Plymouth Hospitals NHS Trust

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected Plymouth Hospitals NHS Trust in July 2016 as a follow up to the comprehensive inspection that was carried out in April 2015. The follow up inspection was announced, and took place on 19, 20, 21 July and 12 August 2016. Further unannounced visits were carried out on 29 July 2016.

During the previous inspection we rated the trust as requires improvement overall. The follow up inspection therefore focussed on those areas rated previously as requires improvement and inadequate. We also inspected well led at trust level.

During our inspection we inspected the following locations:

- Derriford Hospital
- Mount Gould Hospital

We inspected the following core services against the following domains:

- Urgent & emergency services (safe, responsive and well led)
- Medical care (including older people's care), (safe and responsive)
- Surgery (safe, responsive and well led)
- Critical care (responsive)
- Maternity and Gynaecology (safe)
- Services for children and young people (safe)
- End of life care (effective)
- Outpatients & Diagnostic Imaging at both sites (safe, effective – not rated, responsive and well led).

We rated the trust as requires improvement for safe and responsive. Effective and well led were rated as good. Caring was not inspected as part of this follow up inspection, but was rated as outstanding overall at the previous inspection in April 2015. We have aggregated the ratings from the previous inspection and given overall ratings for each core service.

There had been progress in many of the areas where improvements had been required at the previous inspection.

Derriford Hospital the safe domain improved from requires improvement to good for, surgery, maternity, services for children and young people, outpatients and diagnostics. The responsive domain has been rated as requires improvement which is again an improvement on the previous inspection where outpatients and diagnostics and urgent and emergency care were rated as inadequate in 2015.

We rated Mount Gould Hospital as requires improvement overall, safe was rated as good but improvements needed in the responsive and well led domains rated as requires improvement.

Our key findings were as follows:

Safe:

- At Derriford Hospital surgery, maternity and gynaecology, children and young people and outpatients and diagnostic imaging were rated as good. Medical care and urgent and emergency care was rated as requires improvement.
- There was a positive incident reporting culture with evidence of full investigations taking place and learning being identified and shared with staff to improve safety. Staff were confident in reporting incidents although in some areas, incidents were not graded appropriately.
- At Mount Gould, the systems and arrangements for reporting and responding to governance and performance management data had improved but still did not effectively monitor and record risks and incidents. There was no centralised monitoring of safety issues in remote clinics, although leaders visibility and engagement had improved on a local level.
- Staff were open and honest with patients and their relatives when anything went wrong. We saw evidence of people receiving a sincere and timely apology and being informed about actions taken to prevent future occurrences.
- There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse. All staff we spoke with had a good awareness of safeguarding legislation and many had been given prompt cards to assist them in the identification of abuse. Staff knew what to do when they suspected abuse.

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- Standards of hygiene were monitored by staff with specific roles in infection control and clinical areas were visibly clean, hygienic and well organised. Staff followed trust policies regarding infection control and routinely used protective personal equipment (PPE), hand gel and regularly washed their hands. Although in some areas, sharps waste was not always disposed of promptly, and chemicals were stored in ward areas which patients had access to. Where incidences of infection were found, appropriate action was taken to control it.
- At Mount Gould, patients were cared for in a clean and hygienic environment, and there were systems in place to reduce the risk and spread of hospital acquired infections, however, results of audits were not shared with all staff.
- Controlled drugs were stored and checked appropriately, and allergies were clearly recorded on medicine charts. Pharmacy staff worked with staff on the wards to ensure they were aware of safe protocols and any errors were highlighted as soon as possible. Following concerns raised at our last inspection in relation to insulin prescribing the trust had set up a working group to review their policies and procedures. However, intravenous fluids were not always being stored securely and medicines were not always secured on wards where patients were able to self-administer their medicines.
- At Mount Gould, there were improved practices in respect of the management of prescription forms and the trust's policy for the custody of the medicines keys which kept patients safe.
- Staffing levels and skill mix were planned and implemented to keep people safe at all times and staff shortages were monitored and acted on. Managers deployed staff flexibly to cover shortfalls where possible, however in some areas, large numbers of nursing vacancies meant wards were not always staffed to the agreed level. Some gaps were identified in medical rotas and the trust was taking action to minimise the risk, for example, the introduction of doctors' assistants had reduced the burden on junior doctors.
- The trust had set the target for mandatory training to 100%. In many areas this was being met, although in other areas, the figures ranged between 80% to 90%. Most staff we spoke with were aware of how and when to update their training, but in some areas, for example in maternity, clearer processes are required to identify the training needs of staff and compliance with those needs. Related to this, we found staff training was urgently required for emergency procedures using the birthing pool.
- Risk assessments, care plans, triage processes and the use of adult early warning scores kept people safe from the risk of harm, however, the use of a paediatric early warning score was inconsistent and did not ensure children at risk of deterioration were recognised and monitored accordingly. Following the last inspection there were concerns with regard to the insufficient number of child assessments and care plans that had been completed in the children's community nursing team. During this follow up inspection we found the issues had been resolved and patient records were maintained and monitored.
- In the majority of areas, care records were clear, contemporaneous, complete and signed. However in some areas, they were inconsistently completed, and for example in diagnostic imaging, not all images requiring documented evaluations had them recorded.
- Records were kept securely to maintain confidentiality and prevent tampering and were available for staff to view when required in most areas. In oncology outpatients however, we found that records were kept in unlocked trolleys in unlocked rooms overnight and on the paediatric ward, patient details were displayed on an electronic board which visitors could view, potentially compromising a child's confidentiality. In the emergency department, computers were not always logged out to prevent unauthorised access to patient identifiable information.
- Equipment for use in an emergency was regularly checked and prepared for use in all areas. We saw in some areas that faulty equipment had been replaced; however, a number of items had not been serviced within the recommended timescales.
- Improvements had been made to the environment in the clinical decisions unit; a new helipad had opened to provide safer and direct access for patients being transported by helicopter. Some ward areas had been refurbished to meet the needs of patients who lived with dementia, and delivery suite had been partially refurbished following concerns raised during the last

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inspection. However, there were no plans in place to complete the refurbishments on delivery suite. The emergency department remained cramped in a lot of areas and the paediatric unit was not secure.

Effective:

- At this inspection we rated the effective domain in end of life care only. Although we inspected the effective domain in outpatients and diagnostic imaging services we did not rate them due to the lack of national data available to the CQC.
- Patient needs were assessed and treated in line with evidenced based guidance. In outpatients and diagnostic imaging, we saw evidence of audit to ensure that practice was monitored ensuring consistency.
- Pain management and the management of nutrition and hydration was assessed, managed and recorded to ensure patients at the end of life were comfortable.
- Following the previous inspection a local 'quality improvements in environment' project had been undertaken. Areas of improvement were planned for example single rooms available for privacy for patients at the end of life, but these changes had not yet been started.
- End of life outcomes were monitored against national standards. Local audits were delayed in being completed in some areas. Outcomes from previous audits had been used to make changes to patients care.
- Ward staff had sufficient training and the ongoing support and help for the Specialist Palliative Care Team to deliver effective care and treatment.
- The multi-disciplinary working between the Specialist Palliative Care Team and the wider hospital and local community were outstanding. The integrated working supported continuity of care and avoidable admissions to hospital.
- When people in outpatients and diagnostic imaging received care from a range of different staff, teams or services, this was coordinated well ensuring that all relevant teams were involved in the planning and delivery of peoples care and treatment. Staff discussed with inspectors how important it was to work collaboratively to meet the needs of the patient and could give us multiple examples where this was taking place.
- Improvements were seen in the completion of the Treatment Escalation Plans (TEP) but auditing of improvements was not yet fully completed. The management of Deprivation of Liberty safeguards ensured the safety of patients.
- In outpatients and diagnostic imaging, although most staff could access the information they needed to assess, plan and deliver care to people in a timely way there were still improvements to be made. Although the number had reduced significantly since our last inspection, there were still 2000 temporary notes in circulation meaning that treatment decisions were being made without all relevant clinical information. In diagnostic imaging although it had reduced significantly, there were still 2000 images requiring reporting on a backlog. These were being managed in a proactive way and work was still being done to reduce this.

Caring:

- At this inspection, the caring domain was not inspected because during the last inspection in April 2015 the trust was rated outstanding overall for caring.

Responsive:

- We rated responsive at Derriford hospital as requires improvement. Urgent and emergency care, surgery, outpatients and diagnostic imaging were all rated as requires improvement and medical care and critical care were rated good.
- There was a consistent failure to meet the four-hour performance standard in the emergency department, and frequent crowding was becoming "normalised", although the department had called a risk summit with relevant senior managers and hospital executives to raise their concerns and seek trust-wide solutions to the impact of crowding.
- The trust breached the 18-week referral to treatment target operational standard across all surgical specialties, apart from plastic surgery, from March 2015 to June 2015, when the target was abolished by the government (the operational standard is still used by the majority of trusts to monitor their performance). By February 2016, only one surgical speciality was meeting the abolished operational standard and that

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was plastic surgery. Performance had deteriorated to under 50% for neurosurgery. Over the entire period, all specialties except for plastic surgery performed below the England average.

- Since our last inspection in April 2015 the number of cancelled operations had risen. The percentage of patients not treated within 28 days of a cancelled operation had also risen. Due to pressure for their beds and the demand for their services, some patients had to use facilities and premises not appropriate for the services being provided. The theatre booking system had been reviewed and changes implemented, although staff told us there were ongoing issues with the theatre lists not always being finalised at 3pm the day before surgery.
- The trust had a number of initiatives to reduce the number of cancelled operations. For example, the 'golden bed' identified patients who could be discharged earlier to free up beds for elective operations.
- The trust had 67 patients waiting over 52 weeks for their operations, and of these 37 had not been given a date. However, the trust was working hard to reduce these and had action plans in place.
- There were long waiting times and delays for an outpatient appointment. Although significant improvement had been made some people were not able to access the services for assessment, diagnosis or treatment when they needed to due to the management of the backlog in appointments required and high levels of over referral to services. There were a total of 30,862 patients requiring follow up but a majority of these had an appointment date at the time of the inspection. However, we found there was a proactive and innovative approach to how clinic utilisation and capacity was managed. Particularly in rheumatology, psychology and breast imaging.
- At Mount Gould, for some patients, access to new and follow-up appointments were delayed by an ongoing recognised backlog of appointments and typing of clinic letters; however this had reduced since the last inspection. However, the systems and data used to monitor reasons for the short notice cancellation of clinics were not accurate or robust.
- The numbers of medical outliers had reduced since our last inspection as the trust had provided additional medical beds. This meant that patients received a responsive service and their access to medical staff had improved.
- The acute stroke pathway was responsive to the needs of patients and staff provided a proactive service to ensure patients were assessed and treated promptly on arrival at the hospital.
- There was not a clear pathway for patients attending the hospital for care and treatment from the cardiac catheter laboratories. The medical care group were in the process of increasing the services available to patients by the provision of a third mobile cardiac catheter laboratory.
- Information technology systems were not integrated and delayed access to some services, particularly computerised tomography within the emergency department.
- The critical care services had yet to establish the dedicated psychology service in accordance with the guidelines of the Faculty of Intensive Care Medicine core standards and NICE guidance, although had made good progress with commissioners, and already obtained partial funding for the new services.
- The cardiac critical care unit had yet to contribute to the Intensive Care National Audit and Research Centre in order to obtain and learn from valuable benchmarking against other similar units. This had been recognised, and work towards supplying data was underway.
- Complaints were managed well within the outpatients and diagnostic imaging and critical care services and people we spoke with knew how to make a complaint. The service listened to complaints, responded to them, and used them to improve patient care and support. Lessons were learnt from complaints and were disseminated well to different teams. We saw that outcomes to complaints were explained to the complainant and always offered an apology. Patients and their relatives were included in feedback and investigations of complaints, and told when practice had changed because of their input. However, in the emergency department, complaint responses were not completed in a timely manner.
- The individual needs of patients were taken into account when planning and delivering services and patients with complex needs and learning or other

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disabilities were well supported. However in the emergency department, patients' needs were not always being met, particularly in respect of mental health patients and those patients being held in the central 'corridor' area.

- Care was tailored to the needs of patients, and their preferences and circumstances were understood and acknowledged. This was particularly evident with the reasonable adjustments made for patients living with dementia and learning disabilities. Relatives of patients in critical care were able stay close to the hospital in purpose-provided accommodation.
- The numbers of patients experiencing multiple moves between wards had reduced since our last inspection. Patients did not experience moves late at night as frequently as at our last inspection. There had been significant improvements in the general/neurosurgical unit, which was discharging fewer patients at night, and this was continuing to improve. There were almost no patients transferred to another hospital due to lack of a critical care bed. There was a high level of flexibility and response from the teams, and patients were admitted to the units when they needed urgent and emergency care.

Well led:

- We rated well led at the trust as good overall.
- There was a clear statement of vision and values, driven by quality and safety. Staff were aware of the trust's vision, values and strategy in surgery and the emergency department. However, they were not translated into a credible strategy for outpatients with limited defined objectives that were regularly reviewed and relevant. In the service line strategies we looked at, outpatients was rarely mentioned and some strategies had not been updated since 2012.
- The leadership, governance and culture promoted the delivery of high-quality person-centred care. Staff felt that senior managers were visible, approachable and accessible; they told us they felt respected and valued and spoke about an open culture.
- Governance structures and processes were being used to monitor and improve safety and quality, although in the emergency department the recording of meetings was historically inconsistent with limited information being captured, but this had improved in recent months.
- There were good governance structures, processes and systems in place throughout outpatients and diagnostic imaging to ensure accountability, the management of risk, the management of performance, and regular review to gain oversight of how the services were performing. This was particularly highlighted through the oversight and challenge of the management of the outpatients follow up backlog.
- Staff were kept informed and updated about relevant risks and the actions being taken to mitigate them, and were encouraged to share their experiences of what went well and what could be done better, although some staff felt disengaged because they were unable to stay updated or check and respond to emails while at work due to time pressures. Some innovation and improvement projects had been completed and were delivering improved services in the emergency department.
- Within the interventional radiology department, staff told us there were issues with working relationships as the roles and responsibilities of the nursing and radiology staff were not clearly defined. Not all staff within interventional radiology felt their ideas were being listened to and acted upon in relation to developing the department.
- The thoughts and ideas from staff on how the surgical care group could be improved were being listened to and the culture around incident reporting and learning outcomes had changed positively.
- Patients had various forums in which they could raise concerns and ideas including 'tea with matron' sessions.

We saw several areas of outstanding practice including:

- A new role had been developed within the acute medical units and the short stay ward to enable medicines for patients discharges to be prepared more efficiently. A pharmacy technician was seen to work proactively and support ward staff with monitoring the prescribing, preparation and delivery of medicines for patients being discharged.
- The access for patients to receive care and treatment on the stroke pathway had improved since our last inspection. The staff team were proactive and consistently reviewed their practice to speed up the time from patient arrival to treatment. We saw evidence of where patients had been taken straight to

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specific treatment areas and were in receipt of treatment in very short timescales. The staff team reviewed patient treatment pathways with a view to looking at where time could be saved and where any marginal gains could improve patient outcome.

- There had been an outstanding response from the critical care teams and the hospital trust to those areas of concern raised in our previous report. The areas we said the trust must or should improve had all been addressed. Not all were fully completed, particularly where funding was an element of the project, but there had been significant improvement in all areas to patient care, treatment and support.
- The multi-disciplinary working between the hospital and the community services providing end of life care was outstanding. There were processes in place to enable ongoing monitoring of patients in the community and where possible prevent avoidable admissions to hospital.
- The multi-disciplinary working between the hospital staff and the chaplaincy enabled the ongoing parochial and spiritual support of patients and their families at the end of life. Staff felt supported by the chaplaincy and the support provided to patients, whilst not always recorded, was creative in its endeavour to meet the needs of patients at the end of life.
- The use of prompt cards in outpatient areas to give staff easy access to phone numbers and processes involving safeguarding and the management of patients with complex needs.
- The training provided to vascular surgeon trainees by the radiologists to ensure a good understanding of the risks associated with the use of radiation.
- The use of radiologists on the critical care unit to ensure instant information to the clinicians on the unit and to have quick reporting times and added opportunities for learning.
- The use of a mobile phone application in the psychology service to assist in patient initiated contact clinics. This reduced the demand for the clinics and encouraged patients to manage their own care.
- Utilising a patient liaison radiographer to facilitate 'first day chats' in radiotherapy giving more time to patients and to allow the treatment radiographers to have a lessened workload and to ensure the smooth running of the radiotherapy machines.
- The audit processes used (through the fundamentals of care audit and the departmental nursing assessment and assurance framework) to gain oversight and assurance of individual outpatient clinics and diagnostic imaging areas adherence with the regulations in the health and social care act 2010.
- The pathway for patients requiring live-donor kidney transplantation in diagnostic imaging. This ensured that all pre-operative procedures (including a nuclear medicine scan, a chest X-ray, an ultrasound scan and blood tests) completed on one day.
- The diagnostic imaging department achieving Imaging Services Accreditation Scheme accreditation and having ISO accreditation recertified.
- At Mount Gould, the results from programmes of audit in some specialities were being used to develop and improve services for patients and strengthened working relationships in both clinical and administrative teams had led to further improvements in the delivery of outpatient services across the trust.

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

Importantly, the trust must:

- Formalise the recordings of meetings in the emergency department to ensure adequate assurance that the relevant persons are attending and discussions are held to identify learning points. Also ensure actions are recorded and allocated to a person who can progress the actions and progress is monitored.
- Review performance data in the emergency department to ensure it is accurately captured and reported, allowing adequate monitoring and scrutiny.
- Ensure safeguarding training for staff in the emergency department and across all areas is completed to ensure trust compliance targets are met.
- Ensure the paediatric early warning score is implemented fully and used consistently to ensure children are safely assessed and managed.
- Continue to work with commissioners and the local mental health service provider to ensure mental health patients arriving at the emergency department receive the care they require in a timely manner.
- Continue to ensure the emergency department's four-hour performance improves, with an ultimate aim to achieve the 95% standard.

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- Review the storage of intravenous fluids in the emergency department to prevent tampering.
- The provider must ensure that equipment stored on wards and in corridors does not obstruct or impede the access to and through fire exits.
- Ensure all equipment in all areas, and specifically the emergency department, is maintained in accordance with the trust's service schedule. Provide a system to adequately monitor and report on this.
- The provider must review the available storage to patients who self-medicate and retain their own medicines on the wards.
- The provider must make sure that medical records are stored securely overnight in the oncology outpatients department.
- At Mount Gould, the provider must reduce the number of clinics cancelled with less than six weeks notice and reduce the numbers of patients waiting past their to be seen date, capturing the reasons for the delay.
- Ensure audit programmes associated with end of life care are carried out in line with the plan and within reasonable timescales, and that actions and improvements are reviewed.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Plymouth Hospitals NHS Trust

Plymouth Hospitals NHS Trust is the largest hospital trust in the South West Peninsula. It is a teaching trust in partnership with the Peninsula College of Medicine and Dentistry. The trust is not a Foundation Trust. The trust has an integrated Ministry of Defence Hospital Unit which has a staff of approximately 150 military personnel who work within a variety of posts from lead doctors to trainee medical assistants

The population of Plymouth is 259,175; however the trust also provides services to North and East Cornwall, and South and West Devon, with a catchment population of 450,000 and a tertiary care role for up to 2 million people in the South West of England. Plymouth is classed as an urban area, in which the largest age group is 16-44 (41.1%). The distribution of age groups is similar to the England Average. Black, Asian, and minority ethnic(BAME) residents make up 4.0% of the population, within which the largest group are those identifying as Asian / Asian British (1.5%) of total population.

The health of people in Plymouth is varied compared with the England average. Deprivation is higher than average and about 20.9% (9,500) children live in poverty. Life expectancy for both men and women is lower than the England average.

The trust provides comprehensive secondary and tertiary healthcare to people in Plymouth, North and East

Cornwall and South and West Devon. The majority of these services are provided at the Derriford site.

The trust has 12 registered locations:

- Derriford Hospital
- Launceston General Hospital
- Liskeard Community Hospital
- Mount Gould Hospital
- Cumberland Centre
- Plymouth Dialysis Unit
- Plymouth Hospitals NHS Trust HQ
- Royal Cornwall Hospital
- South Hams Hospital (Kingsbridge Hospital)
- Stratton Hospital
- Plymouth Science Park
- Tavistock Hospital

The trust has 1,055 beds consisting of:

- 915 general and acute (inpatient and day case)
- 94 maternity (inpatient and day case)
- 46 critical care (of which 4 are paediatric beds)

There are 5,861.63 whole time equivalent staff employed

at the trust, consisting of:

- 877.2 medical staff
- 1,631.9 nursing staff
- 3,352.6 other staff.

Secondary care services include emergency and trauma services, maternity services, paediatrics and a full range of diagnostic, medical and surgical sub-specialties. Specialist services include kidney transplantation,neurosurgery, pancreatic cancer surgery, cardiothoracic surgery, bone marrow transplant, upper GI surgery, hepatobiliary surgery, plastic surgery, liver transplant evaluation, stereotactic radiosurgery and high risk obstetrics. The trust is a designated cancer centre, major trauma centre and level 3 neonatal care provider.

The City of Plymouth was ranked 67th of 326 local authorities in the English Indices of Deprivation 2010 (1st is 'most deprived'). The Public Health profile indicates that Plymouth is significantly worse than the England average for 17 of 31 indicators (55%), including violent crime and incidence of malignant melanoma.

Our inspection team

Our inspection team was led by:

Chair: Jan Filochowski, retired NHS chief executive.

Head of Hospital Inspections: Mary Cridge, Care Quality Commission.

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The team included CQC inspection managers, inspectors, assistant inspectors and a variety of specialists: Consultants from medicine, anaesthetics, surgery, emergency medicine, paediatrics, obstetrics, and intensive care, a junior doctor, newly qualified nurse, a senior midwife and nurses from medicine, care of the elderly and critical care, and a Director of Nursing. The team also included a radiographer, a pharmacist, analysts and an inspection planner.

How we carried out this inspection

We inspected the following core services as part of the follow up:

Urgent & emergency services (safe, responsive and well led); Medical care (including older people's care), (safe and responsive); Surgery (safe, responsive and well led); Critical care (responsive); Maternity and Gynaecology (safe); Services for children and young people (safe); End of life care (effective); Outpatients & Diagnostic Imaging at Derriford and Mount Gould (safe, effective – not rated, responsive and well led).

Prior to our inspection we reviewed a range of information we held about the organisation. We asked other organisations to share what they knew about the hospital. These included the local clinical commissioning group, the Trust Development Authority (now NHS Improvement), the local council, Healthwatch Plymouth and Healthwatch Devon, the General Medical Council, the Nursing and Midwifery Council and the Royal Colleges.

We held a listening event on 14 July 2016 in Plymouth, where people shared their views and experiences of care and treatment at Plymouth Hospitals NHS Trust. Six people attended this event. People who were unable to attend the event shared their experiences by email, telephone and our website.

We carried out our announced inspection on the 19, 20 and 21 July 2016 and 12 August 2016, and our unannounced inspections at Derriford Hospital on 29 July 2016. We did not carry out an unannounced inspection at Mount Gould Hospital. We held focus groups and drop-in sessions with a range of staff in the hospital including nurses, junior doctors, consultants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, staff side representatives, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from across the trust. We observed how people were being cared for, talked with carers and family members and reviewed patients' records of their care and treatment. We reviewed the information that we held on the trust, including previous inspection reports and information provided by the trust prior to our inspection. We also reviewed feedback people provided via the CQC website.

What people who use the trust's services say

Results for the Friends and Family test for those who would recommend the trust to their friends and family averaged at 96% and have remained stable throughout 2015-16, with a slight increase in results from 2013-14. These are about the same as other trusts in England.

In the CQC inpatient survey results (2015) the trust scored "about the same" as other trusts, and remained largely unchanged from the 2014 results. Six areas had an improved score from the last inpatient survey, including for example rating of hospital food, and nurses including patients in communication and not talking in front of them as if they are not there. The Trust's score has gone down marginally in some areas from the last National Inpatient Survey; in eight areas the patient scores deteriorated by 5% or more and were identified for improvement, for example, the length of time people are on the waiting list and information given to patients on discharge.

The trust performed in line with (or slightly below) the England average in the Patient-Led Assessments of the

Summary of findings

Care Environment indicators for 2015. The scores for cleanliness and privacy/dignity/wellbeing had improved over the last year, but they were slightly worse for food and facilities.

Facts and data about this trust

Plymouth Hospitals NHS Trust has a catchment population of 450,000 and a tertiary care role for up to 2 million people in the South West of England. It has 1,055 beds, and employs 5,861.63 whole time equivalent staff. The trust has an integrated Ministry of Defence Hospital Unit which has a tri-service staff of approximately 150 military personnel working within clinical services. The unit prepares military medical personnel to support exercises and deployed operations and oversees the treatment of military personnel within the trust.

The trust's activity for April 2015 – March 2016 included 117,397 inpatient admissions, 523,502 outpatient contacts (total attendances, all sites 2015-2016), and 94,275 (May 2015 – May 2016) accident and emergency attendances.

Plymouth Hospitals NHS Trust provides outpatient and diagnostic imaging services from Mount Gould Hospital, which is owned and operated by Plymouth Community Healthcare CIC known as Livewell Southwest). It was one of six registered locations referred to as 'satellite sites' that offered an outpatient and diagnostic imaging service for adults, in addition to the service provided at Derriford Hospital.

Between April 2015 and March 2016, Plymouth Hospitals NHS Trust provided an outpatient service of 523,502 outpatient attendances. The outpatient department at Mount Gould Hospital held 16342 appointments between July 2015 and April 2016 of which 11895 were attended (the remainder were either cancelled or not attended), which is 20.4% overall. Did not attend rates (DNA) accounted for 6.7% of appointments made (out of all appointments made including cancelled appointments).

For the period of April 2015 – March 2016 the Trust Revenue was £432m against a full cost of £468m. There was a deficit of £36m for the same period.

The trust had a stable board, with the most recent executive appointments being the director of transformation and the director of people, who were both appointed in February 2016. The chief executive had been in post since September 2012. The six non-executive directors had also been appointed for some time, most prior to 2013 with one new non-executive being appointed in May 2015.

Inspection history:

Plymouth Hospitals NHS Trust had been inspected 10 times since registration with 54 standards being inspected. Derriford Hospital had been inspected four times since June 2012 and the Plymouth Dialysis Unit inspected once as follows:

- January 2012 Plymouth Dialysis Unit: five standards met
- June 2012 Derriford Hospital: one standard checked and met
- November 2012 Derriford Hospital: six standards met, one standard not met
- July 2013 Derriford Hospital : four standards met, five standards not met
- September 2013 Derriford Hospital: one standard checked and met

In April 2015, the trust was inspected against the new inspection methodology, as part of our programme of comprehensive inspections of all acute NHS trusts.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? We rated the provider as requires improvement for this domain. For specific information, please refer to the individual reports for Derriford Hospital and Mount Gould Hospital. We found: • There was a positive incident reporting culture and learning was identified and shared with staff to improve safety. Staff were open, honest and provided apologies and explanations when things went wrong. • Improvements had been made to the environment in the clinical decisions unit, a new helipad had opened to provide safer and direct access for patients being transported by helicopter, and emergency equipment was regularly checked and readily available. • The numbers of patients experiencing harm from pressure damage or falls whilst in hospital had reduced. • Staff were knowledgeable on the procedures and actions to take to safeguard patients. • Where incidences of infection were found, appropriate action was taken to control it. We observed patients with infections were nursed within side rooms and appropriate signage was in place to inform staff and visitors prior to entering the room. • Records were kept securely to maintain confidentiality for the patient but were available for staff to view when required. • In interventional radiology we previously found patients did not have a waiting area and they were recovered in a corridor post-procedure. This meant their privacy and dignity was compromised. The trust told us they have plans in progress to refurbish this area, but work was still outstanding. However, some changes had been made. However: • There were large numbers of nursing vacancies on the medical wards and departments which meant wards were often staffed below the agreed establishment level. • Medicines were not always secured on the medical wards when patients were enabled to self-administer their medicines. **Duty of Candour**	**Requires improvement** 

- The trust had a comprehensive duty of candour policy in place. This set out the statutory framework and background and linked this to the trust principles of being open. There were clear descriptions of roles and responsibilities and the steps to be followed, and the principles were reinforced by duty of candour screen savers on computers in ward areas.
- From interviews with staff and conversations on wards and in focus groups it was clear that duty of candour was well understood. There was evidence from the review of complaints, incidents and investigations that the duty had been appropriately applied.
- The majority of staff understood their responsibilities under the duty of candour requirement and could provide examples when they had been used.
- At the previous inspection at Mount Gould, staff had been unfamiliar with the term duty of candour and were unable to describe what it meant, however during this inspection, staff were well versed in what it meant and what they should do if something went wrong that affected a patient.

Safeguarding

- There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse. All staff we spoke with had a good awareness of safeguarding legislation and many had been given prompt cards to assist them in the identification of abuse. Staff knew what to do when they suspected abuse and there was evidence of reporting occurring as necessary. There were posters displayed in ward areas detailing who the safeguarding team were and how they could be contacted.
- There was appropriate seniority in the child safeguarding team. The team was made up of trained senior staff and included, as required, a named nurse and a named doctor. These 'named' staff had the responsibility for providing expert advice and guidance to fellow professionals. A trust director provided executive team leadership. The safeguarding team had recently been reorganised to incorporate adult and children safeguarding into one team.
- Safeguarding champions were appointed from staff in each area. They attended safeguarding meetings each month, and cascaded information following serious case reviews and safeguarding updates to their colleagues.
- Updating of safeguarding training by staff at Derriford hospital was below trust targets. Staff compliance with training was monitored by the named leads for safeguarding against a trust target of 100% staff attendance. At the time of our visit

compliance with updating training ranged between 74% and 100%. Training levels had been reported at the trust board meeting of 8 April 2016 as being below trust target due to not enough training sessions being offered by the local safeguarding children board (LSCB). There had been discussions between the trust and the LSCB and further session were being offered for Derriford staff to attend.

Incidents

- Where incidents were reported there were policies and procedures, along with governance systems in place for the recording, trending, investigation and learning from incidents. There was evidence that learning was widely shared across the hospital and the trust.
- There was a positive incident reporting culture with evidence of full investigations taking place and learning being identified and shared with staff to improve safety. Staff were confident in reporting incidents without fear of reprisal and told us they felt supported to report incidents and received feedback when they did. This was an improved position from our previous inspection.
- Staff received incident reporting training, which helped them understand their responsibilities, how to use the electronic reporting system and the types of incidents to report, although in the emergency department incidents were not being graded appropriately and in other areas, some reportable incidents were not routinely being recorded, for example, mixed sex breaches and staffing shortages.
- Each ward and department held a team briefing each morning which all staff attended. We observed team briefs and found that any relevant reported incidents and associated learning was discussed at the team brief. This included learning from the wider trust as well as the individual ward or department. At Mount Gould, the incident reporting system allowed for classification of the care group, service line and location, however, incidents were not able to be identified by site, and it was only possible to identify where an incident occurred if it was written in the description or action. This meant that the full extent of the number of incidents reported at Mount Gould Hospital was difficult to assess. In addition, some staff were not clear as to what should be reported, although this was an improved position from the previous inspection.

Staffing

- Staffing levels and skill mix were planned and implemented to keep people safe at all times and staff shortages were

monitored and acted on. Managers deployed staff flexibly to cover shortfalls where possible, however in some areas, large numbers of nursing vacancies meant wards were not always staffed to the agreed or planned level. Some gaps were identified in medical rotas and the trust was taking action to minimise the risk, for example, ongoing recruitment and the introduction of new roles, such as doctors' assistants which had reduced the burden on junior doctors.

- There was a 10% vacancy rate amongst the registered nurses. There were approximately 200 registered nurses employed in the hospital. Out of the 130 ward based registered nurses, there was a 7% vacancy rate which meant each ward had between 5-7 whole time equivalent (WTE) vacancies with the exception of some areas which were nearly at establishment for example cardiology and CCU.
- In the emergency department, since our previous inspection additional nursing staff had been recruited with six more registered nurses due to commence in post in September 2016. Additional registered children's nurses had been successfully recruited and this had allowed the department to ensure at least one was on duty every shift. Staffing in the clinical decisions unit had also been strengthened and we found there were always the required two nurses on duty with one healthcare assistant. A new manager for the unit had started in post and they had strengthened the position further by ensuring staff were protected and not moved to other areas of the department when they were short-staffed. Because the department was often busy, the majority of the nurse in charge's time was focused on providing leadership to majors and resuscitation. Although the band seven senior nurses did assist with clinical time during the day, this was limited and still did not provide oversight of the whole department.
- The midwifery establishment had been established following 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour' (RCOG, 2007). We looked at the last staffing audit dated June to November 2015. The funded establishment was 184.73 whole time equivalent (WTE) posts. Of these, 10. 2 WTE posts were managerial or specialist midwifery roles, leaving 174.73 WTE staff to provide direct clinical care. Most staff felt this was sufficient and the staffing levels also met the ratios established by the local clinical commissioning group (CCG).
- Paediatric Staffing numbers were planned to comply with the Royal College of Nursing document 'Defining staffing levels for children and young people's services'. The planned level of staffing on the wards for 14 patients was three trained staff and

one healthcare assistant. Duty rotas showed these planned levels were met. Numbers of trained staff in the high dependency unit were compliant with Royal College of Nursing standards.

- Staffing levels in the neonatal intensive care unit met national guidelines with one nurse to each child being cared for. This was in accordance with guidance from the British Association of Perinatal Medicine (BAPM) guidelines and meant that each baby received one to one care from a registered paediatric nurse.
- In Radiology there were consultants and registrars who provided on-call medical cover. The registrars were based on site at Derriford with the Consultants working from home with an on-call laptop to provide assistance to the registrar. Radiology management told us that at the time of the inspection there were five radiologist posts vacant, although the trust had appointed two radiologists who will be in post by the end of the year and another post was being advertised for a second time as no suitable candidate was found previously.
- At Mount Gould since the last inspection, the trust had tried to recruit a head of outpatients matron with responsibility for the satellite sites, including Mount Gould. The trust had not been able to recruit to the post, so had delegated some of these responsibilities to existing senior staff.
- Senior nurses within each speciality managed the nursing and health care assistant staffing levels, and made arrangements for staff to work at both Derriford and Mount Gould Hospitals; we saw evidence that in ENT, this was based on a competency checklist.
- Staff told us they felt they continued to provide safe care and that when there were unplanned staff absences, there was a procedure for requesting extra staff from Derriford Hospital which they said worked well. Most staff who worked at Mount Gould Hospital also worked at Derriford Hopsital, so when short notice staff absences occurred, senior staff reallocated staff from Derriford to cover the clinics affected at Mount Gould.
- There were two vacancies for clinical psychologists, which staff told us was having an impact on the chronic pain management service, however attempts to recruit to the posts had been unsuccessful.
- The Director of Governance had initiated a new workforce planning group to span all staff groups with the first meeting having taken place on the 20th May 2016.
- We were told by the trust that an ongoing recruitment process had been in place. There had been a work stream to recruit nurses from overseas which had aspired to recruit 50 nurses.

However, to date only five nurses from this scheme had passed all the recruitment checks and these people were due to commence employment in August and further recruitment is ongoing.

- The trust had implemented the 'Safe Care System' which they used three-times-a-day. Senior nurses on each ward entered how many staff they had on duty, their level of experience and patient acuity. Matrons reviewed this and re-deployed staff as required. A red flag system had recently been introduced to the Safe Care System, which allowed the escalation of situations, for example where staff were behind on observations, medicines and intentional rounding. This was then escalated to the matrons to review staffing levels to re-deploy staff to this area.

Infection Control

- The trust had infection control policies and procedures to support staff in providing care and treatment to patients. An infection control team was active and visible within the trust and there were infection control leads on wards and in departments.
- Standards of hygiene were monitored by staff with specific roles in infection control and clinical areas were visibly clean, hygienic and well organised. Staff followed trust policies regarding infection control, were all bare below the elbow and routinely used protective personal equipment (PPE) and hand gel which were readily available.
- Hand wash basins, soap and alcohol hand gel were readily available throughout the clinical areas for both staff and visitors to use, and staff were observed following good handwashing procedures before, during and after patient contact and procedures. However, access to some hand wash basins on 6 bedded bays was restricted if all beds were in use.
- Sharps waste was not always disposed of promptly on some medical wards and chemicals were stored in surgical and medical clinical areas which patients had access to.
- Where incidences of infection were found, appropriate action was taken to control it. We observed patients with infections were nursed within side rooms and appropriate signage was in place to inform staff and visitors prior to entering the room. Infection control risks were highlighted on the electronic white board so that staff were alerted to additional measures they were required to take.
- Incidents of infection such as methicillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile were

monitored for each area and reported to the infection prevention and control committee. Compared to the national England average the trust generally had a lower number of cases of C.diff and MRSA than other trusts between March 15 and February 2016. However, when comparing the numbers of MSSA cases we found that the trust experienced a higher number of cases than the England average.

Environment and Equipment

- The trust presents something of a challenging environment given the size and age of the estate. The trust had an ongoing development and refurbishment programme in progress. Significant developments included new car parks, a helipad and improvements in summoning help for the clinical decisions unit.
- Many services were being provided in cramped conditions, for example all areas in the emergency department, and where this was the case plans were in place although as a whole the site is restricted in terms of further expansion.
- The emergency department had a dedicated paediatric unit; however, this was not secure. The paediatric unit was located next to the reception area, behind the minors' cubicles. Although the access doors did have a keypad lock, this was not used. The nurses allocated to the unit were not always present, and at times were in a cubicle and not able to see the entrance doors. This meant children were not always protected from the risk of harm from unauthorised persons accessing the unit. Security issues were also identified within maternity, although these were promptly rectified during our inspection.
- At our last inspection we identified issues with the environment in interventional radiology, as it was not fit for purpose. Patients did not have a waiting area and they were recovered in a corridor post-procedure. This meant their privacy and dignity was compromised. The trust told us they have plans in progress to refurbish this area, but work was still outstanding. However, some changes had been made. A curtain had been fitted to screen off the area where patients waited for procedures, and consultants told us they tried to obtain consent from patients on the wards, although this was not always possible due to demands on beds. Patients who had a general anaesthetic were now transferred to main theatre recovery post-procedure.
- At our last inspection, the environment in the delivery suite did not comply with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance. Whilst four of the 13 delivery rooms had been

refurbished, these remained clinical in appearance as opposed to promoting a more 'home-like' environment. This has been shown to reduce stress and promote a normal birth process (Safer Childbirth, Royal College of Obstetricians and Gynaecologists, 2007). There were no further plans in place to renovate the remaining nine birth rooms or the en suite toilets which were shared between two rooms.

- Resuscitation equipment was readily available in all areas and regularly checked. The resuscitation trolleys were tamper-evident, enabling staff to see if the trolley had been opened since the last check.
- In most areas it was possible to identify when equipment had been cleaned by 'I am clean' stickers, and there was evidence of robust processes for returning and maintaining faulty equipment. However, not all equipment was serviced in accordance with service schedules. Of the 650 items of equipment recorded on the trust's service schedule as being in the emergency department, 401 items (61.7%) were out of date. 290 items (44.6%) had last been serviced in 2014 or earlier, despite having a 12-month service schedule. There were 12 items of equipment that had not been serviced since April 2009. This meant equipment was at risk of failing, potentially delaying patients' care and treatment.

Are services at this trust effective?

Good

The rating of good is taken from the previous inspection.

At this inspection the effective domain for end of life care was rated as good. Although we inspected the effective domain in outpatient and diagnostic imaging service at both sites, we did not rate them due to the lack of national data available to the CQC. For specific information, please refer to the individual reports for Derriford Hospital and Mount Gould Hospital.

We found:

- Patient needs were assessed and treated in line with evidenced based guidance in end of life care and outpatients and diagnositc imaging. Pain management and the management of nutrition and hydration was assessed, managed and recorded to ensure patients at the end of life were comfortable.
- Following the previous inspection a local quality improvements in environment project had been undertaken. Areas of improvement were planned, for example single rooms available for privacy for patients at the end of life. The change had not yet been started.

- End of life outcomes were monitored against national standards. Local audits were delayed in being completed in some areas. Outcomes from previous audits had been used to make changes to patients care.
- Ward staff had sufficient training and the ongoing support and help from the Specialist Palliative care Team to deliver effective care and treatment.
- The multi-disciplinary working between the Specialist Palliative Care Team and the wider hospital and local community were outstanding. The integrated working supported a continuity of care and avoidable admissions to hospital.

However:

- Improvements were seen in the completion of the Treatment Escalation Plans (TEP) but auditing of improvements was not yet fully completed. The management of Deprivation of Liberty safeguards ensured the safety of patients.
- Although the number had reduced significantly since our last inspection, there were still 2000 temporary notes in circulation meaning that treatment decisions were being made without all relevant clinical information. In diagnostic imaging although it had reduced significantly, there were still 2000 images requiring reporting on a backlog. These were being managed in a proactive way and work was still being done to reduce this.

Evidence based care and treatment

- Patients' needs and treatment were delivered in line with evidence based guidance. The trust Clinical Effectiveness Group was responsible for reviewing the compliance status for all published NICE guidance. The trust gave consideration to the clinical guidelines, interventional procedures, quality standards and other best practice guidelines issued by NICE and implemented these where appropriate to end of life and palliative care patients.
- The Specialist Palliative Care Team (SPCT) had written the Standard Operating Procedure (SOP) for end of life care (May 2016). This drew upon,
  - One chance to get it right (2014)
  - Dying without dignity report (2015)
  - Care of dying adults in the last days of life – NICE Guideline (2015)
  - Every moment counts (2015)
  - Ambitions for palliative and end of life care. (2016)
- Relevant and current evidence based guidance, standards, best practice and legislation were identified and used to develop

services and were generally disseminated well through outpatients and diagnostic imaging. When safety alerts were released they were circulated to all staff by email. It was an expectation that all staff read the alert and signed a signatory sheet when a safety alert was released. The outpatient matron followed up anyone who had not signed the sheet to ensure completion.

- In outpatients and diagnostic imaging, although most staff could access the information they needed to assess, plan and deliver care to people in a timely way there were still improvements to be made. Although the number had reduced significantly since our last inspection, there were still 2000 temporary notes in circulation meaning that treatment decisions were being made without all relevant clinical information. In diagnostic imaging although it had reduced significantly, there were still 2000 images requiring reporting on a backlog. These were being managed in a proactive way and work was still being done to reduce this.

Patient outcomes

- Plymouth Hospitals had submitted data to the National Care of the Dying audit 2014 and saw improvements from the previous audit. The most recent National Care of the Dying Audit 2014 action plan showed that of the seven areas requiring further action, six areas had been completed.
- Some areas of improved practice compared to national averages included; the recognition that the patient was thought to be dying was reviewed regularly in 85% (national average 91%) of patients and led by a senior doctor in 64% of cases. This is an improvement on 2013 audit (22%) but less than national average. At the time of death a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order was in place for 96% (national average 94%) of patients' notes. Discussion about the cardio-pulmonary resuscitation decision with the nominated person important to the patient was documented in 67% (national average 78%) of cases. It was recorded that the nominated person important to 77% (national average 80%) of patients had opportunities to discuss the patient's condition with a senior healthcare professional. In 80% (national average 84%) of cases the people important to the dying patient were notified of the imminent death.
- End of life outcomes were monitored against national standards. Local audits were delayed in being completed in some areas. Outcomes from previous audits had been used to make changes to patients care.

- There was no participation in the Gold Standards Framework accreditation scheme and no plans in place to begin accreditation.
- Senior staff had presented patient outcome audit results at national and European conferences.
- A senior nurse sat on the National Institute of Clinical Excellence (NICE) board and had developed a working group around pain management.
- In outpatients and diagnostic imaging, patient outcomes were monitored in the therapies unit and recorded on computer systems. They were then benchmarked against other services in terms of DNA rates, patient progress (in terms of cost after treatment) and number of treatments available to patients. The unit performed well on these benchmarks compared to the national picture and work was being done to bring better services to the unit. Many staff members were involved in research and clinical audit to improve the service.
- Diagnostic reference levels were regularly audited and implemented in the imaging department.
- The pain management and diagnostic imaging departments undertook regular programmes of audit specific to Mount Gould Hospital.

Multidisciplinary working

- The multi-disciplinary working between the Specialist Palliative Care Team and the wider hospital and local community were outstanding. The integrated working supported a continuity of care and prevention of avoidable admissions to hospital.
- Multi-disciplinary (MDT) meetings for all cancer specialities were held each week with up to 30 meetings being held. Weekly community MDT meetings took place and were attended by the consultant working at both the local hospice and at Derriford hospital. This provided opportunity for follow up and continuity of care.
- The specialist palliative care team worked closely with the community hospice service and in collaboration with the Hospice at Home team and the Crisis Care team. This integrated working meant that there was an ongoing communication between these services during hospital admission, discharge and any readmissions. The IT systems in place were linked between the SPCT, community team and hospice to ensure a smooth transfer of information and ongoing review for any readmissions. The integrated working had identified a reduction in avoidable admissions during 2015 with an

identified bed days saving each month. For example, in December 2015, 85 bed days had been saved by an admission prevention action by the crisis community team working with the other integrated services including the hospital teams.
- A senior staff member had engaged external organisations to help develop new policies and procedures.
- When people in outpatients and diagnostic imaging received care from a range of different staff, teams or services, this was coordinated well ensuring that all relevant teams were involved in the planning and delivery of peoples care and treatment. Staff discussed with inspectors how important it was to work collaboratively to meet the needs of the patient and could give us multiple examples where this was taking place.
- The outpatient's service made good use of clinical nurse specialists. Many clinics around the hospital, such as main outpatients and ophthalmology, were nurse led with support given from consultants. Where there were issues there were clear and quick escalation processes. The early pregnancy unit, located in the Lancaster Suite, was a nurse-led service. The nurses examined, scanned, diagnosed and treated the patients but could also arrange consultant-level investigations where appropriate.
- Diagnostic imaging staff were involved in the assessment and planning of ongoing care. Radiologists supported all multi-disciplinary team meetings (MDTs) that required their input. We were told that radiologists were given dedicated time to prepare for all MDTs. We were also told that the number of cases that can be discussed at each MDT had been capped to ensure that the quality of these meetings was maintained and to avoid large numbers of cases being discussed where a previous MDT has needed to be rescheduled, such as after a bank holiday.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- All staff we spoke with in all areas had a good understanding of the mental capacity act and deprivation of liberty safeguards. Staff were able to describe the processes involved and who to contact for more information. One healthcare assistant in the main outpatients unit had done a piece of work on their diploma level three training in deprivation of liberty safeguards. In immunology and allergy service the mental capacity act was regularly discussed to ensure continual awareness and learning. As a result of this staff had a strong understanding of the mental capacity act.

Summary of findings

- For those patients who lacked mental capacity to give an informed consent, policies were in place to follow the Mental Capacity Act (2005). The legal framework for this policy requires organisations to work towards the best interest of adults at risk and vulnerable individuals who lack mental capacity. Medical and nursing staff confirmed that should a patient not have sufficient capacity to make decisions, a best interest process was followed. We saw information for staff on the wards to inform them about the Mental Capacity Act (MCA) and best interest process.
- For patients who lacked mental capacity and who had no-one to support/advise them, referral to the Independent Mental Capacity Advocate service (IMCA) was arranged by staff. Patients who lacked Mental Capacity to consent to treatment and needed longer term restraint or restriction of behaviours, as part of their clinical care, were referred for Deprivation of Liberty Safeguard (DoLS).
- The trust Deprivation of Liberty guidance had been revised and updated this year (2016). To ensure compliance with DoLS processes, staff confirmed further training and revised local processes had been delivered. From April 2014 to March 2015 23 DoLS applications were made. From April 2015 to March 2016 148 DOLS applications had been made. The increase was due in part to the changes made to the criteria for referral.
- The trust had replaced Do Not Attempt Resuscitation(DNAR) with the Treatment Escalation Plan (TEP)documentation, which had been in place since 2012.The TEP form was a Devon wide document and recorded important clinical decisions regarding resuscitation and other ceilings of care.

Are services at this trust caring?

Outstanding 

Are services at this trust responsive?

Requires improvement 

We rated responsive as requires improvement because:

- People were frequently unable to access services in a timely way for initial diagnosis and treatment with people experiencing unacceptable waits for some surgical services.
- The Trusts inability to maintain and operate its surgical services at times of escalation and the failure to address the backlog of patients awaiting outpatient and diagnostic services remain of concern. Since our last inspection in April 2015 the number of cancelled operations had risen. The percentage of patients not treated within 28 days of a cancelled operation had also risen.

- Due to pressure for their beds and the demand for their services, some patients had to use facilities and premises not appropriate for the services being provided.
- Complaint responses were not completed in a timely manner in the emergency department
- The theatre booking system had been reviewed and changes implemented, although staff told us there were ongoing issues with the theatre lists not always being finalised at 3pm the day before surgery. Systems in place were not robust and patients were placed at risk of harm.

However:

- The numbers of medical outliers had reduced since our last inspection as the trust had provided additional medical beds. This meant that patients received a responsive service and their access to medical staff had improved.
- Support for patients with learning disability and dementia was good across all services with the specialist nurses reported as being easily accessible.
- The acute stroke pathway was responsive to the needs of patients and staff provided a proactive service to ensure patients were assessed and treated promptly on arrival at the hospital.

Service planning and delivery to meet the needs of local people

- The trust worked with commissioners to plan and meet the needs of patients across all services. Where these were not being met, for example routine spinal surgery, some patients had been transferred to other health care providers.
- During the previous inspection, patients requiring medical care and treatment had not always been able to be admitted to a medical ward due to the pressures on beds across the hospital. The service had been reviewed and additional medical wards formed to provide 60 more medical beds together with dedicated medical staff to provide care and treatment. This was a significant improvement on the quality and consistency of care and treatment to patients.
- A monthly nurse-led chronic kidney disease clinic had been developed in four off site locations to take the service to the patient. The trust had received positive feedback from patients regarding this service and there had been a positive impact on the reduction of waiting lists.
- The acute neurology service provided a facility for patients to attend the ambulatory care unit for assessment rather than

routinely admit them to hospital. The trust had monitored the access times for patients with epilepsy through this clinic and found they exceeded the NICE guidelines around access times to treatment for patients with epilepsy.

- The trust had worked with an external company regarding funding to establish a mobile infusion unit. This enabled clinically appropriate patients with multiple sclerosis to be able to receive their infusion in a bespoke facility and improved their access to services.
- A number of services had improved flexibility and choice for patients, including a weekend service to support patients who had experienced a stroke; an additional endoscopy theatre list on weekdays running between 8.30 am to 6.30pm and on Saturdays from 8.30am to 4.30pm; gastroenterology clinics had been expanded to provide services in the evenings and at weekends; and hepatology evening clinics had been introduced to enable patients to attend at times convenient to them.
- The pathway for patients attending the cardiac catheter laboratories were complex and did not provide a seamless journey.

Meeting people's individual needs

- The needs of different people were taken into account when planning and delivering services. This was particularly evident with the reasonable adjustments made for patients living with dementia and learning disabilities. We found that environments were equipped to manage the specific needs of these patients and that training had been rolled out to all staff.
- Facilities were in place throughout the hospital for patients and visitors with physical disabilities. These included, for example, disabled access to all areas, patient lifts and disabled toilets. However, a disabled toilet was provided just inside the minors' area of the emergency department, but this was not clearly signposted from the waiting room.
- Patients with learning disabilities were well-supported. Most departments had communication aids available, and a learning disability team was able to attend to support patients if required. The computer system had the means to 'flag' patients with learning disabilities and send alerts to the team, although not all staff were aware of how to use this system. There is a well-established learning disabilities team who provide training and support to staff across the organisation being available Monday to Saturday. The outpatient department was particularly highlighted as an area where patients with learning

disabilities are well supported with patients being identified prior to their appointment so that any adjustments can be put in place to ensure they are supported to get the best out of their consultation.

- The learning disabilities team support clinical staff with assessment of needs and ensure they are involved with discharge planning for those with complex needs. This is being supported by an easy read version of a discharge plan.
- Patients with mental health did not receive an adequate service in the emergency department. The psychiatric liaison service was available for staff to contact for support, but only between 9am and 9pm, although staff told us that reviews generally didn't start until 11am.
- The trust was responsive to the needs of long-stay patients in critical care, and made arrangements to enable the relatives of patients experiencing a long-stay in hospital to have local accommodation and to get a discounted car-parking rate.
- Call bell audits were carried out by wards and departments and showed positive outcomes. During our inspection we observed four wards for the accessibility of call bells for patients. We saw that all call bells, with the exception of those for five patients, were within reach of the patient. Of the five patients who did not have a call bell, one was sat away from their bed space while it was being cleaned. The other four patients were either very poorly or living with dementia and staff said they did not use the call bell. These patients were located in an observation bay close to the nurse's station and there was also a desk in the bay so that nurses could observe and monitor the patients.
- The trust had devised a number of information leaflets for patients to complement verbal information that was discussed as part of the care pathway. These included explanations about the different types of surgery and medical conditions. All leaflets seen were in English, although we did see information posters displayed in public areas in other languages. Translation services were available and staff knew how to access them.
- All surgery wards were, on 1 August 2016, going to introduce the 'Let's be open' strategy to implement open visiting on the surgery wards.

Dementia

- The hospital had a dementia care lead nurse and consultant who provided support to staff and patients. The Alzheimer's

Society's Dementia Friends Scheme was in operation. This is a national programme for people to learn more about dementia and the ways in which people can help others living with dementia.

- The hospital environment had been refurbished to reflect the care and support needs for people living with dementia. We saw thought had been given to the colour of the walls and bays and rooms on the wards, and were painted in different colours and had different pictures to enable patients to find their bed. Signage throughout the hospital assisted patients and visitors living with dementia by the use of pictures and colours.
- Patients living with dementia were identified by discreet identification on the staff whiteboard and in their notes to ensure staff were all fully aware of their additional needs. We saw staff were responsive and showed empathy and understanding to one patient who lived with dementia who was unsettled on the ward.
- The care of the elderly wards had refurbished their day rooms to provide a more homely atmosphere and the furnishings and décor were in the style of a 'front room'. Activities were available on the care of the elderly wards for patients to access. For example, memory boxes, reminiscence tools, colouring books, jigsaws, board games, television and music provision. Twiddle muffs had been introduced onto the wards. These are knitted muffs for patients to put their hands inside and have different textures or attachments to distract them.

Access and flow

- The emergency department was consistently failing to meet the standard that requires 95% of patients to be discharged, admitted or transferred within four hours of arriving at the department. The department employed a flow coordinator to monitor patient flow through the department and staff held a daily review of all the breaches to determine the breach reasons and identify those which were not due to a clinical need. These were reported monthly within performance reviews and shared with the clinical site team.
- Crowding in the emergency department was on the risk register as a "serious risk". The risk was entered on the register in June 2016 and several mitigating actions had been identified, including the progression of a strategic business case to expand and redesign the emergency department, with a target completion date of September 2016. However, we were told the redevelopment had been put on hold because there were no finances available for it.

Summary of findings

- Between March 2015 and February 2016 all of the medical specialties were performing below the England average for the Referral to Treatment Times within 18 weeks. Data showed that in March 2015 only 70% of all patients received referral to treatment within 18 weeks but this had improved to 90% by January 2016. The worst performing specialities were Cardiology, at an average of 75.9% versus an England average of 88.1% and General Medicine with an average of 87.5% versus an England average of 96.9%. This meant that patients attending Derriford hospital generally waited longer than patients receiving treatment in other parts of England, and the national target of 92% had not been met.
- The trust breached the 18-week referral to treatment target operational standard across all surgical specialties, apart from plastic surgery, from March 2015 to June 2015, when the target was abolished by the government (the operational standard is still used by the majority of trusts to monitor their performance). Performance had deteriorated to under 50% for neurosurgery.
- Since our last inspection the number of cancelled operations had risen. Between July and September 2015, 664 operations were cancelled and 563 of these were re-booked within 28 days, but 101 were not. Between October and December 2015 409 operations were cancelled, with 341 being re-booked within 28 days, but the remaining 68 were not. Between January and March 2016 the number of cancelled operations was 618 and 122 were not re-booked within 28 days. The number of cancelled operations between April and June 2016 had reduced to 394, with 87 operations not being re-booked within 28 days.
- The surgical care group management team told us they were receiving more referrals and patient acuity was increasing which was having an impact on their treatment times and cancelled operations. They were in the process of increasing their collaboration with primary care. They told us this would reduce the number of unnecessary referrals and would assist in setting up efficient pathways and assessments for patients. This was a new initiative which needed time to become embedded.
- At our last inspection we raised concerns about the theatre scheduling system, as operating lists were not being managed to make sure they were being utilised effectively. For example there were late starts and lists were being under or over-populated. At this inspection the surgical care group told us that a new computer system had been obtained to address these issues, however it had not been as successful as they had hoped. Work was continuing on this at the time of our inspection.

Summary of findings

- There were issues with finalising theatre lists by 3pm prior to the day of surgery, which were ongoing and had not been resolved at the time of our inspection.
- There were long waiting times and delays for an outpatient appointment. Although significant improvement had been made some people were not able to access the services for assessment, diagnosis or treatment when they needed to due to the management of the backlog in appointments required and high levels of over referral to services. There were a total of 30,862 patients requiring follow up but a majority of these had an appointment date at the time of the inspection. During the last inspection there were 3000 patients waiting over one year for a follow up appointment. During this inspection this had been reduced to 560 patients with half of them having a follow up appointment.
- The bed occupancy rates at the hospital from July 2015 to July 2016 were similar to the England average and the average length of stay for elective and non-elective patients is generally lower than average at the trust and Derriford Hospital level, except Clinical oncology which is higher compared to the England average.
- At the last inspection we identified there were medical outlying patients on a number of different wards and that medical cover was not consistent or established. The trust had followed guidance from the Royal College of Physicians to increase the number of medical wards to reduce the average number of medical patients on non-medical wards. Staff were positive in their comments about this and stated the medial cover and continuity of care for patients had improved.
- Data provided by the trust identified that 23% of all patients moved wards two or more times during their stay at the hospital. Out of these patients, 8% moved wards three or more times during their admission. The numbers of patients moving wards had reduced in the past year and close monitoring took place to establish the reasons for this happening.
- There were almost no patients transferred to another hospital due to lack of a critical care bed. There was a high level of flexibility and response from the teams, and patients were admitted to the units when they needed urgent and emergency care.
- There was a complex discharge team working within the hospital who liaised with ward staff and external providers to make arrangements for patients who had complex care needs.

This was an integrated team which included social care staff, who worked for the local council, together with health staff. The team provided a single point of contact for wards when planning patient discharges.

- A scheme had been introduced within the hospital known as the 'golden bed'. This focussed ward staff on reviewing all of the patients who could potentially be discharged that day, before 10am, thus making a bed available early in the day to plan admissions. Staff we spoke with were positive about this process and the impact it had had on ensuring attention was paid to discharging patients earlier in the day.
- The trust electronic database of all patients provided a reference point for senior staff to review the location of all patients and the stage of their treatment and care. The site management meetings used this system a minimum of twice a day, but generally at three points in the day, to review the flow of patients through the hospital. The system enabled staff to quickly identify where patients were waiting for admission to a ward or discharge out of the hospital. This provided an up to date picture of the pressures on beds and where and what the key concerns were.

Learning from complaints and concerns

- There was a complaints policy in place and we met with the complaints team who were able to provide evidence of adherence to the policies and processes, and evidence of investigations and escalation occurring as necessary. In general, the trust was handling complaints in a timely manner and in accordance with policy, although in the emergency department during April 2016, only 50% of complaints were returned by the emergency department within the agreed timeline.
- The trust employed a variety of means to share learning from complaints across all departments, for example at daily team reviews, in safety and governance newsletters and by email.
- Complaint themes were discussed at governance meetings and learning from these was shared with staff at their meetings. An improvement plan for complaints aimed at driving better quality response was part of the work ongoing.
- People were involved with complaints and given feedback as they wished to receive it once an issue had been investigated. Staff demonstrated how they had involved patients and relatives with complaint feedback and the way the service

planned to make or had made changes. Feedback had included holding meetings with those involved, or writing to the person concerned if this was how they preferred to hear back from the hospital.

- At our last inspection information about the Patient Advice and Liaison Service (PALS) was not available on all wards and units. This had since been addressed and we saw leaflets on each ward and unit advising how to access PALS. PALS provided support to patients and relatives who wished to make a complaint. The new welcome centre also provided a place where patients and relatives could access information.
- Senior staff on wards told us they tried to resolve complaints locally on the wards with the complainant.
- Since our last inspection in April 2015, surgery services had received the highest number of complaints within the trust. The three most complained about areas for surgery were safe and quality care, access and waiting, and information, communication and consent.

Are services at this trust well-led?

Good

Overall we rated the trust as good for well led because:

- The executive team had considered the findings of our inspection in 2015 and had given a clear focus and commitment to ensuring actions were put in place.
- While many aspects have been addressed the challenge of the external environment and constant pressure on capacity had not deterred their commitment to providing high standards of patients experience and support to staff.
- Systems and processes which had been under review or reviewed since the previous inspection were seen to be embedding and providing assurance for quality and safety.
- It was evident that while finance was a key driver this did not prevent innovation and development of clinical services.
- The executive leadership team were visible and were using a range of activities through which to engage with staff. Change as a result of staff feedback could be seen from a review of the appraisals process to staff stories being presented at trust board.
- Several members of the executive team were involved in the Devon Success Regime work which despite occupying additional time had not impacted on the visibility of leaders in the organisation. While this was a key piece of work the day to

day running of the trust had not been impacted. The recent executive appointments and the upcoming non executive recruitment were seen as opportunities for new voices and challenge at a time of internal and system wide uncertainty.

However:

- Whilst the Board was clearly committed to improving the experience of people working for the trust there was no evidence that this area, specifically the workforce race equality standard, had received any significant focus to date. Although work with the service lines was planned action on raising the profile alongside internal and external engagement required improvement.

Vision and strategy

- The trust's vision and strategy is set out in a document "At the Heart of Health in the Peninsula" which was published in June 2013. The stated vision is to become one of the country's leading specialist centres delivering excellent care, teaching, training and research. The strategy sets out the influencing factors which included serving the diverse population locally and more widely across the peninsula, focusing on the quality of care, increasing the confidence of patients, GPs and commissioners, developing research and innovation and collaborating with local partners. The vision and strategy are summed up in the phrase "Leading with excellence, caring with compassion" and this appears on all trust documentation and was visible in public and ward areas at Derriford Hospital. The trust's strategy going forward is being influenced by the Devon Success Regime which was requiring the trust and partners across the county to think radically about the way services are provided and where. At the time of the inspection there were no specific developments but there was a significant amount of work underway. The chief executive and a number of executives and senior staff were closely involved in this. The trust's leadership team were clear that the safety and quality of care was of paramount importance.
- The vision and strategy is underpinned by the following values which were developed in conjunction with staff in April 2007 with the fifth value being added as part of the strategy in 2013. They are:
  - Put patients first
  - Take ownership
  - Respect others
  - Be positive

  - Listen, learn, improve
- The values were prominently displayed throughout the trust. The trust had a campaign underway to refresh the values and staff were able to volunteer to be featured in a new poster campaign. The purpose of the campaign was to reinforce the values, help raise staff morale and reflect the diversity of staff. The trust had a related social media campaign called #1bigteam. Six posters shared on social media had reached 13,863 on Facebook and an engagement rate of 5.7% on Twitter.
- As on the previous inspection the majority of staff that the team met during the inspection were aware of the values and talked about how they applied to their work. The publicity surrounding the previous inspection report had been used in part to focus on the values. Values driven leadership continued to be promoted through the corporate programme around engagement, communication and behaviours known as the Plymouth Way.

Governance, risk management and quality measurement

- The governance structures within the trust were clear and had been reviewed and revised since the last inspection. The committee structures were aligned to corporate objectives and risks. Three key committees, Safety & Quality, Finance & Investment and Workforce & Organisational Development reported into the Board. The arrangements were set out in the Board Assurance Framework and associated policies and these were effective in clearly describing levels of responsibility and accountability. The trust has recently reviewed and refreshed the membership of the board committees to ensure that each person attending had a clear purpose. This had reduced duplication and had dealt with a lack of clarity in the previous arrangements.

- Operational performance of services at the trust were managed in a Care Group structure with service lines aligned to and reporting into the groups. The four groups were Medicine, Surgery, Women and Children and Clinical Support Services. While all were in place the more recent appointment of clinical directors for surgery and medicine were noted to be making good progress. Care group performance data was not currently able to clearly demonstrate each care group however work on automating the reports for workforce and quality governance reporting was planned.
- The performance reporting framework had been aligned to CQC's five key questions. An integrated performance report was

produced that included a summary performance dashboard covering safe, effective, caring, responsive and well-led. The report includes external as well as internal assessments and these included the CQC risk rating, NHS Choices and a governance risk rating using National Health Service Improvement (NHSI) performance measures. A new trust-wide governance toolkit had been rolled out across the trust and was about to be introduced to the emergency department at the time of the inspection. The new toolkit included resources to ensure governance systems were consistent throughout the hospital and provided regular assurance reports from wards and departments through to service lines and care groups.

- The risk management arrangements were effective in providing good visibility on the key risks. At the time of the previous inspection the trust had identified the need to increase the pace with which risks were addressed and to improve the consistency. There appeared to be a sharper focus on holding care groups and service lines to account. The improvements in some areas, for example in reducing the patients who had waited the longest for follow up, suggested this was having an impact. Whilst risks continued to be well understood there was still some variation in assigning owners to risks and clearly recording mitigation and action.
- Executive lead for quality assurance and improvement is shared between the medical director and director of nursing with oversight and attendance at appropriate meetings. Review of serious incidents occurs weekly with the director of nursing chairing the quality governance and learning group which encompasses all care groups being seen as playing an essential part in communication and dissemination of learning.

Leadership of the trust

- At the time of the previous inspection it was reported that there had been significant change at Board and Executive level over the previous three years and that prior to that there had been significant and rapid turnover of non executives. One year on there was a sense of greater stability with the current chair in post since August 2012 and the chief executive in post since September 2012. The chief operating officer, director of nursing and medical director have all been in post for over two years. Since the last inspection two new executive directors, of Finance and Human Resources, have been appointed. Both bring significant levels of experience with them and both have clearly already had a significant and positive impact. Both executives attend the joint union meetings making good contributions to some long standing problems. There had been

a change in the deputy chief executive role, this was now held by the Director of Site Services and Planning. The role had been redrawn slightly to enable the chief executive to give sufficient time to the Success Regime and the arrangements were working well.

- The term of office of a number of the non-executive members of the board was coming to an end and recruitment was underway at the time of the inspection. The non-executives in post at the time of the inspection demonstrated a clear understanding of the issues facing the trust and a tangible sense of commitment to do the right things in the right way. They referred to the previous inspection having given a renewed focus on key performance areas and also such issues as medical staffing.
- At the last inspection the team were told about the plans for board development. There had not been any significant progress on this although it was a priority for the chairman once the new non-executives were appointed.
- The sense of a strong shared purpose amongst the trust's leadership team that was evident at the last inspection was still there, along with a determination to support staff and to drive improvement. It was clear that the board demonstrate the trust values in a consistent way.
- The executive team were mirroring the daily 'huddle' meetings which were held in wards and departments. We observed one of the huddles which was attended by all the executive team and the chair. The format included a review of key performance from the previous day with a focus on what went well and what could be done differently with members of the team checking and challenging each other.

Culture within the trust

- At the last inspection the team found a vibrant and positive culture within the trust. The trust leadership, especially the chief executive and director of nursing, were highly visible. This sense of positivity was still very evident.
- The chief executive was said to be visible and was accessible to staff through open sessions and use of social media. The director of nursing had an open door policy which coupled with spending a day a week working on wards, made them available to a range of staff not just the senior nurses.
- We spoke with many staff across the trust with over 80 attending focus groups before and during the inspection. There

was an overwhelming view that staff were passionate and focused on patient care with teams working hard to deliver care and treatment despite the challenges of staffing and adapting to the pressures on beds in some areas.

- Many staff we met at focus groups had read the report from the previous inspection and felt the inspection had led to positive changes and were keen to show and tell us of examples. The medical consultant body were confident in the leadership of the chief executive who was said to be supportive and engaged with them although it was felt that the care group structure had led to a lot of management tiers.
- The NHS staff survey results for 2015 showed a slowly improving picture. Although 67 questions showed an improvement on the previous year the overall engagement score of 3.69 is below the national average of 3.8. There were 14 negative indictors and only one positive indicator out of 34. The negatives included staff feeling pressure to work when unwell, quality of appraisals and effective team working. The positive indicator was that staff were recognised and valued by managers and the organisation.
- Aside from the staff survey there were a number of positive indicators of a positive culture. These included sickness rates which were lower overall than the England average and better retention of staff with annual turnover having reduced from 12.8% in May 2015 to 10.3% in July 2016.

Equalities and Diversity – including Workforce Race Equality Standard

- The trust had published a Race Equality Scheme in 2015 as required. At the time of the inspection an expanded scheme was due to be published in August. The trust are looking at equality as a whole. The trust has an equality steering group but the changes in the Human Resources department had had an impact and there was a sense that this work had fallen behind. At the time of the inspection there was a plan to review the terms of reference and the membership of the steering group.
- The staff survey results appear to indicate that staff from a Black Minority Ethnic (BME) background have a more positive experience than their white colleagues. However the detailed analysis had not been undertaken at the time of the inspection.
- Whilst the Board was clearly committed to improving the experience of people working for the trust there was no evidence that this area, specifically the workforce race equality

standard, had received any significant focus to date. Although work with the service lines was planned action on raising the profile alongside internal and external engagement required improvement.

Fit and Proper Persons

- The trust became subject to a new regulation (Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014) on 27 November 2014. This regulation states that individuals in authority (board members) in organisations that deliver care are responsible for the overall quality and safety of that care. The regulation is about ensuring that board members are fit and proper to carry out that role.
- The trust was prepared to meet the requirements related to Fit and Proper Persons. The processes relating to the recruitment of executive and non-executive directors had been adjusted to take account of the requirement. The trust had introduced a system of an annual self declaration for existing board members. The team reviewed a number of personnel files for current directors and saw that this process had been completed in line with the requirements including the annual self declaration. The team were informed that contracts for board members were being adjusted to include a requirement to notify of any relevant issues as they arose between the annual declarations. Fit and Proper Persons requirements would also form part of the appraisal of all board members.

Public engagement

- Trust strategies, including the Quality Improvement Strategy, referred to patient engagement and involving them at an early stage in the design of services. Patients and lay representatives were included on committees. Significantly the Patient Experience Committee, which reported to a sub committee of the Board, was chaired by a patient and was recognised as an effective committee that was having an impact. A Patients Council has been operating for over 12 months, chaired by a shadow governor and attended by the Director of Nursing. The Council was providing good challenge and had been consulted as part of the complaints improvement plan.
- Members of the public were directly engaged and involved through volunteering at the trust. At the time of the inspection there were over 600 volunteers actively involved at the trust. Volunteers undertake a range of roles including supporting patients to eat their meals and supporting families who have relatives in critical care.

- The trust has both governors and members from the time when it was preparing to become a foundation trust. The trust maintains governor and member areas on its website and continues to engage with them. Some of the shadow governors are involved on trust committees.

Staff engagement

- The trust had a programme of engagement as part of the response to the 2015 staff survey. This included a series of " Big Conversations" with staff on four key area as follows -
- Appraisal: working to improve the quality of experience in the appraisal process
- Sense of staff feeling valued and recognised – helping to build the Trust as workplace where staff feel valued for their contribution.
- Raising concerns: supporting a culture where staff feel safe to speak up and concerns are acted upon.
- Flexible working: encouraging ways of working to help staff balance work and home-life.
- At the time of the inspection this programme had engaged with around 600 staff across the four topics. The conversations had been held in a range of ways, from setting up 'Big Conversation' stands and talk to staff, visits to areas, emails and postcards. The feedback is informing a programme of changes and improvements and is being run through the Human Resources and Organisational Development teams.
- With plans to improve staff wellbeing and increase the facilities there had been a recent staff story at the trust board where more detail on the plans had been presented.
- The trust introduced a staff council, called "Your Voice" in July 2015. It meets every couple of months and hosted by the chief executive. Attendance has varied but is usually about 20 people and usually non-clinical staff. The HR team said they wanted to encourage clinical staff to attend and were reviewing the times that the council met to make this easier.
- A staff volunteering programme was in the process of being introduced in response to feedback at the staff council. Some staff who are not involved directly with patients expressed a wish to volunteer, for example supporting patients to eat, in order to feel closer to the work and purpose of the trust. Training was being arranged to enable this to start.
- There was evidence of good engagement with staff side and that relationships have improved with the arrival of the new HR director. Staff side can see their influence on policies and also on getting key policies such as the sickness policy reviewed. At

the previous inspection staff side were not involved in any bullying cases and there had not been any for some time. Although this was not flagged in the last staff survey there had been an increase in the conversations about bullying but these tended to be peer or upwards bullying and not managers towards staff. Staff side reported an increase in the sense of pressure within the trust which they put down to continuing and significant financial pressures and the uncertainties caused by the success regime.

Innovation, improvement and sustainability

- The Trust's Rheumatology Team had won the General Medicine category at this year's Health Service Journal Value in Healthcare Awards, for an innovative patient-led appointment system, known as the Direct Access service.
- The trust had appointed a clinical procurement nurse whose role was to focus on making savings in a range of areas. Project work had included a review of clinical waste and recycling in theatres where recycling had increased by 50%.
- The trust had had significant financial challenges for a number of years and was operating in one of the most challenged healthcare economies nationally. Financial leadership and management within the trust continued to be robust and patient centred. The Trust's financial plan for the year was to achieve a planned deficit of £36.5m for the year. This planned deficit is expected to reduce once fully integrated with the Devon Success Regime plan. At the time of the inspection acceptance of the Success Regime plan and its implications for individual organisations had still to be approved by NHS Improvement and NHS England. The board were cognisant of the financial pressures being vigilant that this did not impinge on patient safety and standards of care.
- The team considered that the finance team had made a clear and credible assessment of the situation. There had also been a very positive development in that the conversation within the trust had turned away from any unfairness in the allocation of funding and towards marshalling their forces to take the action that was needed.

Overview of ratings

Our ratings for Derriford Hospital

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

Our ratings for Mount Gould Hospital

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

Our ratings for Plymouth Hospitals NHS Trust

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

Overview of ratings

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.
2. Caring was not inspected as part of this inspection. It was judged as outstanding overall at the previous inspection.
3. We have not included the ratings for Mount Gould in the overall trust ratings. we have aggregated the ratings of the previous inspection to give overall ratings for each service.

Outstanding practice and areas for improvement

Outstanding practice

- A new role had been developed within the acute medical units and the short stay ward to enable medicines for patients discharges to be prepared more efficiently. A pharmacy technician was seen to work proactively and support ward staff with monitoring the prescribing, preparation and delivery of medicines for patients being discharged.
- The access for patients to receive care and treatment on the stroke pathway had improved since our last inspection. The staff team were proactive and consistently reviewed their practice to speed up the time from patient arrival to treatment. We saw evidence of where patients had been taken straight to specific treatment areas and were in receipt of treatment in very short timescales. The staff team reviewed patient treatment pathways with a view to looking at where time could be saved and where any marginal gains could improve patient outcome.
- There had been an outstanding response from the critical care teams and the hospital trust to those areas of concern raised in our previous report. The areas we said the trust must or should improve had all been addressed. Not all were fully completed, particularly where funding was an element of the project, but there had been significant improvement in all areas to patient care, treatment and support.
- The multi-disciplinary working between the hospital and the community services providing end of life care was outstanding. There were processes in place to enable ongoing monitoring of patients in the community and where possible prevent avoidable admissions to hospital.
- The multi-disciplinary working between the hospital staff and the chaplaincy enabled the ongoing parochial and spiritual support of patients and their families at the end of life. Staff felt supported by the chaplaincy and the support provided to patients, whilst not always recorded, was creative in its endeavour to meet the needs of patients at the end of life.
- The use of prompt cards in outpatient areas to give staff easy access to phone numbers and processes involving safeguarding and the management of patients with complex needs.
- The training provided to vascular surgeon trainees by the radiologists to ensure a good understanding of the risks associated with the use of radiation.
- The use of radiologists on the critical care unit to ensure instant information to the clinicians on the unit and to have quick reporting times and added opportunities for learning.
- The use of a mobile phone application in the psychology service to assist in patient initiated contact clinics. This reduced the demand for the clinics and encouraged patients to manage their own care.
- Utilising a patient liaison radiographer to facilitate 'first day chats' in radiotherapy giving more time to patients and to allow the treatment radiographers to have a lessened workload and to ensure the smooth running of the radiotherapy machines.
- The audit processes used (through the fundamentals of care audit and the departmental nursing assessment and assurance framework) to gain oversight and assurance of individual outpatient clinics and diagnostic imaging areas adherence with the regulations in the health and social care act 2010.
- The pathway for patients requiring live-donor kidney transplantation in diagnostic imaging. This ensured that all pre-operative procedures (including a nuclear medicine scan, a chest X-ray, an ultrasound scan and blood tests) completed on one day.
- The diagnostic imaging department achieving Imaging Services Accreditation Scheme accreditation and having ISO accreditation recertified.
- At Mount Gould, the results from programmes of audit in some specialities were being used to develop and improve services for patients and strengthened working relationships in both clinical and administrative teams had led to further improvements in the delivery of outpatient services across the trust.

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

- Formalise the recordings of meetings in the emergency department to ensure adequate assurance that the relevant persons are attending and discussions are held to identify learning points. Also ensure actions are recorded and allocated to a person who can progress the actions and progress is monitored.
- Review performance data in the emergency department to ensure it is accurately captured and reported, allowing adequate monitoring and scrutiny.
- Ensure safeguarding training for staff in the emergency department and across all areas is completed to ensure trust compliance targets are met.
- Ensure the paediatric early warning score is implemented fully and used consistently to ensure children are safely assessed and managed.
- Continue to work with commissioners and the local mental health service provider to ensure mental health patients arriving at the emergency department receive the care they require in a timely manner.
- Continue to ensure the emergency department's four-hour performance improves, with an ultimate aim to achieve the 95% standard.
- Review the storage of intravenous fluids in the emergency department to prevent tampering.
- Ensure that equipment stored on wards and in corridors does not obstruct or impede the access to and through fire exits.
- Ensure all equipment in all areas and specifically the emergency department is maintained in accordance with the trust's service schedule.
- Review the available storage to patients who self-medicate and retain their own medicines on the wards.
- Make sure that medical records are stored securely overnight in the oncology outpatients department.
- Ensure audit programmes associated with end of life care are carried out in line with the plan and within reasonable timescales, and that actions and improvements are reviewed.
- At Mount Gould, reduce the number of clinics cancelled with less than six weeks notice and reduce the numbers of patients waiting past their to be seen date, capturing the reasons for the delay.

Please refer to the location reports for details of areas where the trust SHOULD make improvements.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(1) Care and treatment must be provided in a safe way for service users. 12(2) without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include (a) assessing the risks to the health and safety of service users of receiving care or treatment (b) doing all that is reasonably practicable to mitigate any such risks (g) the proper and safe management of medicines The emergency department's four-hour performance target of 95% was not being met. Mental health patients arriving at the emergency department did not receive the care they require in a timely manner. Paediatric early warning scores were not being completed or acted upon in all cases. Safeguarding training for staff in the emergency department was not meeting trust compliance targets. Intravenous fluids in the majors and minors preparation area were stored in an unlocked cupboard. Intravenous fluids, including various presentations of glucose, sodium chloride and compound sodium lactate, are vulnerable to tampering and should be kept in a locked store. While the preparation area was not in a public thoroughfare, it was not observed at all times and unauthorised persons could have gained access without

This section is primarily information for the provider

Requirement notices

being challenged. We asked one of the senior nurses about this and were told the pharmacy department had approved this; however, there was no risk assessment or mitigating actions available.

There was not secure storage on wards where patients who self-medicate retain their own medicines.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment 15(1) All premises and equipment used by the service provider must be (d) properly used (e) properly maintained Not all equipment in the emergency department was serviced in accordance with service schedules. Of the 650 items of equipment recorded on the trust's service schedule as being in the emergency department, 401 items (61.7%) were out of date. 290 items (44.6%) had last been serviced in 2014 or earlier, despite having a 12-month service schedule. There were 12 items of equipment that had not been serviced since April 2009. This meant equipment was at risk of failing, potentially delaying patients' care and treatment. In the clinical decision unit the wall-mounted oxygen flow meters and suction gauges were all overdue servicing by more than 12 months. The unit manager told us this had been raised with the medical equipment management service but they had been unable to provide a date for when the servicing would be completed. Equipment stored on wards and in corridors could obstruct or impede the access to and through fire exits.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements of this part.

17(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to

(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

(d) maintain securely such other records as are necessary to be kept in relation to the management of the regulated activity.

(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e)

Governance meetings in the emergency department were not recorded accurately in minutes to provide assurance that learning points were identified and actioned, and that progress was monitored.

Data relating to the performance of the emergency department was not recorded consistently and did not provide adequate assurances.

While we did not observe any triage delays, the data for patients who self-presented was inconsistently recorded.

Data provided by the trust showed the initial assessment time from ambulance arrival was consistently within one

Requirement notices

minute. However, the manner in which the data was entered into the system failed to consider the time the patient was waiting before the nurse in charge took the handover.

Patient records were not stored securely at all times. These should only be accessed and amended by authorised people.

A significant number of clinics were cancelled and the provider did not consistently capture the reasons why clinics are cancelled with less than six weeks notice.

A significant number of patients were waiting past their to be seen date on follow-up and pending waiting lists.

In oncology outpatient records were stored in unlocked trolleys which were stored overnight in an unlocked clinic room. Although the building locked at 7pm there was no one monitoring the notes before the time.

End of life audits were not all carried out in line with the planned programme and the implementation of change was not reviewed for some audits.