University Hospitals Plymouth NHS Trust

Derriford Hospital

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Outstanding**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Derriford Hospital

Requires Improvement 

University Hospitals Plymouth NHS Trust is the largest hospital trust in the south west peninsula and is a teaching trust in partnership with both Plymouth University Peninsula Schools of Medicine and Dentistry and the University of Exeter Medical School. They also support the Universities of Plymouth and Exeter in the delivery of courses for the Faculty of Health and Social Work.

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, deployed operations and oversees the treatment of military personnel within the trust.

The trust provides secondary and specialised healthcare to people in Plymouth, North and East Cornwall and South and West Devon. The catchment population for secondary care is 450,000 with a tertiary care role for almost two million people in the south west of England. The majority of these services are provided at the Derriford site.

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 three neonatal care provider.

We carried out a short notice announced focused inspection of medical care (including services for older people) and urgent and emergency care at Derriford Hospital on 20 and 21 September 2022. This was to check the trust had made improvements since our last inspection in 2021 and because we had concerns about the quality of services.

At our last comprehensive inspection, we rated medical care and the trust overall as requires improvement. Urgent and emergency care was not rated.

We visited Derriford Hospital during a period of significant and sustained pressure on urgent and emergency care and medical services across the UK. The pressures at Derriford Hospital were largely due to limited availability of social care beds and packages of care in the community which has impacted on the number of medically fit patients able to be discharged into social care facilities. This impacted on flow throughout the hospital causing patients to experience long delays when awaiting to be admitted into the emergency department and onto a medical ward, once a decision to admit had been made.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Medical care (including older people's care)

Requires Improvement 

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service did not always have enough staff to care for patients and keep them safe.
- Staff training did not always meet the trust compliance target.
- Medicines were not always well managed to keep patients safe.
- Patients did not always receive treatment in the right speciality ward or area.

However:

- Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- The service planned care to meet the needs of local people, took account of patients' individual needs and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

Requires Improvement 

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff but not everyone completed it.

Some staff did not keep up-to-date with their mandatory training. Training information we reviewed showed 73% of staff had completed resuscitation training, which was a deterioration since our last inspection in 2021. Advanced life support and immediate life support training showed 47% and 54% of staff had respectively completed this training. Manual Handling compliance training had improved and were mostly above 80%.

Managers monitored mandatory training and alerted staff when they needed to update their training. However, we were told staff did not attend the training that was offered. Staff on the wards we visited told us they were very busy on the wards and often did additional shifts which impacted on their ability to attend training.

Medical care (including older people's care)

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had access to training on how to recognise and report abuse but did not always complete it. Staff knew how to apply the principles of safeguarding.

Not all staff had completed safeguarding level two and level three in adults. For example, in acute medicines, 90% of nursing staff had completed certificate level one training in safeguarding, 87% of medical and nursing staff had completed safeguarding level two but only 7% of nursing staff had completed level three. In most areas of medical care, safeguarding adults level one and two were mostly below 90%, but safeguarding adults level three was particularly poor for both medical and nursing staff ranging between nought and 33%. This was not in line with the Royal College of Nursing intercollegiate document.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff were able to describe how they supported patients with protected characteristics to provide person centred care.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had access to policies on the computer systems and could access the safeguarding team if they needed advice. Staff were knowledgeable about the trust's safeguarding adults at risk policy and processes and were clear about their responsibilities. They described what actions they would take should they have safeguarding concerns about a patient. All staff were confident to take action to ensure the safety of patients.

The safeguarding children and safeguarding adults leads fed into a quarterly steering group which the deputy chief nurse chaired. They presented a quarterly and annual report of activity to the steering group. The safeguarding lead for adults also represented the trust and were accountable, and present at partnership meetings for Cornwall and Devon. They explained that these meetings were limited for the Devon area but advised they did attend if they were invited.

Staff followed safe procedures for children visiting the ward. The trust provided information to staff within safeguarding policies and procedures of the action to take when they had concerns about child protection and domestic abuse. The Deprivation of Liberty Safeguard lead attended bi-monthly safety and quality committee. The safeguarding lead for children attended mortality and morbidity meetings where they looked at trends and themes in safeguarding referrals.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. In all areas we visited, the floors, walls, curtains, trolleys and areas in general were visibly clean. However, some corridors were cluttered with equipment.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. There were dedicated teams of cleaning staff who ensured the areas were clean and tidy. There were daily schedules and weekly tasks, alongside deep cleaning as and when required. Cleaning staff were able to show us their work schedules. Cleaning equipment was colour coded, clean and well maintained, and stored in a locked area.

Medical care (including older people's care)

Staff followed infection control principles including the use of personal protective equipment (PPE). There was clear guidance for staff around what PPE they needed to wear. Nursing and medical staff washed their hands and applied hand sanitiser gel between each patient contact. We also saw non-clinical staff, including reception and administrative staff and cleaning staff using hand gel.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used green 'I am clean' stickers to label when equipment had been cleaned. We saw this used in all wards we visited.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

During our inspection, the wards we visited were visibly clean. However, we found corridors on Stannon and Braunton wards cluttered with equipment. There was equipment on Braunton ward blocking fire exits. On Stannon ward we found a medicines cabinet that was faulty and did not lock properly. These issues were raised with the chief nurse who advised actions were taken to address these immediately.

Patients could reach call bells and staff responded quickly when called. Patients we spoke with told us staff responded in a timely way when they called for assistance.

Staff carried out daily safety checks of specialist equipment. All wards had completed daily checks in line with local requirements and royal college of emergency medicine recommendations.

The service had enough suitable equipment to help them to safely care for patients. We saw a range of equipment was readily available and most staff said they had access to the equipment they needed for the care and treatment of patients.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Patients were monitored and assessed using the National Early Warning Score (NEWS2) framework. This was a system of monitoring patient's vital signs, such as temperature, respiration rate, blood pressure and pain. A score was calculated, and actions were advised for nursing staff according to the score. A patient whose condition was deteriorating could be identified and their condition escalated for further medical review. Records we reviewed showed this was completed correctly and in a timely way.

Staff responded promptly to any sudden deterioration in a patient's health. Staff knew about and dealt with any specific risk issues. We saw evidence of patients whose condition was deteriorating, being escalated for medical review in line with guidance.

The sepsis protocol was embedded within the service and there was a dedicated sepsis policy within the Essential Adult Inpatient Observations, Reporting and Escalation Policy.

Medical care (including older people's care)

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Nursing staff completed risk assessments on admission. Each patient had a suite of risk assessments/screening undertaken to ensure their safety could be maintained e.g. falls, pressure ulcers, venous thromboembolism (VTE) (blood clots that can develop deep in the veins of the body), nutrition and dementia.

Staff knew about and dealt with any specific risk issues. Nurses worked to reduce the risk of patient falls by placing patients at the highest risk of falls in bays where they could most easily be observed. The service had implemented a system where staff were designated to bays where patients were at risks of falls. They wore a bright coloured lanyard so other staff could identify they were designated to these areas so they could avoid being called away. However, due to staff shortages on most days, staff often had to support the rest of the ward instead of keeping oversight of their designated bays. Staff completed a frailty score for each patient on an electronic system on admission. Frailty scoring was used to assess older people's mobility and ability to live independently and complete the tasks of daily living.

The service had 24-hour access to mental health liaison and specialist mental health support. The mental health liaison team told us there were two mental health support workers who attended the wards and provided support and advice to the medical care team. Most staff we spoke with reported timely access to mental health support.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. Doctors and nurses attended daily morning safety briefings to ensure important information was shared between staff.

There were daily matrons' meetings to discuss a wide range of information across the medical care group. This included: escalation beds; significant events such as falls and acuity; a review of harm events; infection prevention control issues; COVID-19 patients; challenging behaviour and deteriorating patients. Audits were also reviewed, together with staffing for day and night; discharge exchange and the safety status.

Staffing

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank staff a full induction.

The service did not always have enough nursing and support staff to keep patients safe. Ongoing recruitment and staff development was a high priority, however, the trust continued to experience shortage of staff due to sickness absence.

Staffing ratios were closely monitored and risk was balanced across the care group to all areas based on patient risk profiles and acuity.

The trust had also implemented a number of incentives to encourage staff to work in other areas of the service where they were short staffed.

Managers accurately calculated and reviewed the number and grade of nurses, nursing associates and healthcare assistants needed for each shift in accordance with national guidance. A daily matron huddle scrutinised staffing and acuity to adjust staffing shortfalls across the care group. Ward managers used an acuity tool to measure staffing and

acuity accurately and reported levels at relevant site meetings. This worked on a red, amber, green (RAG) rating basis, identifying where there was cause for concern. This tool was combined with professional judgement to ensure safe care was being provided to patients. Real time data of actual staffing levels and patient acuity could be viewed, and staff redeployed as required.

The ward manager could adjust staffing levels daily according to the needs of patients. Staff were re-allocated to areas where there were staff shortages. The number of nurses and healthcare assistants did not always match the planned numbers. We were told by staff when the ward had full complement of nurses, staff were often moved to other areas of the hospital. This had led to a number of staff leaving or being sick.

The service continued to be under significant pressure and had seen a steady increase in vacancy rates. Information from the trust showed vacancy rate for nursing staff was 8% across medical care. This was an increase since our last inspection where we reported vacancies was 7% in August 2021. In their August 2022 integrated performance report, the trust reported an increasing turnover rate at 12% in June 2022 across the trust.

The service had a reducing sickness rate. Information from the trust showed between September 2021 and August 2022, nursing staff within medical care had an average sickness rate ranging from the highest in gastroenterology at 9% to the lowest at 4.5% in nephrology and transplantation. In most areas, sickness rates had reduced over the last 12 months. For example, in thoracic medicine, sickness had reduced by 4.8%. In healthcare for the elderly, this had reduced by 4%. The areas which saw the highest increase in sickness absence was endoscopy at 8.3%. The trust reported the continued sickness rates was due to stress and anxiety and more recently, because of a spike in Covid-19 cases.

While the service used bank and agency staff to fill gaps in rotas, they were not always successful in filling those shifts. The trust reported a continued deterioration in fill rates between July 2021 and June 2022. Overall, across the trust, 75.5% of shifts were filled in June 2022 compared to 88.8% in July 2021.

Managers requested bank and agency staff familiar with the service. We observed bank staff being used on one of the wards who was familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. At the time of the inspection, there were 369 full time equivalent (FTE) medical staff employed by the medical care group against a budget of 372 FTE. There was a vacancy of 3 FTE medical staff.

The medical staff matched the planned number. We spoke with six junior doctors who told us there was good medical cover across medical care.

The service had low and reducing vacancy rates for medical staff. The trust reported in their integrated performance report for August 2022 that 20 new medical staff joined the trust in May 2022.

Sickness rates for medical staff were steadily increasing. Information from the trust showed between September 2021 and August 2022, medical staff within medical care had an average sickness rate ranging from the highest in healthcare

of the elderly at 5.74% to the lowest at 1.5% in nephrology and transplantation. In most areas, sickness rates have increased over the last 12 months. For example, in thoracic medicine, sickness had increased by 1.9%. In gastroenterology services, this had increased by 1.3%. The areas which saw the highest decrease in sickness absence was diabetic and endocrinology at 5.25%.

The service had reducing rates of bank and locum staff. The trust continued to actively recruit to vacancies and had implemented a new system for recruiting medical staff to streamline the process and to ensure recruitment processes are undertaken in a timely way.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work. The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. We reviewed four records and saw they were comprehensive and contained key information. Staff used paper records for medical and nursing notes. They also had access to an electronic system.

When patients transferred to a new team, there were no delays in staff accessing their records. Nursing, and medical notes moved with patients when they moved wards. Staff used a handover document to inform the new ward of the patients' needs.

Records were not always stored securely. On Braunton ward we found an unlocked computer on a corridor trolley that was accessible to anyone on the ward. While access to the ward was restricted, there was a risk that anyone on the ward at the time could access the information on the computer. We raised this with staff on the ward who took swift action to lock the computer.

Medicines

Systems and processes for the safe management of medicines were not always effective.

The systems and processes to check expiry dates and storage of medicines were not always effective. Medicines refrigerators and treatment room temperature records showed medicines were stored at the correct temperatures. There were weekly medicine audits where all medicines were checked, discarded if out of date and reordered. However, we found a number of discrepancies which were highlighted to staff during our visit. We found 18 boxes of medicines out of date. These were found on Thrushel ward, the discharge lounge and Stannon ward. A number of the medicine storage cabinets on Staunton ward, a care of the elderly ward, did not lock due to the mechanism being faulty. The trust provided assurance that actions were being taken to rectify these immediately.

Medicine supply to wards was managed from the main dispensary supported by a robotic dispensing unit that managed both named patient and ward stocks. Ward based clinical pharmacy teams worked to ensure medicines were prescribed safely and in a timely fashion from admission to discharge, and that patients had the information they required relating to the medicines they took home.

Medical care (including older people's care)

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff completed medicines records accurately and kept them up-to-date.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff knew how to report incidents or near misses on the trust's electronic reporting system. Staff felt confident in raising an incident should they need to. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

The trust acted rapidly following alerts or highlighted risks to ensure patients were kept safe. Procedures were amended in line with any National Patient Safety Agency alerts and changes in guidance.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. All incidents were reported directly onto the incident reporting system. This provided a single record of each incident, subsequent investigation, agreed learning, and evidence of the learning and its effectiveness.

Staff reported serious incidents clearly and in line with trust policy. There were systems to make sure incidents were reported and investigated appropriately. Staff were open, transparent and honest about reporting incidents and said they would have no hesitation in reporting incidents and were clear about how they would report them. All staff received training on incident reporting. Staff said they were encouraged to report incidents promptly.

Staff understood duty of candour. Staff we spoke with demonstrated a clear understanding of duty of candour and discussed how they would be open and honest with patients when things went wrong. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

We did not see any examples where duty of candour had been applied during the inspection however, staff demonstrated an understanding of their responsibilities and could describe the process and what they would do.

Staff received feedback from investigation of incidents, both internal and external to the service. Learning from incidents started at the point where the event happened, with any necessary local action being taken to minimise a similar event from reoccurring.

Staff met to discuss the feedback and look at improvements to patient care. Staff we spoke with told us learning from incidents was discussed at morning safety huddle meetings and details of learning from significant incidents was shared across the trust through emails and debriefs.

Managers debriefed and supported staff after any serious incident. Most staff confirmed they received feedback after reporting an incident and an action plan was shared. Learning was shared using a variety of methods. There was an immediate response and any local action taken to help prevent a reoccurrence and formal feedback methods such as team meetings to help spread any learning from events. However, a number of staff reported that they did not have time to read all the various communications due to the increased pressures on the ward.

Medical care (including older people's care)

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population.

All aspects of performance continued to be affected by the lack of available beds across the hospital. The trust demography covers three main local authorities, Devon, Plymouth and Cornwall. The trust bed base continued to be affected by patients who were fit for discharge but there were no available beds in the community for their ongoing care.

Trust data showed delayed discharges had increased from 7% in 2021 to 11% in August 2022. In April 2022 this rose to 14%.

Managers worked with the wider health care system to plan care and deliver services. The clinical site team held daily meetings with the wider healthcare system to understand demand and to request or offer mutual aid.

Service leaders told us that the number of patients having falls had increased since January 2022. They had made a number of changes and steps to improve. These included analysing incidents and Root Cause Analysis (RCA) to establish themes and trends. Some of the actions implemented included introducing yellow wrist bands for patients who are at higher risks of falls so they could be identified easily. Learning events were also held to raise awareness among staff on the impact on patients when they have a fall. The trust also introduced yellow lanyards for staff who were assigned to bays where patients were at higher risks of falls. This would ensure those staff were easily identified and were not called away from their duties. We were told rates of falls in August were better than last year.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Patients were cared for in either female or male bays wherever possible.

Facilities and premises were mostly appropriate for the services being delivered. Most ward areas we observed were appropriate for the care being provided. They had adequate space and access to equipment. However, some parts of the hospital were challenged in terms of the size of the wards, to meet the demand for services. As a result, some areas were cluttered and lacked sufficient storage. On the stroke ward, we found an additional bed had been placed in a bay which did not allow sufficient space to access the sink. On two medical wards, we found patients had been moved from the emergency department and were cared for in the corridor of the wards while awaiting patients to be discharged.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff told us they knew how to request services and there was not an issue with accessing these in a timely manner.

Medical care (including older people's care)

The service had systems to help care for patients in need of additional support or specialist intervention. Specialist nurses were available to ensure additional support or intervention was provided, for example diabetes and frailty nurses.

The service relieved pressure on other departments when they could treat patients in a day. We saw initiatives within specialities to support patients who could be safely discharged from the service. The frailty team included a consultant, nurses, physiotherapists, occupational therapists and a pharmacist to support older people to prevent admission or support timely discharge wherever possible.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff we spoke with, especially on speciality wards caring for older people, were understanding of the needs of patients living with dementia. We observed staff being compassionate when interacting with older patients. Patients we spoke with told us staff were kind and caring and responded to their needs in a timely way.

Wards were designed to meet the needs of patients living with dementia. We observed clear signage throughout patient areas on wards. For example, pictures as well as words being used to show where toilets were located. However, the design, colour scheme and signage in the discharge lounge were not suitable to meet the needs of patients living with dementia. The corridors in one of the wards caring for older people were cluttered with equipment.

Access and flow

People could not always access the service when they needed it and did not always receive the right care promptly.

The trust faced challenges with access and flow which meant they could not always ensure patients accessed the service when they needed it, and to receive timely treatment. Some of the challenges were beyond the control of the medical care group. The medical care group remained under significant pressure and the issues driving this were beyond the control of the service and the trust.

Patients could not always access and receive treatment in the right speciality ward or area. However, this was improving. The hospital monitored the demand on its service. The Operational Pressures Escalation Framework (OPEL) detailed how the trust identified and responded to pressures within its system daily, as well as at times of extraordinary pressure. This framework related to adult beds and included medical beds. Each day bed meetings took place to review the flow of patients through the hospital.

On the days we carried our inspection, the trust was at the highest escalation level, OPEL four. Since the last inspection in September 2021, the trust had mostly been in this highest level of escalation. This indicated the high level of pressure the hospital had been under.

The care group and system partners were working collaboratively to address issues around flow. Recently, issues around flow had been compounded by increased attendances, high acuity resulting in more admissions, staff absence as a result of COVID-19 sickness and isolation and/ or stress, and system wide issues relating to community beds or packages of care in the community.

The team were committed to identifying the best way of doing things and standardising processes. On the second day of our inspection, the trust implemented their pre-planned action which was to introduce a new boarding model to aid flow from the emergency department to the rest of the hospital. This model had been used in another hospital trust and Derriford hospital had adapted this to meet their needs. The trust had reviewed the average number of patients they discharged daily and would move the same number of patients from the emergency department (ED) to the ward ahead of discharges having taken place. Patients who were ready for discharge on the day and were waiting for their medicines and/ or transport were transferred to the discharge lounge or to a waiting area on the wards that had this available. Patients transferring from ED would then take the bed space of patients who were planned to be discharge on the day. This system was implemented three times a day.

Data from the trust showed a decreasing trend in medical outliers from 979 patients in March 2022 to 455 in August 2022. We spoke with the medical care triumvirate who told us medical staffing had improved which had led to a reduced number of outlier patients.

Staff told us the discharge lounge did not work effectively. Patients often waited a long time before they received their medicines to take home because there was not an effective way for pharmacy staff to be made aware if patients had moved from the ward to the discharge lounge. This often resulted in delays for patients to be discharged.

Managers and staff worked to make sure patients did not stay longer than they needed to. The referral processes to the acute assessment unit from the emergency department had been streamlined. This ensured same day emergency care patients were cared for in the correct environment from the outset and length of stay was reduced. Managers and staff started planning each patient's discharge as early as possible. We spoke with the discharge to assess team who told us patients were referred as soon as there was a plan for discharge and they would assess the patient's needs for when they went home. They would link with community staff such as physiotherapists and occupational therapists, so their ongoing needs were met in the community.

Managers monitored that patient moves between wards/services were kept to a minimum.Staff tried to avoid moving patients between wards at night, but this did occur in times of increased demand. Staff told us they were aware this was against trust policy and reported when this did occur as an incident so it could be monitored.

During the period from July 2021 to June 2022 there had been 1385 overnight moves. However, there had been a significant decrease since March 2022 where 164 moves took place to 113 in April, 87 in May and 68 in June. Part of the trust new flow model was aimed at moving patients earlier in the day so overnight movement would be reduced further.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. However, we were told some care homes would not accept patients early in the morning or later in the afternoon. Patients had to be discharged within a short timeframe during the day for care homes to accept the patient. This created challenges for the medical team if patients' medicines were not ready or if there were transport issues.

Escalation systems in the trust worked on a bronze/silver/gold schedule. This meant meetings were held throughout the day to review flow and take action when required. The escalation process was continuous throughout the day and ensured staff at ward, management and board level were aware of the current flow situation.

There was also a "go live" team who provided advice and support on the new flow model so any learning could be captured. Staff could also contact the team for advice if there were any issues when boarding patients on the wards.

Medical care (including older people's care)

Data provided by system partners showed the trust was not meeting the target for discharging patients who did not require further ongoing care. For example from 1 September to 30 September 2022, against a discharge target of 114 patients per day, the trust on average discharged 101 patients.

Although the trust had implemented a number of actions to improve flow through the hospital and to decompress ED, they remained under significant pressure due to the lack of available beds within the hospital to accommodate the number of patients accessing the service. This was exacerbated by the number of available community beds, care packages and social care beds so patients could be safely discharged. This also had an impact on staff wellbeing who continued to work under pressure.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. However, staff reported they were not always visible in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The leadership team of managers, medical and nursing staff clearly understood the challenges in restoring the service and delivering good quality care. They had the right skills and abilities to run the service providing high quality and sustainable care. The consultants and heads of nursing were an experienced team with a commitment to the patients who used the service, and to their staff and each other. It was an integrated team with an emphasis on providing consistent and high-quality care.

Staff reported leaders were not always visible on the wards however, they were able to escalate concerns and feedback through the ward managers and the matrons. On the day of the inspection, we observed the chief executive officer visiting the medical wards. The executive team were clear on the risks the hospital faced and worked closely with system partners to find solutions. During our inspection we interviewed the medical care group triumvirate and local leadership. They were able to tell us about current challenges and how they were addressing them. For example, they had been successful in reducing the number of patients who were medical outliers by increasing the medical workforce so there was more capacity within the service to review patients.

Leaders had engaged with a number of reviews from stakeholders and valued the feedback they received. They implemented actions where areas of improvements had been identified. The chief operating officer monitored those actions and reported these at relevant meetings with system partners.

Command and control structures were established. System GOLD for strategic overall command of the organisation resources; System SILVER for tactical and operational command and managing the response to an incident; and System BRONZE for operational command for managing the main working elements of the response to an incident. We observed SILVER command on one occasion was used as a situation report instead of actions being taken. However, this changed on the following day where we saw that actions were agreed and delegated accordingly.

We spoke with staff who had been supported to undertake additional training and develop their skills. For example, a health care assistant was supported to undertake the nurse associate training. They were complementary of the support they had received during their training and to enable them to undertake this role.

Culture

Staff felt respected, supported and valued by their immediate line managers. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture and staff felt able to raise their concerns, but often felt discouraged when they saw no change or improvement.

Staff we spoke with told us they were respected, supported and valued by their line managers. They were able to raise concerns, however, they did not feel actions always had the desired outcomes. For example, ward staff felt they were continuously running below planned numbers of qualified staff and when they managed to fill all shifts, staff were moved to other areas.

In a number of areas we visited, staff morale was low. This was due to staff shortages and the significant pressures on the service. During our inspection, the trust had also implemented a new boarding model when patients would be moved to a ward in advance of a space becoming available three times a day. Staff felt this increased pressure on the ward to make room for new patients being admitted. While the trust sent various communication on the actions that were taken and their rationale, staff told us they did not always have time to read all the communications that were sent as they were very busy caring for patients, managing discharges and patients moves.

The leadership team were aware of the impact of moving staff had, but explained they had to make tough decisions to balance the risks across wards and other departments. In response, a number of incentives had been introduced to encourage staff to be flexible in the areas they work.

There were co-operative, supportive, and appreciative relationships amongst staff and teams worked collaboratively. There was a mutual appreciation of roles between medical, nursing, and allied health professionals and we observed good team working.

The therapies team expressed challenges they had faced throughout and following the pandemic. For example, challenges with maintaining social distancing or space. Staff explained they were asked not to write notes on wards and not have therapy multi-disciplinary meetings in ward spaces. This had posed a challenge as meetings could be delayed while suitable alternative space was sought. The team were working to improve relationships by having regular meetings with ward managers and matrons. This was intended to improve understanding and benefits of therapies. Staff felt this was improving but still had some work to do.

Staff we spoke with were passionate and committed to providing high quality care for patients.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a clear governance structure driving change. Staff at all levels were clear about their responsibilities, roles and accountability within the governance framework.

Medical care (including older people's care)

There was a clear performance management reporting structure with monthly governance meetings looking at operational performance. This included a review of incidents reported, complaints, staffing, audit status, infection control, risks identified on the risk register and risk management, and education and training.

Policies were readily available on the intranet supported by standard operating procedures and processes.

The care group triumvirate met on a weekly basis to review service-related issues and to agree any immediate actions to address quality and safety. Service line managers had daily huddles and monthly executive performance led reviews with the care group triumvirate and presented at the care group quality assurance group.

Meetings were well attended by individuals with the appropriate level of seniority for decisions to be made. There was a standard agenda, which ensured discussion of clinical incidents and patient experience, as well as assurance reports from specialities within the care group.

We reviewed meeting minutes and saw there was a sufficient level of detail to document the conversations that had taken place and the decisions made.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The trust had systems for identifying risks and plans to mitigate or reduce them. The service maintained a local service level risk register which clearly identified individual risks and the action taken to mitigate the risks. The position was monitored by the clinical governance lead and matrons at monthly meetings. Information was presented to the trust board to provide assurance.

Risk management performance was presented at a dedicated care group risk management committee as part of a rolling schedule where teams presented to the committee. The risk management committee was also where serious risks were approved

The trust used a board assurance framework to provide information about severe and very likely risks, these included risks related to the new boarding model and bed capacity.

The service monitored the effectiveness of care, treatment and performance. The service took part in national and local audits and evidence of improvements or trends were monitored. Performance data and quality management information was collated and examined to look for trends, identify areas of good practice, or question any poor results.

Mortality rates were monitored and reviewed regularly with quarterly executive summary reports outlining the data and learning lessons from unexpected deaths.

The trust kept a dashboard to monitor performance data. This data was collated to determine the current performance. This information was presented to the trust board and system partners to provide assurance.

There were local contingency plans for the service where there were significant capacity and staffing issues, and problems with equipment. Actions were described for staff to follow and escalate depending on the status of the situation.

Medical care (including older people's care)

The trust had implemented a new system to streamline approval of business cases for the recruitment of medical staff. This meant there was a more efficient way for signatories to approve various levels of the process and reduce the length of time from business case proposals to recruitment.

The trust had worked with the NHS England and Improvement national team to focus on actions to improve discharge. This included clinically led planning for discharge and requesting patients' medicines on the day before discharge were due to take place.

The medical director was working with the care group clinical directors and senior medical staff to implement an internal professional standard to promote an understanding of each departments challenges and facilitate closer working relationships.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff had access to information about patients to ensure they had sufficient and up-to-date knowledge to provide safe care and treatment. All staff had access to the trust's intranet, which contained the information and guidance for staff to carry out their duties. Staff we spoke with were familiar with the trust intranet and knew where to find the information they needed.

The main information screens on wards had notifications to communicate with staff about the trust escalation levels, the number of patients awaiting a bed from the emergency department and the number of ambulances waiting to offload patients.

The therapies team expressed challenges due to the need to input patient data on four to five different systems for each patient. They told us it was frustrating that systems do not all talk to each other and the additional replication of information took up valuable time. We were told that this had been escalated through governance processes as it impacted the service delivery capability of the therapies team.

During the inspection we saw most records were kept securely. Paper records were stored in lockable trolleys or in rooms with restricted access. However, we observed a computer was left unlocked and unattended in the ward corridor. While access to the ward was restricted, there was a risk patients or visitors who were already on the ward could view information on this laptop. Ward staff took immediate action to secure this computer once we raised this with them.

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service had recently separated the AAU (Acute Assessment Unit) and frailty lead roles. A staff review survey showed that staff were positive about this change, felt more appreciated and had their voices heard.

Medical care (including older people's care)

The service were doing ongoing work with staff to ensure positive feedback was encouraged. For example, the service had introduced 'PositiviTree' to get feedback shared with the teams.

The trust was engaged with system partners and stakeholders to identify improvements and solutions to the significant pressures the service faced.

The 2021 staff satisfaction survey results from the trust showed a deterioration in performance in most areas across the medical care group compared to the results in 2020. The number of staff who responded to the survey in 2021 was 837 compared to 737 in 2020. Forty-seven percent of staff who responded stated they looked forward to going to work. This was a deterioration from the results in 2020 where the result was 57%. Forty-eight percent of staff said they would feel confident the organisation would address concerns about unsafe clinical practice compared to 58% in 2020. In 2020, 62% of staff said they would recommend the hospital as a place to work compared to 47% in 2021.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Medical care (including services for older people):

- The trust must review and improve their processes for monitoring the expiry dates of medicines. They must also ensure medicines are stored securely in all areas. Regulation 12 (2)(g)
- The trust must ensure risks to patients, staff and visitors are assessed and corridors and walkways are kept clear of equipment. They must do all that is reasonably practicable to mitigate such risks. Regulation 12 (2)(b)
- The trust must ensure there is always enough nursing and support staff to keep patients safe and they receive mandatory training including update to meet the trust target. Regulation 18 (1)(2)

Action the trust SHOULD take to improve:

Medical care including services for older people:

- The trust should continue to improve systems so patients are admitted onto the most appropriate specialty ward for their conditions.
- The trust should ensure electronic devices are locked when not in use.
- The trust should identify and implement actions so the discharge lounge can work more effectively.
- The trust should implement improvements so they consistently meet the discharge target for patients not requiring ongoing going care.
- The trust should identify ways to improve staff satisfaction.

Urgent and emergency services

Requires Improvement 

The emergency department at Derriford Hospital is the largest in the South West of England and operates 24 hours-a day, seven days-a-week. It is a designated major trauma centre for adults, providing care for the most severely injured trauma patients from across the South West. Additionally, the department provides trauma unit facilities for children, meaning it can receive and stabilise children prior to them being transferred to an appropriate paediatric major trauma centre.

During the latter part of 2020 the trust introduced senior triage assessment rapid treatment (START) to the emergency department, so there is one entry point to the department for ambulances and those who make their own way. The reception has a seated waiting area and a glass-fronted reception desk with a lowered counter for wheelchair users. A separate seated waiting area exists for patients requiring assessment and treatment of minor illness or injury.

The emergency department has; 7 resuscitation bays, 21 cubicles for major illness and injury, an ambulatory emergency care area and a paediatric area in a dedicated paediatric department. Within the resuscitation area there is an overhead x-ray facility.

The hospital also benefits from an acute assessment unit which houses primary care streaming and frailty care pathways. These are designed to deliver timely care in collaboration with primary care partners and avoid hospital admission where possible.

We inspected and rated the following key questions; was the service safe, was the service responsive and was the service well led. The previous ratings for the key questions effective and caring remain the same.

- We found:
- Staff understood how to protect patients from abuse. The service generally controlled infection risk well. Staff mostly assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed reported safety incidents well and learned lessons from them.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. Key services were available seven days a week.
- Staff treated patients with compassion and kindness and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Departmental leaders were visible and accessible and offered support. Staff were clear about their roles and accountabilities.
- The service engaged with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The service did not always have enough staff to care for patients and keep them safe. There were gaps in nurse and medical staffing, but we saw managers proactively used temporary staffing and were working to recruit into vacant positions.

Urgent and emergency services

- Staff did not always have the time to access training in key skills, and training did not always meet the trust compliance target.
- The trust faced challenges with access and flow which meant they could not always ensure patients accessed the emergency department when needed, to receive timely treatment. Performance data showed delays in patients both accessing the emergency department and waiting to be seen.
- Due to overcrowding of the department, patients were not always treated within an environment that allowed privacy and dignity.
- Capacity of admission avoidance pathways was not always sufficient to divert patients from the emergency department.
- Staff did not always feel valued or respected by the wider organisation.

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had completed their annual training updates.

Nursing and medical staff had access to training specific for their role on how to recognise and report abuse. However, staff could not always be released from clinical duties to attend, the emergency department (ED) did not meet the trust's compliance target for mandatory safeguarding training. We saw 71% of nursing and medical staff had completed training in level two safeguarding adults and 67% had completed level three child protection. Compliance for level three safeguarding adults was significantly lower at 17%.

The leadership team we spoke with told us with recent recruitment, the ED education team was now fully established. The education team supported all areas of training compliance and there were plans to address where safeguarding training was not meeting trust targets. The department also had plans for using their 'military take over' days to support staff training. 'Military take over' days are when medical and nursing staff from the military take over care provision within an area of the ED which allows staff on shift to be covered for education and development.

Staff who required training had been scheduled time to complete their updates and this was factored into the staffing rota for the department. However, this time was not protected when staffing levels were low, and staff would be reallocated into clinical duties. Staff told us they were offered payment for completing training outside of contracted hours.

The department had the support of an internal safeguarding team, and staff knew how to contact them should specialist support be needed.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff showed us how electronic alerts were added to the patient records system to communicate a patient at risk.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were knowledgeable about the safeguarding policy and processes and were clear about their responsibilities. They described actions they would take should they have safeguarding concerns about a patient. All staff we spoke with were confident to challenge to ensure the safety of patients. Staff we spoke with understood which agencies to refer to when a safeguarding risk was present. We saw use of internal and external systems for both adult and children's safeguarding referrals. Details of local safeguarding arrangements were displayed in the department for staff reference. During inspection we saw staff had followed their safeguarding referral policy for a vulnerable patient with safeguarding concerns.

Staff followed safe procedures for children visiting the ward. The paediatric emergency department was co-located within the ED and was appropriate for the care and treatment of children and young people. It was separate from the main emergency department and there was a safe and secure waiting area for children and their families.

Staff we spoke with told us that there were times of lone working for reception staff in this area, and when they were unable to staff the reception, this was closed and paediatric patients were required to check in at the main reception.

Cleanliness, infection control and hygiene

The service generally controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. However, they did not always keep equipment and the premises visibly clean.

Not all areas were visibly clean. The department had suitable furnishings but not all were well-maintained. We saw domestic staff undertaking cleaning and national cleaning audits showed good compliance over the previous six months. However, we saw bodily fluids dried on an assessment couch, some seating showed signs of damage and staff we spoke with told us the toilet facilities were often unclean.

Staff generally followed infection control principles including the use of personal protective equipment (PPE). We saw staff follow the five moments of handwashing, and all staff we saw were bare below the elbow. PPE was available in all areas, and staff used PPE such as gloves and aprons when delivering care. There was adequate stock of PPE throughout the department.

Managers monitored hand hygiene compliance. Of 318 observations from 1 June 2022 to 31 August 2022, 5% of staff did not perform hand decontamination after patient contact. The department conducted hand hygiene assessments to help staff identify poor hand hygiene technique. Infection, prevention, and control was part of the departments core audit programme.

During our inspection we saw staff managing the coordination of a patient waiting in an ambulance known to be COVID-19 positive. All staff were aware of the patient's infection status and the patient was held in the ambulance until an isolation area within the hospital was available. Regular communication was held with the clinical site team to expedite admission to an appropriate area.

Urgent and emergency services

Staff did not always clean equipment after patient contact or label equipment to show when it was last cleaned. During an observation, staff did not clean the treatment equipment between patients. We saw no use of 'I am clean' stickers throughout the department, nor did we see staff clean equipment before use.

We saw the department was preparing for a deep clean of the Majors area which was scheduled to take place after the inspection.

Environment and equipment

Given the lack of patient flow, high number emergency department attendances and limited capacity, staff worked tirelessly to protect patients, but the design and some parts of the premises did not always keep patients safe.

Despite efforts to maximise space in the ED, the environment remained insufficient to meet the needs of patients and placed patients at an increased risk of harm. We observed there was not enough room and resources to cope with the number of patients attending the department. All adult areas were operating over full capacity for the duration of the inspection and were subject to overcrowding.

Patients were in very close proximity to others, waiting in all given spaces inside and outside the emergency department. This not only made working conditions difficult but also negatively impacted on patients' privacy and dignity. In the corridor in majors, we saw staff moving mobile screens to provide some level of privacy for intimate procedures, but there was no room to provide these screens on a more permanent arrangement.

Patients were treated on trolleys in the ED corridor where it was not always possible to ensure patients' privacy and dignity were protected. Patients requiring procedures which might expose them, for example an ECG, were moved and screens were provided to maintain privacy. Some conversations between staff and patients treated in the corridor could be heard by those nearby. It was difficult for patients to share personal or confidential information without being overheard by other patients and relatives in the department. Despite staffs' best attempts, confidential information could not always be protected.

Staff apologised when patients' needs were not met and took steps to improve their experience, although this was challenging. We saw staff providing blankets to patients waiting overnight in the waiting room and patients we spoke with were complimentary of the care provided under the pressured system the staff were working within.

Patients attending by ambulance were held on ambulances when the department was at capacity. Whilst this was not what senior staff in the department wanted, it allowed for patients to be monitored by ambulance staff whilst waiting for transfer into the department.

We saw the department had a designated desk at the ambulance entrance to accommodate a 'hospital ambulance liaison officer (HALO). The HALO is a paramedic who facilitates and supports communication and activity between the hospital and ambulance team.

A pre-ED cohorting area, locally known as the HALO corridor, had been developed to respond to extreme and sustained overcrowding in ED. The intention was to support and improve the ability of the ambulance service to respond to

category one and category two ambulance calls, improve handover delays and reduce the risk of serious incidents occurring. We saw up to six patients cared for by a dedicated paramedic employed by the trust in non-cubicle spaces. There was a standard operating procedure for the management of patients in this area, however, not all contracted paramedics we spoke with were familiar with it.

Managers continued to formally review overcrowding within the department and this featured on the local risk register.

Changes had been made to the layout of the department since the last inspection. For example, the reception desk had been relocated to be adjacent to the clinical ambulatory area. This meant that it was easier for reception staff to communicate with the clinical team in ambulatory care.

Staff we spoke with told us of a new ambulatory working group with the aim of understanding the ambulatory environment and how it could be reconfigured for improving safety and efficiency. This group was in its infancy, but staff were motivated and passionate in making necessary changes.

Patients did not always have access to call bells but staff responded quickly when call bells were used. During our inspection, we saw there was up to eight patients being nursed on trolleys in the ED corridor or in front of the nurse base. These patients were cared for by ED staff, who had been dedicated to look after the patients in the corridor. Patients in the corridor did not have access to a patient call bell and some could not easily call a nurse for assistance. The department were in the process of providing call bells within these non-cubicle spaces and were awaiting confirmation of installation dates from the agreed contractor.

The design of some of the environment followed national guidance. The department had a designated mental health assessment room. The room was comfortably furnished and there was 360° access to an alert call bell system. The room was in the clinical decision unit, but due to the recent closure of this unit, footfall in and around this area was low. We saw an up-to-date risk assessment of how patient and staff safety was maintained.

There was a paediatric area which was secure and had appropriate facilities for the care of children and younger people. This area was co-located within the main department but had a separate entrance and reception area.

The service did not have suitable facilities to meet the needs of patients' and their families. There were four toilet facilities within the department, however, not all of these were easy to access. Due to the volume of patients, visitors and staff within the department, staff told us these were not enough to meet demand. As the ED was not intended for sustained length of stays, patients in non-cubicle spaces in the department waiting over 24 hours did not have access to basic wash facilities or bedside tables for mealtimes.

Efforts had been made to make the waiting area more comfortable, and new televisions had been installed to give patient’s updates and provide entertainment during long waiting times.

Whilst the department was cluttered due to the demand exceeding the size of the area, staff made efforts to keep the patient cubicles as clutter free as possible.

Staff did not routinely carry out safety checks of specialist equipment in line with trust policy. We saw daily safety checks of emergency equipment and resuscitation equipment were inconsistent. There were no assurances that emergency equipment was available and fit for use. However, both clinical and non-clinical staff, were aware of the location of the emergency equipment. The location and how to use it was included in the induction of all staff.

The service had enough suitable equipment to help them to safely care for patients, however, not all equipment we saw had been serviced in line with the service schedule. Managers we spoke with told us a new role had been recruited to for the management and oversight of medical devices within the department. There were plans as part of this new role to ensure all equipment complied with the service schedule. Staff told us it had been difficult to release equipment for servicing due to the continuous use of some core items.

The resus area was well equipped. Staff had immediate access to trust and national care pathways, such as stroke, and during inspection we saw a specialist nurse supporting staff in resus. There were X-ray facilities adjacent to the ED for prompt diagnostic testing.

Staff showed us two new electronic devices that supported patients who communicated via British sign language (BSL). Staff demonstrated how the device could interpret spoken voice into visual BSL which helped communication for patients with hearing loss.

We saw investment in new pressure relieving mattress toppers for patients at risk of pressure tissue damage. There was a good stock of these located within the department to ensure they were accessible for use.

Staff disposed of clinical waste safely. Needle sharps bins were stored correctly. Waste bins had clear signage for the segregation of different types of waste. No waste bins or needle sharps bins were seen to be overfilled during our inspection.

Assessing and responding to patient risk

Staff completed risk assessments for each patient, but due to the volume of patients attending the emergency department these were often delayed. Staff identified and quickly acted upon patients at risk of deterioration. The risk to patients and staff were mostly created by systems outside of the trust's control.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The department used the national early warning score (NEWS2) system to identify acutely ill patients, which supported staff with the early recognition of deteriorating patients. This system scored a set of observations and prompted an appropriate response dependent on the score or whether the score was increasing. The NEWS we looked at during our inspection were mostly completed on time and escalated and monitored in line with frequency rules. We saw where required they were escalated to the nurse in charge and emergency practitioner in charge. For children and young people, the paediatric early warning score (PEWS) was used.

From the actions we told the trust to take at the previous inspection, the department had digitised most nursing and medical documentation, including triage, clerking, reviews, and discharge summaries. We saw how this new electronic patient record system gave staff instant access to clinical and operational information of the patients attending ED. NEWS information was clearly displayed which gave senior staff improved oversight of patients at risk of deterioration.

Managers monitored compliance against NEWS2 completion. This showed a good compliance with the use of the NEWS2 scoring system with correct associated escalation. The audit also highlighted that not all escalation actions were documented within the patient records which supported what we saw during inspection.

Urgent and emergency services

Improvements were made to streamline access to records and making documentation easier to time stamp to enable timely triage. However, the continuous high volume of patients attending the ED meant that time to initial assessment and clinical observations were frequently not completed within 15 minutes. The department had set a target of 50% of patients to be triaged within 15 minutes. Although the department had achieved slow and continued improvement since June 2022 it had failed to yet meet this target.

Staff did not always document completed risk assessments for each patient on admission, using a recognised tool. Risk assessment tools, such as skin integrity and pressure care body maps, falls and mental health, were included in the emergency department documentation. Staff showed us electronic patient care records that detailed up to date skin body maps, falls and nutritional risk assessments and associated care planning. 4 out of 6 records we reviewed did not have all relevant risk assessments completed. In these cases, staff we spoke with were able to verbally communicate patient risks and care planning to reduce these risks.

Staff knew about and mostly dealt with any specific risk issues. Staff we spoke with were knowledgeable and confident in the management of patient risk. Staff understood what resources were available to them to reduce risk of patient harm. The department had recently purchased a stock of pressure redistribution mattresses to support patients at increased risk of developing pressure ulcers and we saw these in use.

Improvement was needed in the management of suspected sepsis. Internal auditing showed that staff correctly screened patients for sepsis. However, they did not always achieve all sepsis six diagnostic and therapeutic actions within one hour of initial diagnosis. We saw the department were in the end development stages of a real time sepsis report on the electronic patient records system currently used within the ED. Once live, the report would give ED staff real time data on sepsis, from time to sepsis screening and commencement of the sepsis six bundle to the percentage of admissions with sepsis. This data was specific to patients located within the ED.

We saw there had been an increase in reported patient falls, and associated increase in patient harm because of these incidents. Staff we spoke with understood the individual interventions they could implement to reduce the risk of a patient falling, but these were not always achievable in the context of overcrowding in the emergency department. Patients at risk of falling were discussed at shift handover and safety huddles.

Venous thromboembolism (VTE) risk assessments were completed in the medical assessment and doctors told us these were completed prior to prescribing preventative medicines to patients. VTE assessments had been completed in the records we checked, and patients had been prescribed preventative medicines where appropriate

The service had 24-hour access to mental health liaison and specialist mental health support. Nurses made appropriate referrals to the mental health liaison team when needed and sought support for patients who presented at the ED with behaviours which placed them or others at risk.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Staff shared key information to keep patients safe when handing over their care to others. Handover records were fully completed with key risk information to enable the incoming ward to implement measures to manage the patient safely. ED staff also accompanied high risk patients on transfer and gave face to face verbal handovers.

Shift changes and handovers included all necessary key information to keep patients safe. We observed both the nursing and medical handover. Both handovers followed a structured approach and considered the overall

departmental risks as well as individual patient information. The nursing handover covered key areas including patients with high NEWS, at risk of pressure ulcers and falling, and patients who lacked capacity. Nursing handovers provided an overview of capacity, staffing and escalation processes. We also saw managers or lead nurses deliver key messages to staff during these handovers.

There was a standard operating procedure for handovers between ambulance staff and ED staff. This detailed agreed hospital handover thresholds for escalation and the action both ambulance and hospital should take at each escalation level.

Staffing

Nurse staffing

There were gaps in nurse staffing but there was ongoing recruitment to ensure that there were enough staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Local managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service experienced challenges in ensuring there were enough nursing and support staff to keep patients safe. Staff said it had been normal for there to be gaps on staff rotas daily across the emergency department and that it was a regular occurrence for staff to finish shifts late. However, following a successful recruitment programme, staff numbers had improved.

Managers calculated and reviewed the number and grade of nurses, nursing associates and healthcare assistants needed for each shift. Patient acuity and staffing across the hospital was reviewed daily by senior leaders and the department. Due to improved staffing levels within ED, staff told us they had been reallocated on some occasions to support other areas in the hospital where there had been a staffing shortfall.

Since the last inspection, the department had introduced a new senior staffing model which included a band six nurse in charge of majors, a band six nurse in charge of ambulance triage and a band seven nurse for an overall 'helicopter' view of the unit. Staff spoke positively of this change, and we saw this role improved communication throughout the department and more efficient management of clinical and operational issues.

The number of nurses and healthcare assistants did not always match the planned numbers. We saw an improving nursing establishment and shift fill rate; however, this had not yet met the trust target of 90% fill rate for day shifts. The department achieved their 90% fill rate target for night shifts during the months of June and August 2022.

The newly established band seven nurse in charge role showed a shift fill rate of over 95% in August, but time was required to evaluate the sustainability of this metric.

The service had reducing vacancy rates. The department had an overall vacancy rate of 12.69% for nursing and health care support worker positions. This was a significant improvement from the vacancy rate we saw during the previous inspection. However, the department still had high vacancy rates for band five adult nurses with 25.62% of positions not recruited to. The department had a rolling recruitment advertisement and proactive use of temporary staffing to fill shift gaps.

The service had a static turnover rate. Overall staff turnover had been between 15% and 17% between April 2022 and August 2022. This was above the trust target of 10% or less.

Managers proactively used bank and agency staff and requested staff familiar with the service. Managers proactively used temporary staffing to fill gaps in the rota and had a regular workforce of temporary staff through agencies and NHS professionals. Staff told us regular use of the same agency staff helped with clinical and operational knowledge of the department. With the ongoing recruitment challenges, managers told us they were working with the agencies to increase their temporary staffing numbers.

Managers made sure all bank and agency staff had a full induction and understood the service. We spoke with one member of temporary staff. They told us they had received an induction covering all the information they required to safely do their job. This included provision of identification badges and training, and access to essential systems, such as electronic patient records, electronic prescribing and medicines administration.

Managers made sure staff received annual appraisals. 84% of nursing staff had received an annual appraisal. Staff we spoke with were positive about the content of their appraisal meetings and felt supported by the line managers.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. There were insufficient numbers of middle grade doctors and rotas were not always filled.

The Royal College of Emergency Medicine (RCEM) recommends (RCEM Workforce Recommendations 2018: Consultant Staffing in Emergency Departments in the UK, February 2019) consultants are on duty in the department from 8am to midnight in all medium and large systems. With usually more than 100,000 patient attendances each year, the adult emergency department at Derriford hospital would be classed as large sized. This would require 25-36 whole-time equivalent (WTE) consultants specialising in emergency medicine to be employed to cover the rota. The department had at the time of our inspection 18.73 WTE consultants in post against a funded 21.38 WTE. This fell short of the recommended safe level.

The service had a 14% vacancy rate for medical staff. Vacancies were predominantly at middle grade level, and staff told us these posts were hard to recruit to with factors such as competitive rates at other regional hospitals having an impact.

The trust continued to actively recruit to vacancies. Senior staff we spoke with told us the recruitment process was slow and cumbersome, however we saw the trust had implemented a new system for recruiting medical staff to streamline the process and to ensure recruitment was undertaken in a timely way.

Sickness rates for medical staff were variable. Information from the trust showed between September 2021 and August 2022, medical staff within urgent and emergency care had an average sickness rate ranging between 1.52% and 7.12%, with the most recent month of September 2022 showing 4.54%.

The service had a reducing rate of bank and locum staff. 91% of cover required was for specialist registrar (middle grade) shifts. We saw the rate of unfilled medical shifts had improved steadily over the last 6 months.

Urgent and emergency services

Managers could access locums when they needed additional medical staff. Data showed an improving fill rate for temporary staff from 58% in January 2022 to 81% in August 2022.

Managers made sure locums had a full induction to the service before they started work.

The service always had a consultant on call during evenings and weekends.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement

Access and flow

People could not always access the service when they needed it and despite staff efforts to provide the right care, this was not always within the expected timescales. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients had continued to deteriorate.

The department was continuously overcrowded, we saw a lack of flow through the inpatient areas and barriers to discharging patients from acute to social care which contributed to the bottleneck in the ED. However, we saw the trust had applied consistent challenge by setting internal targets for improving the flow of patients. This included discharges earlier in the day, increasing weekend discharges to support 7-day flow and reducing the number of complex patient discharge delays.

As part of pre-planned action, during the inspection we saw the trust had commenced a new patient flow strategy which aimed to transfer patients from the ED or medical assessment unit (MAU) to inpatient wards ahead of pre-emptive beds. This, commonly known as 'boarding,' aimed to facilitate transfers earlier in the day, spread risk across the organisation and help support internal patient flow. This initiative has been used across other acute trusts, but it was too early into its implementation to evaluate how effective it had been at Derriford Hospital. Early feedback from ED staff felt it did not resolve the underlying issue of capacity and so acutely unwell patients remained in the ED for sustained periods of time.

Concerns were raised by ED staff that patient flow worsened during night-time hours. The new patient flow strategy did not address lack of patient flow during night-time hours and staff told us the emergency department was expected to manage the risk in the absence of inpatient beds.

Managers monitored waiting times and continued to work to improve patients' access to emergency services when needed and received treatment within agreed timeframes and national targets. However, demands on the service and challenges with access and flow meant this was not consistently achieved.

Managers shared active waiting times in the department with the trust senior leadership team as part of a daily escalation process. During the first day of inspection, we saw department escalation to 'bronze' command, the first level

of senior escalation. The bronze command meeting communicated little action planning to address issues raised by the emergency department, we also saw little action planning at silver command, second level of senior escalation. This observation was fed back to the trust's senior leadership team during the inspection, and we saw improvement in the communication of action planning and target timescales during bronze and silver command on our second day on site.

Performance data showed delays in patients both accessing the emergency department and waiting to be seen. There was a risk patients were unable to access care and treatment in a timely way. There was also an additional risk to the system when ambulances were held for lengthy periods of time and unable to respond to other calls where patients required timely care and treatment. There were delays in patients being transferred from the ambulance to the emergency department. On day one of our inspection, we saw 15 ambulances waiting. Trend data for ambulance handover times of more than one hour had continued to increase since the last inspection.

Ambulance handover delays had worsened as the number of conveyances increased. Derriford Hospital had the second highest number of ambulance hours lost because of handover delays in the southwest region. In August, the trust reported a loss of 4,781 hours of ambulance time lost for the 30 days preceding 17 August 2022. This was 3,512 more hours lost than comparison with the same period in 2021. This increased the risk of ambulances being unable to attend emergency calls.

Senior managers within ED worked collaboratively with the ambulance service and had developed good professional relationships with the ambulance leadership team. An agreed rota of paramedics saw consistent staffing of the HALO desk which supported continuity of decision making.

We saw patients waiting longer than 12 hours in the emergency department. Once a decision had been made to admit a patient, the waiting time had consistently increased during the year reaching an all-time high of 774 breaches in the month of August 2022. At the time of inspection, we saw up to 41 patients waiting for admission of which 14 of these patients had waited longer than 12 hours. On the first day of inspection, we spoke with a patient who had been in the department since 10am, the same patient was still in the department when we visited the second day at 8am. The trust had an internal target of no more than 11 patients per day waiting more than 12 hours once a decision had been made to admit, but this figure was often breached with 25 patients waiting more than 12 hours for an inpatient bed during a 24-hour period in August.

Although performance data showed a steady improvement in wait times for initial assessments, the mean wait time continued to be above 30 minutes. Staff we spoke with said this was a common occurrence given the relentless overcrowding within the department.

Managers and staff worked to make sure patients did not stay longer than they needed to, but an overall crisis in regional bed capacity meant that patients frequently waited longer than required for assessment and treatment.

The trust shared with us admission pathways to manage how patients entered the acute care system, avoiding emergency care settings when this was not required.

We saw patients could be admitted directly to the medical triage unit (MTU) through the Acute GP Service (in hours) or direct to the Acute Medical Units (out of hours) from primary care. There were five trolley spaces on the acute assessment unit dedicated to the management of direct community referrals. This pathway was re-established in

September 2022 and designed to reduce time to clinical review, reduce length of stay and avoidance of admission through ED. The pathway was available 24 hours a day. However, at times of increased bed capacity pressures, all medical triage unit trolley spaces were used as additional inpatient beds. In this instance, patient pathways reverted to entry through ED.

Some clinical specialties had developed same day emergency care (SDEC) pathways to ensure patients were seen by the right person in the right place at the right time and avoid admission through ED. Patient helplines and primary care access for advice and guidance had also been developed within some specialties.

The ED had access to refer patients to a seven chaired acute frailty unit. The unit provided access to same day diagnostics and comprehensive geriatric assessment.

Staff within ED told us that all these pathways and strategies were not consistently used, and accessibility was dependant on overall trust bed capacity.

Staff told us they had good working relationships with specialties, but this did not always result in timeliness of specialty reviews. Staff told us they felt workforce pressure across the whole trust and a lack of risk sharing, were factors contributing to the delays in specialty teams reviewing patients whilst situated within ED.

The number of patients leaving the service before being seen for treatments was 7.7%, this was 1.5% higher compared to national figures. The service saw a reduction in reattendances since 2021 and was below the national average. For patients reattending ED within 3 weeks of an original admission, a 'highlight' sticker was used to emphasise the patient's need to reattend.

Managers and staff started planning each patient's discharge as early as possible. We observed the acute frailty team attend the ED to assist with early identification of discharge needs. As part of the daily escalation meetings, patients requiring repatriation in to and out of the hospital were identified and actions communicated to ensure these transfers were completed within the expected timeframes.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. We saw policies and flow charts to support staff in managing care and discharge of those with mental health needs.

Staff supported patients when they were referred or transferred between services.

The department sought feedback from people using their service, responses to the friends and family test were low and showed a varied recommendation rate from 70% to 94%. Patients we spoke with despite long waits, privacy and dignity issues, and a constrained and busy clinical environment, were complimentary of the service they had been provided.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Urgent and emergency services

Leaders in the emergency department demonstrated the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible, supportive, and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The department leadership team were committed to safe patient care and supporting their staff. They demonstrated to us they had the skills and abilities to run the service, particularly in such a challenging environment in which to provide safe and quality care and treatment. We found a team who had a clear view of the departmental approach and their own role, as well as the key issues both currently and longer term. This was consistent among the staff we spoke with.

Managers prioritised staff education and wellbeing. This was demonstrated through the recruitment of a fully established education team and work they were undertaking to improve mental health provision for both patients and staff. However, initiatives to support staff wellbeing were not always accessible. Staff told us a dedicated 'time out/ wellbeing' space had been created, but due to the movement of this space over time it was now situated within an ex-clinical space meaning it was no longer the welcoming and quiet environment it needed to be. Staff also told us that counselling and drop-in wellbeing sessions were often held during work time, and they were unable to leave clinical practise to attend.

Both medical and nursing leadership had a good understanding of the pressures staff worked within. They were knowledgeable about staffing and worked to produce and present several workforce papers.

Leaders understood the challenges to quality and sustainability and could identify actions needed to address it. During our inspection we interviewed the medical care group triumvirate and local leadership. They were able to tell us about current challenges and how they were addressing them. For example, nurse staffing was a challenge. Leaders had a recruitment plan, and we saw the ED recruitment campaign being updated with new video communications.

We saw the department's longer-term plans for the expansion of the urgent and emergency care pathways with a purpose-built emergency department.

Departmental leaders were visible and approachable. Staff told us the emergency department senior leadership team were visible and had good working relationships with their managers. Managers told us they would support the day-to-day operation at times of peak demand and staff. We saw there had been focus on creating an improved leadership within the department with the recruitment of senior nurse roles. However, some staff we spoke with told us the trust executive team were less visible.

Culture

Staff felt respected, supported, and valued within their department but did not perceive the same feelings from the wider trust. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. Staff felt able to raise their concerns, but often felt discouraged when they saw no change or improvement.

Nurses and doctors said they gave the best care they could to all patients attending ED however, they told us the department was frequently overwhelmed with patients and this made it difficult to carry out all the required tasks in a timely manner. Staff were open in their feelings of despair of not always being able to provide safe care given the persistent overcrowding in the department.

Urgent and emergency services

Staff felt generally supported, respected, and valued. Most clinical staff spoke highly of the support they received from line managers and colleagues within the emergency department. Staff told us morale was low following the previous inspection, and although this was improving, resilience to maintain positivity within the current working environment was becoming impossible. The burden of risk the staff faced daily added to their negative feelings.

Staff we spoke with showed us they were in date with their appraisals and welcomed a change from 'how are you performing' to 'what can be done to support you.' Since the last inspection we spoke with staff who had been supported to develop from Band 5 to Band 6 roles. They spoke positively of their transition and the training they had received to be successful in these roles.

There were co-operative, supportive, and appreciative relationships amongst staff and teams worked collaboratively. There was a mutual appreciation of roles between medical and nursing staff, and we observed good team working. Staff told us emergency department managers helped when the service was under pressure. Junior doctors spoke highly of the support and guidance they had received from consultants.

Although staff were encouraged to take breaks, we saw staff were not always able to safely leave clinical duties, and so chose to remain with their patients.

Staff we spoke with felt they were not supported by other teams within the trust and felt the emergency department was expected to manage and bear the responsibility of the increase in demand on services. Staff told us they felt the trust communications to the wider teams often labelled the issues with access to the emergency department as a local problem and not as a shared risk for the whole organisation. The staff told us they did not feel the pressure in the emergency department was everybody's business.

Many staff told us they were concerned the level of overcrowding and volume of patients within the emergency department was becoming normalised. Staff told us despite the daily escalation of overcrowding within the department, little action or change was seen. Staff told us that they were in a repetitive cycle of 'doing the same things' over and over and never resolving the cause of the capacity crisis. The department had recently recommenced an emergency department staff council to support staff to feedback concerns or ideas for change. 'Your voice' listening sessions had been established for senior members of the leadership team.

The department generally received positive feedback from patients but not all patients felt able to communicate their concerns during their stay in the emergency department. Patients told us they did not want to add burden to busy staff despite having concerns about their care. The inspection team challenged the trust leadership team about gathering feedback from patients who felt unable to actively raise their concerns. Our evaluation of patient feedback was accepted, and the leadership discussed how real time feedback could be improved to capture all patients.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Risks were recorded at department, care group and trust level. Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of the impact giving a red, amber, green (RAG) rating.

Urgent and emergency services

We discussed the top risks for the service with the leadership team. These were captured on the departmental, care group and trust risk registers and discussed during departmental governance meetings. We saw the risk register contained details of controls in place to mitigate the risk to the lowest possible level and a next review date. Risks were reviewed regularly. The risks documented on the local risk register matched the concerns of the staff.

The service monitored key performance indicators and presented these monthly through the emergency care board.

Areas for improvement

MUSTS

Urgent and Emergency Care

- The department must have safe and sufficient numbers of nurses and all grades of medical staff to meet the needs of patients, and they receive mandatory training including updates to meet the trust targets. (Regulation 18 (1) (2))
- The trust must ensure there is sufficient provision of basic toileting facilities to meet the needs of patients, relatives and staff. *(Regulation 10 (1) (2) (a))*
- The trust must ensure that medical equipment is safe for use and maintenance schedules are kept up to date. (*Regulation 15 (1) (c) (e))*
- The trust must ensure they continue to improve the flow through the department to keep patients waiting in corridors to a minimum. *(Regulation 12 (1) (2) (b))*

SHOULDS

Urgent and Emergency Care

- The trust should continue to work towards improvement for time to triage and compliance against NEWS2 audit. *(Regulation12(2)(a))*

Our inspection team

We carried out an unannounced focused inspection of the emergency department at Derriford Hospital on 21 and 22 September 2022 as a follow up from our inspection in 2021. At the time of our inspection the department was under adverse pressure.

We also inspected elements of the medical care core service including wards at this hospital. This included visiting the medical assessment unit and admissions areas to discuss patient flow from the emergency department. During this inspection we inspected using our pressure resilience 5 focused framework.

We did not cover all key lines of enquiry. We inspected and rated safe, responsive, and well led key questions.

The team that inspected the service comprised an Inspection Manager, a CQC lead inspector, 1 CQC inspector, a nurse specialist advisor and an urgent and emergency care Consultant. The inspection team was overseen by Catherine Campbell Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

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

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