff and the central patient safety team.
- Regular meetings took place, such as monthly divisional directors meetings, monthly management board meetings, patient safety meetings and urgent and emergency strategy meetings.
- Governance meetings were held monthly. Separate meetings were held for Doncaster Royal Infirmary (DRI) and Bassetlaw District General Hospital (BDGH). Staff told us they were planning to introduce combined cross site governance meetings. Relevant information from unit governance meetings was included in the divisional clinical governance meeting.
- We reviewed minutes from the clinical governance meetings and saw that items on the agenda included learning from incidents and complaints, staffing, policy reviews and review of the risk register.
- Staff we spoke with told us that there had not been any regular operation and communication meetings held since the beginning of the year. These meetings were held to discuss any progress and extra learning. When we raised this with the service leads they were unaware that meetings had not taken place.
- An urgent and emergency care workstream had been established to ensure closer working between the trust and commissioners.

Managing risks, issues and performance

- There had not been sufficient oversight or action taken in response to the concerns identified at the previous inspection in December 2017. At this inspection, we still found similar issues with paediatric nurse staffing and lack of audits around deteriorating children.
- Following our inspection, we formally wrote to the trust under section 31 of the Health and Social Care

Act (HSCA), outlining the concerns we had identified at this inspection and the risks posed to patients, with the potential to cause harm. The trust provided an action plan and this continues to be monitored through regular engagement with the trust. We were satisfied that no immediate enforcement action needed to be taken.

- We reviewed the department risk register which had identified eight risks. Six of the risks related to Bassetlaw District General Hospital. Most of the risks had been opened in 2015 and 2016 and included delay in the review of x-ray reports, lack of space in the clinical decisions unit (CDU) and high temperatures in the department in the summer months. The mental health assessment room had not been identified as a risk due to its non-compliance to standards. Lack of paediatric nurses had only been identified as low risk and was not due for review until September 2019.
- The department took part in national and local audits, including the Royal College of Emergency Medicine (RCEM) audits and had developed action plans to address areas of non-compliance.
- Service leads told us they had a robust winter plan in place. The use of escalation beds on wards had been discussed to ensure flow through the department.

Managing information

- Staff had access to all relevant policies and procedures on the trust intranet. 'My ED' had been developed to store all the protocols in one place with easy access.
- The department collected, analysed and used information to support activities. Performance reports were produced monthly and, with other services reports, were presented at the board meeting.
- A high intensity group was in place that reviewed specific patients that used the department regularly. The purpose of the meeting was to support and reduce the need of the patients using the department.

Engagement

- In October 2018, the trust held a 'System Perfect' week. As part of this week the team wanted to gain a better understanding of how and why patients used ED, as well as how care and treatment could be improved for patients. Local events were held to engage with patients, the public and local businesses. There was also a proactive social media campaign to encourage full use of all health provision within the local area.
- Comment cards were available in the department for patients to provide feedback.
- Staff we spoke with told us that they did not have regular team meetings and that they felt that these would be beneficial. Staff were kept up to date with information through emails and newsletters. We saw evidence of communication to staff to keep them up to date with the work that had taken place in the department.

Learning, continuous improvement and innovation

- One of the consultants had received a Royal College of Nursing (RCN) award for his work in developing doctors from overseas so that they could apply for a certificate of eligibility for specialist registration (CESR).

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

The provider must ensure that nurse staffing levels, including paediatric trained nurses, are increased to ensure the safety of patients.

The provider must ensure the room used to care for patients with mental health needs conforms to the Psychiatric Liaison Accreditation Network (PLAN) standards.

The provider must ensure medications are stored appropriately and staff comply with trust guidance.

The provider must ensure that there is an appropriate number of substantive consultants employed at Bassetlaw District General Hospital.

The provider must ensure all staff have completed relevant safeguarding training. Safeguarding training must meet the recommendations of the intercollegiate guidance for level three.

The provider must ensure that all staff have completed appraisals.

Action the hospital SHOULD take to improve

The provider should ensure there are robust actions taken to achieve optimal clinical outcomes for patients as indicated by the RCEM audits.

The provider should ensure the risks on the risk register match all the risks identified during the inspection.

The provider should ensure that patient information leaflets are available in different languages.

The provider should ensure that the department has regular team meetings.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing