University Hospitals Plymouth NHS Trust

Inspection report

Derriford Road
Crownhill
Plymouth
PL6 8DH
Tel: 01752202082
www.plymouthhospitals.nhs.uk

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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Requires Improvement
Are services well-led?	Good
Combined quality and resource rating	Requires Improvement

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

We carried out this unannounced inspection of urgent and emergency care and medical care services provided by University Hospitals Plymouth NHS Trust as part of our continual checks on the safety and quality of healthcare services, because at our last inspection we rated the trust overall as requires improvement, and because we received information giving us concerns about the safety and quality of the services.

We also inspected the well-led key question for the trust overall.

Our overall rating of services stayed the same. We rated them as requires improvement because:

- We rated caring as outstanding, effective as good, and safe, responsive and well led as requires improvement.
- We rated medical care as requires improvement.
- We have not rated the urgent and emergency care core service because of the pressure the emergency department was under at the time of inspection. As such we were not able to see the totality of the service.
- In rating the trust, we took into account the current ratings of the seven services not inspected this time.

Our inspection found significant concerns and challenges in urgent and emergency care and medical care, largely impacted by challenges within the wider health and social care system. Because of our concerns, we placed conditions on the trust's registration requiring them to take action with the health and social care system to improve patient safety and experience. We took this action because:

- Services were not meeting the needs of patients. Patients did not always have timely access to services.
- There were continually patients being cared for in ambulances outside a crowded emergency department. Patients in the emergency department could not be moved promptly to medical and surgical wards because there was no capacity. Patients could not be discharged in a timely way.

Our findings

- Patients were not always cared for in the best place for their treatment needs. Specialty patients were often cared for on non-specialty wards.
- There were not always enough staff with the right skills, training and experience to keep patients safe and to provide the right care and treatment.
- Social distancing was not always possible and pathways designed to reduce cross-infection could not always be followed.

However:

- Equipment and premises were visibly clean and clinical waste was managed well.
- Staff, while under immense pressure, worked hard to provide compassionate care to patients and to involve patients and those close to them in care and treatment decisions.
- Leadership had strengthened and although there was more still to be done to develop local leaders, staff felt supported by their local managers.

How we carried out the inspection

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

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:

We told the trust it must take action to bring services into line with three legal requirements. This action related to two services and the wider trust.

Urgent and emergency care

- Ensure all risks are accurately assessed and mitigated, including risks to patients through an inability to social distance.
- Ensure staff have access to an information system that enables them to see the measures and risks in the department. This must include auditing quality standards, intentional rounding and boarding.
- Ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced medical and nursing staff working in the department. This must include ensuring staff in charge of a shift have enough skills and experience to be in charge of shifts.
- Ensure staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This must include mandatory training, management of challenging behaviour and training for reception staff to ensure they can manage the situations they are exposed to.

Our findings

- Assess, monitor and improve the services provided. This includes ensuring audits for equipment checks and servicing, boarding patients, intentional rounding and quality standards are completed.

Medical care

- Ensure there are always enough nursing and support staff to keep patients safe.
- Ensure there is always adequate cover and support for the medical workforce, including out of hours.
- Ensure exceptions are reported and raised with the guardian of safe working hours.

Action the trust SHOULD take to improve:

Trust wide

- Continue to embed the distributed leadership model throughout the organisation.
- Further develop its leadership development and succession planning and introduce this throughout the organisation.
- Satisfy itself that infection prevention and control arrangements are overseen adequately by a director of infection prevention and control with sufficient capacity once the existing post-holder leaves the organisation.
- Engage further with all stakeholders in the health and social care system to drive forwards strategic solutions to the ongoing system pressures, particularly around urgent and emergency care.
- Progress its finance strategy and strengthen its operational focus on financial impacts.
- Continue its work around engagement, culture and wellbeing in order to better support all staff, as well as those areas identified as being of concern.
- Review its complaints processes to satisfy itself that complainants receive answers to all points of their complaints.
- Consider how to increase awareness amongst staff of the freedom to speak-up guardians.
- Continue to work on its equality, diversity and inclusion agenda.
- Produce a 'risk appetite' statement.
- Work with service lines and care groups to improve the structure of recorded risks so the impact is articulated more clearly.
- Empower staff fulfilling the 'bronze' role of the trust's command structure to take actions and not just escalate issues.
- Continue its work to introduce electronic records systems and deliver against its digital strategy.
- Review how the patient council can engage with quality improvement work.
- Continue its rollout of the 'People First' (quality improvement) strategy.

Urgent and emergency care

- Make sure all records are accurate and complete in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.
- Consider seeking patients' feedback to continually evaluate and improve the service.
- Continue to develop a band six management programme to support and develop management potential.

Our findings

- Consider making the HALO standard operating policy clearer to all staff to enable a better understanding of responsibility.
- Consider developing systems to support patient activity, for example making access to services easier, such as same day emergency care.

Medical care

- Enable all nursing and medical staff to receive and complete mandatory training in line with trust targets.
- Introduce a lead with oversight of falls and their cause.
- Securely store records.
- Review and improve processes for monitoring the expiry dates of medicines once opened.
- Provide staff with regular appraisals.
- Review the effectiveness of Freedom to Speak Up Guardians to ensure staff are confident to raise concerns.
- Consider ways to improve the effectiveness of engagement with staff.

Is this organisation well-led?

Our rating of well-led improved. We rated it as good because:

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills.

There had been several changes at board level since our last inspection, including a new medical director, chief operating officer and some new non-executive directors. Additional supporting structures had also been implemented, including a deputy chief operating officer and chief nursing officers.

Recruitment processes ensured board directors were “fit and proper” at the time of appointment, and annually thereafter.

Executive directors and senior leaders felt there was good challenge from non-executive directors at sub-board committees. We heard this challenge was not always evident at public board because it had already taken place in the sub-committees. Non-executive directors also commented on the positive and respectful challenge between executive directors, which they noted as a positive change since our last inspection.

Senior leaders felt well-supported by colleagues, while also being able to challenge and resolve differences of opinion positively.

The trust’s ambition to have a distributed leadership model with greater autonomy and accountability at local level was progressing, but not yet embedded throughout the organisation.

Our findings

Leadership development was being rolled out across the organisation, although to date this had focused on the senior leadership level and had not yet filtered down to lower level leaders.

Future leadership of infection, prevention and control was a concern as the director was due to retire at the end of the year and decisions about recruitment or reallocation of the role had yet to be agreed. It was being considered whether the chief nurse could take the role on, but we were concerned about their capacity to do this given the size of their portfolio.

Vision and Strategy

The trust had a vision for what it wanted to achieve. The vision was focused on sustainability of services and aligned to local plans within the wider health economy. However, there was not a clear strategy, developed with all relevant stakeholders, to turn the vision into action.

There were multiple strategies covering a wide range of areas, for example health inequalities, quality assurance and quality improvement. However, the strategies did not demonstrate strong engagement with all stakeholders, particularly the wider health and social care system. Pace of delivery had also been slow in several areas, reportedly due to the impact of the COVID-19 pandemic, although some progress was being made. We were told support team had prioritised response to the COVID-19 pandemic which had caused delays in delivering some improvement actions.

The trust used volunteers well to supplement the paid workforce in providing additional support to patients, especially during the pandemic. This was supported by a volunteer strategy, which clearly defined roles and accountabilities to ensure volunteers were not used to undertake roles which should be completed by the paid workforce.

There were attempts to partner with the integrated care system (ICS) to explore combined care delivery, including looking at whether hotels could be staffed and used as interval discharge locations, but this needed greater engagement from other partners.

The trust did not yet have a finance strategy for addressing its underlying deficit, although there were plans to present a draft strategy to the board in January 2022.

Culture

Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The trust was making progress with promoting equality and diversity in daily work and provided opportunities for career development. The trust had an open culture where patients, their families and staff could raise concerns without fear, however a small number of staff felt they were discouraged from reporting incidents.

The majority of staff felt the trust was a friendly place to work with patient safety at its heart.

Every senior leader told us they were exceptionally proud of the staff in the trust and believed the level of care under the immense pressures of a pandemic and increased demand was “breathtaking”.

Compassionate leadership was demonstrated, which had helped build a culture of trust and honesty within the board.

Our findings

There were some staffing groups where poor cultures had developed, particularly around relationships within departments and with senior leaders. The trust was aware of these areas and had invested in external support and facilitation to understand the cultural challenges and make progress in tackling these. While there was still work to do, improvements were noticeable.

A cultural dashboard was used alongside other measures, including feedback from staff networks and Freedom to Speak-Up Guardians, to support the leadership team in identifying areas where culture needed further attention.

While complaint investigations were not always completed in a timely fashion, most complainants were kept up-to-date with progress and received open and sensitive responses. However, a small number of complaint responses did not address all the concerns raised by the complainant.

Freedom to Speak-Up Guardians reported positive relationships with the board and felt issues were listened to and action taken in response to concerns raised. However, they were conscious that although significant efforts had been made to publicise the freedom to speak-up process and introduce the guardians, there was still a small reliance on "word of mouth" to get the message across.

Most staff felt supported by the trust's leadership, however due to the focus on operational pressures there were some groups who felt less supported by executive directors because they were too busy "firefighting". The board were aware of the challenges and had a real focus on improving wellbeing.

A minority of staff felt the trust was failing to create a positive culture of involvement. A perceived lack of strategy from the trust to get out of the "crisis" was impacting on morale for those staff, with a very small number stating they felt "disrespected" because of the lack of recognition from the trust.

Several staff reported a poor culture in relation to incident reporting, particularly around reporting staff shortages. There was a reluctance to report short staffing because of a perceived lack of action, and in one example a manager had "told off" the reporter and told them not to report it again.

Equality and diversity was regarded as an important area for the trust, and the leads for this area of work spoke positively about the trust's engagement. However, they recognised more needed to be done, particularly in delivering training across the trust and developing more diverse recruitment processes. We were told there were plans to deliver this work.

The NHS staff survey (2020) showed disparity in the working experiences of black and minority ethnic staff when compared to white staff.

While finance teams had a good focus on the trust's financial position, there was very little attention being paid to finance by operational and clinical teams. There was a risk this lack of focus could lead to further deterioration of the trust's financial position and some cultural work was needed in order to address this.

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.

Our findings

An independent, external governance review was reportedly due to be commissioned in September 2021 but was paused while the trust await the outcome of our inspection. However, some internal work had been undertaken to review and strengthen governance arrangements and the improvements were noticeable. Additional roles had been introduced to support the quality governance agenda and the governance structures had been strengthened. Further internal work was ongoing to explore what governance needed to look like in the next one to three years, with a focus on building the culture of "governance is everyone's business".

Within the care groups, the triumvirate leaders worked together on governance. They were supported within each care group by a quality manager who was responsible for overseeing the detail within each service line. Each care group had a quality assurance group (QAG), which the service lines attended and reported in to. Each quality assurance group fed into the trust's quality assurance committee on a quarterly basis. The trust felt there was much better oversight at care group level compared with our previous inspection. However, work was ongoing to improve consistency amongst the care groups.

Committee structures had been revisited and terms of reference updated, including clearer areas of responsibility and any overlaps with other committees. The committees' work was informed by the board assurance framework (BAF), and the new framework document was cascaded down the organisation for use in non-board committees.

The chief nurse and medical director shared patient safety-related governance responsibilities and accountabilities. While the chief nurse chaired the quality assurance committee, the medical director worked alongside the chief nurse in that committee.

Internal and external audit was integral with the trust's governance processes and provided challenge and assurance to the board.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Financial pressures did not compromise the quality of care. However, decision-making did not always appear to balance this against the long-term financial impacts on the trust's underlying deficit position.

As part of a relaunch of how risk was managed by the trust, a new risk policy had been written and was due to be ratified later in the month of our inspection. The new policy clarified responsibilities around risk and was being supported by a relaunched risk training package across the organisation.

The trust did not have a 'risk appetite' statement, although discussions had started and it was recognised this needed to be completed as part of the risk policy refresh which was ongoing. A discussion was planned at the next month's board development session to agree the statement.

Work had been undertaken with the board around redesigning the board assurance framework (BAF) and realigning the risk committee to link much more clearly with the framework risks. Issues specific to the board assurance framework are reviewed formally at every public board meeting (which took place bi-monthly), and an update on BAF issues presented to the private board on the alternate months in-between.

Our findings

Risks from service lines through to care groups and the board were recorded and escalated according to policy and reflected what we heard during our inspection. Although the BAF was lengthy at over 90 pages, everyone we spoke with told us it worked well for the trust but would be reviewed again and shortened in time.

A new risk committee, chaired by the chief nurse, had been established to bring risk oversight for the whole trust into one place. This committee reported into the risk and audit assurance committee, a sub-board committee. Each ward and non-clinical service, through their service line and care group (or non-clinical equivalents), reported into the risk committee to give an overview of risk across the trust. The risk committee received any risk register items rated as 15 and above, and also reviewed any risks with a score of 12 or above for three months and longer. These were described as 'corporate risks'.

Care groups oversaw their own quality performance and risk to give "frontline ownership". This was facilitated through each care group's quality assurance group (QAG), which triangulated performance and risk data against incidents and staffing, amongst other information. However, risk registers needed some work so they described the risk impact and not just the cause. This was ongoing work and part of the revised online training package being rolled out across the trust.

Actions designed to reduce risks were monitored and audited. A risk management report presented a breakdown of all risks and of serious risks by service line, and showed how many actions were open, how many were completed and how many were overdue.

Revised investigation processes for serious incidents (SIs) had reportedly improved timeliness and accuracy. New '24-hour' meetings had been established for care groups to undertake a prompt desktop review and confirm the level of investigation required and identify any immediate learning opportunities. All serious incident reports were signed off by the medical director and/or chief nurse to ensure actions were focused on improvement and were deliverable.

A new 'Office for Patient Protection' was being designed to bring oversight and coordination of safeguarding and Deprivation of Liberty Safeguards (DoLS) into one place.

The trust's command structure (bronze, silver and gold) worked well to ensure risks and issues were escalated promptly within the organisation, which meant the executive directors were cited on these daily. However, there was little focus on actions at the bronze call and instead a reliance on escalation and direction from silver. This was recognised and additional work was being undertaken with the staff who covered the silver group to ensure they could empower the staff in the bronze group.

The health and care system in Plymouth, and the wider south west, was under significant pressure which was creating challenges and risks within the trust and particularly the emergency department. This was recognised by the board who acknowledged that as members of the system they needed to work strategically with partners to overcome the challenges. However, progress was slow in this area.

The trust made decisions every day around clinical prioritisation of workload to try and manage the urgent and emergency pressures alongside elective recovery. Decisions were made earlier in the year to reduce social distancing before guidance came out which permitted that approach, in order to provide more capacity within the hospital. This was a risk assessed and monitored through triangulation of data, including hospital-acquired infection data.

While the financial position of the trust was challenging with a significant underlying deficit, we did not see financial controls compromising care. Operational and financial plans were dovetailed, and new performance reviews were

reported to be having good quality rounded conversations about finance and performance. Investment was being made where needed to maintain levels of care, although we were concerned about the financial stability of the trust and their ability to make the recurring savings needed to balance the books. Recurrent investments were being made but many of these would take time for financial benefits to be realised and may not deliver cost offsetting. There was a risk the trust's financial position could deteriorate further.

The £57 million maintenance backlog had been reviewed, with every line being individually risk assessed and prioritised to ensure the most serious risks were tackled first.

Information management

The service collected reliable data and analysed it. Staff could usually find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were secure. Data or notifications were consistently submitted to external organisations as required. However, information systems were not always integrated.

There were strong processes to protect patients' confidential information and to ensure it was used properly. The Caldicott Guardian was knowledgeable and engaged in this work.

Non-executive directors felt the trust had made good use of technology to ensure the board could function remotely throughout the pandemic, maintaining a strong sense of unity.

Existing quality and staffing dashboards were planned to be combined in a single dashboard to provide a heatmap across the trust focusing on the impact of staffing challenges on quality of service.

A new 'triangulation meeting' had been established which met weekly to draw information together from a range of sources, including complaints, incidents and safeguarding, to identify themes and hotspot areas. Attendees included care group quality managers, safeguarding lead nurse, complaints team, risk and incident team and legal representatives. The work undertaken by this group was reported into the quality assurance committee.

Regular audits were completed and presented within the trust's integrated performance report to provide assurance to the board.

The lack of electronic records system throughout the hospital meant data was not always easily available without manual interrogation. It also meant paper records were heavily relied on in clinical areas. The trust was exploring how it could make better use of an existing system being used in one area of the hospital, and were exploring an electronic patient record system which would link with the other providers across Devon and Cornwall to improve information sharing.

A digital strategy and associated board were driving improvements in this area, but progress had been slow. The impact of the COVID-19 pandemic had, however, enabled some faster progress to be made in digital investment.

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.

Our findings

Engagement with staff had improved, although the trust acknowledged it was challenging for executive directors to be physically visible to every member of staff at ward level given the size of the organisation and workforce and the shift working arrangements for the majority of staff.

Senior leaders believed staff engagement was positive and driven by a culture of speaking up and making changes led by the frontline. Engagement was being closely supported by the organisational development and human resources teams, as well by the people first strategy. We were told the quality assurance team worked with teams to establish routines of huddle practice including 'Team Health' and that this had supported teams to feel more hopeful, aligned and empowered to make improvements.

While executive directors had continued to be visible within the hospital, non-executive directors continued to work remotely and had little in-person engagement opportunity as a result, which they felt was a continuing challenge. However, there were some benefits from working remotely, including enabling non-executive directors to attend virtual quality committees and observe 'further down' into the organisation.

Communication with staff was challenging, particularly given the impact of the pandemic and ongoing demand. Staff were often "head down in the day job" and the trust was aware not all communication efforts were having the desired impact. Daily email communications continued, alongside staff huddles and executive-led 'Your voice' sessions.

There were several staff networks, including for black and minority ethnic (BAME) staff, women, disabled, LGBT+ and for staff who followed a faith. Additionally, a men's conversation group had been established. These were having a positive impact on trust policies and the networks had a voice with the senior leadership team.

The BAME staff network was co-chaired by two individuals elected by members of the network. The chief operating officer had helped facilitate this process, ensuring it was a staff-led decision-making process. The network had been active in sharing what it was like to work for the trust as a BAME person and were good at speaking truth to power.

Patient stories were a continuing feature of public board meetings. However, there was a better balance of positive and difficult experiences compared with the findings of our previous inspection which found they were focused on positive stories.

A patient council helped the trust keep the patient's voice central to improvements and changes. They were involved in various projects and linked into the board. However, they did not link with the quality improvement academy and felt the patient's viewpoint was often missed in this area. The trust acknowledged this was important and recognised that their involvement had been reduced during the pandemic. They told us they will be involving the patient council in more projects in future.

Staff-side representatives (trade union reps) did not always feel engaged by the senior leadership team, although some examples of positive engagement were shared.

While the trust was represented in various forums across the health and social care system, more work was needed from all parties in that system to engage fully to tackle the pressures being experienced in the trust.

Learning, continuous improvement and innovation

Our findings

Staff were committed to continually learning and improving services. The trust had a good understanding of quality improvement methods and the skills to use them, roll-out of the programme was deliberate and purposeful. Leaders encouraged innovation and participation in research.

The trust's quality improvement (QI) strategy was called People First. Work was still ongoing to embed this fully throughout the organisation, although good progress had been made in clinical support services which includes imaging, pharmacy, pathology and health care sciences. Despite not being fully embedded, quality improvement activity was taking place in all care groups. Where improvement activities were being undertaken, there was a strong methodology to support this and an inclusive process to review and share progress and early outputs. The trust planned to have rolled out People First to the whole organisation by 2023.

A quality improvement committee, which sat alongside the quality assurance committee, took themes from serious incidents and other areas identified by quality assurance committee to identify any potential quality improvement opportunities.

The new medical examining service reviewed 100% of deaths, working with families and keeping them at the centre of any learning.

The mortality review group had been refreshed and was focusing on mortality in a wider sense across the organisation, including the patient's experience of death. Both qualitative and quantitative information were used, rather than just dealing with mortality data. The patient experience team was engaged in the learning from deaths work.

Learning from incidents was cascaded locally through safety briefs and clinical governance meetings and more widely across the organisation using the 'React Bulletin', which was issued through the daily email on an adhoc basis when there was learning to share.

As part of the devolved leadership model being embedded in the organisation, and to support greater autonomy in budgetary matters at a local level, the trust was delivering budget holder training to enable local leaders to manage budgets for their area within 'control totals' for the care group.

There was an active research department which was engaged in local, national and international research programmes. They worked closely with frontline staff but recognised a need to embed themselves more within the service lines.

Key to tables					
Ratings	**Not rated**	**Inadequate**	**Requires improvement**	**Good**	**Outstanding**
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement →← Jan 2022	Good ↑ Jan 2022	Outstanding →← Jan 2022	Requires Improvement →← Jan 2022	Good ↑ Jan 2022	Requires Improvement →← Jan 2022

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Requires Improvement	Good	Outstanding	Requires Improvement	Requires Improvement	Requires Improvement
Ambulance	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Adult social	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Mental health	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Community	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Primary medical	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall trust	Requires Improvement ➔➔ Jan 2022	Good ↑ Jan 2022	Outstanding ➔➔ Jan 2022	Requires Improvement ➔➔ Jan 2022	Good ↑ Jan 2022	Requires Improvement ➔➔ Jan 2022

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Mount Gould Hospital	Good Nov 2016	Not rated	Good Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016
Derriford Hospital	Requires Improvement ➔➔ Jan 2022	Good ↑ Jan 2022	Outstanding ➔➔ Jan 2022	Requires Improvement ➔➔ Jan 2022	Requires Improvement ➔➔ Jan 2022	Requires Improvement ➔➔ Jan 2022
Overall trust	Requires Improvement ➔➔ Jan 2022	Good ↑ Jan 2022	Outstanding ➔➔ Jan 2022	Requires Improvement ➔➔ Jan 2022	Good ↑ Jan 2022	Requires Improvement ➔➔ Jan 2022

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Mount Gould Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Good Nov 2016	Not rated	Good Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016
Overall	Good Nov 2016	Not rated	Good Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016

Rating for Derriford Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement →← Jan 2022	Good ↑ Jan 2022	Good →← Jan 2022	Requires Improvement →← Jan 2022	Good ↑ Jan 2022	Requires Improvement →← Jan 2022
Services for children & young people	Good Nov 2016	Good Nov 2016	Outstanding Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Critical care	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
End of life care	Good Nov 2016	Good Nov 2016	Outstanding Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Surgery	Requires improvement Dec 2019	Requires improvement Dec 2019	Good Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019
Urgent and emergency services	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Diagnostic imaging	Requires improvement Dec 2019	Not rated	Good Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019
Maternity	Good Dec 2019	Good Dec 2019	Outstanding Dec 2019	Good Dec 2019	Good Dec 2019	Good Dec 2019
Outpatients	Good Aug 2018	Not rated	Good Aug 2018	Requires improvement Aug 2018	Good Aug 2018	Good Aug 2018
Overall	Requires Improvement →← Jan 2022	Good ↑ Jan 2022	Outstanding →← Jan 2022	Requires Improvement →← Jan 2022	Requires Improvement →← Jan 2022	Requires Improvement →← Jan 2022

Derriford Hospital

Derriford Road
Crownhill
Plymouth
PL6 8DH
Tel: 01752202082
www.plymouthhospitals.nhs.uk

Description of this hospital

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 and 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 visited Derriford Hospital during a period of high pressure on medical services across the UK. The pressures were created due to increased attendances, changed public behaviour, reduced access to community services and increased public anxiety after the third phase of the COVID-19 pandemic. There was also a marked increase in the acuity of patient illness, with staff seeing more severely unwell patients.

Urgent and emergency services

Inspected but not rated

Is the service safe?

Inspected but not rated

The service was inspected but not rated

Mandatory training

The service provided mandatory training in key skills including life support training to all staff but not all staff had not undertaken training updates as required.

Staff had access to mandatory training but pressures on the department meant that not all staff training was up to date. Not all staff had completed higher levels of conflict resolution training to help protect them in certain situations. The trust provided conflict resolution training and following a series of incidents of violence and aggression, this aimed to reduce the risk of harm to staff and patients. Level one training was completed once every three years and became mandatory in September 2020 for patient-facing staff. Compliance was 88% for nursing staff in the emergency department and 61% for medical staff. Level two and three training was offered to staff identified as working in areas of high-risk of violence and was completed annually. Staff were not clear which areas were high risk areas, as the whole department appeared high risk to them. Compliance with level two and level three training in total for the emergency department was 25%. This was also due to the high attendance in the department so staff were not able to take time to complete this training.

Nursing and medical staff completed basic life support training and further immediate life support training was provided to some senior nursing and medical staff. All nurses completed paediatric immediate life support training (PILS) annually.

The majority of nurses had undertaken their mandatory update training, but around 30% of the medical staff remained had not which may pose a risk to patients.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff were alerted when training was due for update. Work was ongoing to develop an emergency care module that would support the learning and development of registered band six nurses.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had updated their training or received training at the appropriate level on how to recognise and report abuse and they knew how to apply it.

The pressures the department was under did not enable all staff to complete level three safeguarding training. To mitigate that risk and to support staff, a member of the safeguarding team attended the emergency department daily Monday to Friday each week to support staff and provide advice.

Urgent and emergency services

Nursing staff received training specific for their role on how to recognise and report abuse, but this had not yet been completed by all staff. Flow charts had been produced and were available for staff which identified actions for staff to take should they recognise any signs of abuse in adults and children.

For safeguarding adults, it was clear what level of training was required for each staffing group. Training covered domestic violence, female genital mutilation and child protection.

Update safeguarding training had been completed by most department staff. Training had been started and by July 2021 an audit showed that 87% of staff had completed level two and 65% of staff had received level three child protection training. Of all emergency department staff, 79% had completed child protection training level three.

Medical staff received training specific for their role on how to recognise and report abuse, although only around three quarters of the medical team had updated their training. Medical staff told us they felt competent to identify and raise concerns and able to seek advice if needed.

By September 2021 74% of medical staff had completed level two training and 75% had completed child protection training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were clear about how they would identify patients at risk of abuse. A range of medical, nursing, administrative and ancillary staff were able to clearly describe what the signs were of suspected abuse and what actions they would take. The trust used an electronic system to record and identify patients where there was a known safeguarding concern.

Staff confirmed there was a good relationship and referral pathway to the safeguarding team and the child and adolescent mental health service (CAMHS). Although the CAMHS was not 24-hour seven-day service, if there were any concerns or requirements for assessment, these patients were admitted and assessed the next working day.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff knew who they should inform either in the department or within the trust with concerns. There was a trust-wide team of higher-level trained safeguarding staff who had the responsibility to investigate any safeguarding concerns and provide advice and support to the department. These were raised with the relevant local authority who had the statutory duty to act on allegations of abuse.

Cleanliness, infection control and hygiene

The service mostly 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. However, the pressure on the department meant that the pathways to reduce the risk of cross infection could not always be followed.

There was a COVID-19 assessment area where patients identified as having symptoms were assessed before admission. Preadmission temperature checks, COVID-19 wellbeing assessment and mask distribution had been introduced for most patients. Patients with identified risks were prioritised to be streamed to the designated amber area to be seen and treated while being safely assessed for COVID-19.

Staff followed infection control principles including the use of personal protective equipment (PPE). However, not all patients followed the trust guidelines to reduce the risks of cross infection.

Urgent and emergency services

The redesign of the department meant that patients entered by different doors and so promoted social distancing to reduce the risk of cross infection. The developed ambulatory assessment unit/minor's area had been separated from the major's area and a red and amber pathway had been set up from the front door for patients considered at risk of COVID-19.

The Plym area of the emergency department received patients suspected of having COVID-19. There was a clear designation of green, amber and red areas within this area. Patients suspected of having COVID-19 were tested and remained in the department until the results were received. Results were provided within 90 minutes. This facility was available 24 hours a day.

Staff training for infection prevention and control was provided. By September 2021, 80% of staff had completed the training. Regular updates regarding changes to guidance were made available to staff via emails and bulletins, and staff told us they had been well informed.

There was adequate stock of personal protective equipment (PPE) throughout the department. There had been no shortages of PPE and staff had been face fit tested for tight fitting respirator masks to avoid transmission of COVID-19. Staff had received effective training in putting on (donning) and removing (doffing) PPE safely to prevent the risk of cross infection. Other areas of the department which may pose a risk such as places used for aerosol generating procedures (AGPs), also had full personal protective equipment.

Guidelines on the use of PPE had been reissued across the department and staff understood their responsibilities. The trust's "Plym ED (COVID) Handbook" identified a transit zone which was an area where patients with possible COVID-19, who were wearing a mask, may be encountered at a distance. These areas did not require PPE if staff were not involved in patient care, other than a standard mask.

Staff wore the personal protective equipment (PPE) to reduce the risk of cross infection. Staff used equipment and control measures well to protect patients, themselves and others from infection.

Audits were ongoing to provide assurance that the use of PPE was embedded and cleaning was completed.

Not all patients followed the trust guidelines to reduce the risks of cross infection and staff were not always ensuring they had been asked to do so.

All patients/visitors were offered a face covering on arrival to the department. However, in the ambulatory assessment/minor's area and the major's area there were patients on corridors who were not able to social distance and were not wearing face masks. Staff said that sometimes patients refused and often they didn't have time to offer the masks and ensure they were worn. Hand sanitiser and hand wash points were evident, and staff remind patients to use them.

The transfer of patients through the department had been improved to reduce the risk of cross infection. However, there remained delays of these patients within the department.

Patients transfers out of minors waiting area to the wider hospital were managed so that they did not enter the emergency department main area.

The route into the Plym unit was not always immediate and depended on the patient's symptoms and test results. One patient had been in the corridor for nine hours before receiving a positive COVID-19 test, leaving the department/patients and staff exposed to COVID-19 risk.

Urgent and emergency services

There was no separation for patients within the Plym area and patients were delayed in being transferred to the designated areas of the hospital. For example, patients with a negative result were in a ward setting with no screening or separation from those COVID–19 positive patients, because there was no capacity within the hospital to move patients.

There were times when both negative and positive COVID-19 patients had to remain in the Plym unit for extended periods of time due to the full hospital capacity. For example: during a time when the Plym area was full there were four patients who tested positive for COVID-19 and could not be moved because the hospital did not have capacity in a designated COVID-19 ward, so remained in an area with COVID-19 negative patients. Staff confirmed that as the department was mostly under pressure, this situation was not unusual and was risk assessed and managed as best as they could. This was a cause of concern for staff. The Plym Unit staffing was regularly short staffed with two staff looking after 15 suspected or confirmed COVID patients. This had an effect on how infection control was managed in this area.

All patients planned for admission into the wider hospital were COVID-19 tested prior to admission.

All areas we saw on our inspection were visibly clean and had suitable furnishings which were visibly clean and well-maintained.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Environment and equipment

The design, maintenance and use of the emergency department had been reorganised to promote safety. However, the pressure on the department meant that some safety guidelines were not followed. Staff were trained to use equipment, but some equipment checks were not completed. Staff managed clinical waste well.

The pressure on the service meant that facilities did not always meet the needs of patients and their families.

The emergency department had been reconfigured in response to the COVID-19 pandemic, to meet national guidance, and to improve patient flow. There were separate pathways for patients with known or suspected COVID-19 (red), unknown status (amber) or known negative status (green).

Patients arriving by ambulance, ambulatory patients (walk-in) patients, and GP referrals would enter the department via different doors and triage areas.

Generally, the areas appeared uncluttered, fire exits were clear and accessible.

Ambulatory Assessment unit.

In the ambulatory assessment unit, there were socially distanced chairs for use by patients whilst they waited. The trust had followed the Royal College of Emergency Medicine best practice guidelines and spaces were marked to be kept vacant, but there was no “policing” of this, and the guidelines were mostly ignored by the public. We saw that most of the time, all seats were taken, and patients were sitting or lying on the floor.

In order to minimise cross infection risks, patients were required to wear face coverings but again, as the department was at capacity for most of the time, staff were too busy to ensure this was maintained.

Urgent and emergency services

Not all patient areas were in view of reception staff. This presented a significant risk of patients who may deteriorate or collapse without being seen.

The Paediatric unit

The paediatric unit was a separate unit within the main emergency department, with a separate entrance. The paediatric area was secure and had facilities for the care of children. The reception area for the paediatric area was often not able to be staffed as there were no available administrative staff. Recruitment was ongoing. When it was not open, some children were admitted through the adult ambulatory care area. This was not appropriate for children as it may expose them to situations they could find distressing.

There was a second internal waiting area within the paediatric unit which was well equipped and easily visible to staff. However, the layout of the paediatric area in a square made it difficult to observe patients in the cubicles on the back corridor, which posed a risk of responding in a timely way if a patient deteriorated.

Majors area

The ambulance arrival area in the emergency department had four resuscitation bays with flexibility of a further three being used for 'front loaded investigations' (FLIC). This area was also used for paediatric resuscitation. There were 17 cubicles for major illness and injury and four cubicles for minor illness and injuries.

Because of the pressure the department was under patients were also being cared for in areas not intended for clinical use, these areas were being routinely used. Spaces were marked on the floor for patients to be cared for in the corridor or the open middle area of majors; there was allocation for five patients on trolleys in each of these areas. This was not in line with best practice guidelines set out by the Royal College of Emergency Medicine for Emergency Department Infection Prevention and Control during the Coronavirus Pandemic.

Patients on trolleys did not have any privacy and their dignity was compromised.

The Plym unit

As a result of the COVID-19 pandemic a further area "Plym" had been provided as a nine bedded area for the streaming of patients considered at risk of having Covid-19. The unit opened at the start of the pandemic and had access to a room with the specific air flow needed for safer practice when using aerosol producing procedures.

The Clinical Decisions Unit

There was also a 10-bedded clinical decision unit (CDU) and seating for six patients in the clinical decision unit lounge. This unit was used for the overview of patients who may be able to be treated and then return home within 48 to 72 hours. The unit also provided access to two purpose-built assessment rooms for patients awaiting mental health assessment.

The hospital also had a front door frailty assessment unit. This was designed to deliver timely care in collaboration with primary care partners and avoid whenever possible hospital admission for elderly frail patients.

Changes had been made so that cubicles for children and adolescents which were ligature free. Risk assessments for ligature risks had been completed.

Urgent and emergency services

Staff who were working alone or were vulnerable did not have access to body alarms and had to use the alarm in the cubicle. This had not been addressed since our last inspection. However, we observed when one of the alarms was called by accident the staff in the major's area of the department responded immediately.

The service had enough suitable equipment to help them to safely care for patients. Not all equipment was serviced in line with the maintenance schedule.

We saw from the emergency department equipment asset list that some pieces of equipment were out of service date. These included: an external defibrillator, a warming blanket and unit, a doppler scanner, electrocardiograph monitor and oxygen regulators and flow meters.

Staff did not always carry out daily safety checks of specialist equipment.

Due to the lack of staff and increased capacity pressures, equipment checks were not consistently completed. We saw that different areas of the emergency department checked resuscitation trolleys at differing levels of frequency. Some checks were undertaken daily, some weekly and most showed gaps when planned checking had not been completed. This created a risk that emergency resuscitation equipment had not been checked and we saw some items missing and out of date.

The design of the environment for patients awaiting mental health assessment followed national guidance.

This had improved since our last inspection and there were two mental health rooms, away from the main part of the department. This area was quieter and had been designed in line with national guidance relating to mental health.

Patients could mostly reach call bells and staff responded quickly when called.

Patients waiting for an x-ray could access an alarm to call for assistance, and close circuit television was available to enable staff to see patients waiting outside of the department. This had improved from our last inspection and ensured patients could alert staff when needed.

Patients waiting in department corridors did not have access to call bells to raise alarm or request assistance. Patients needed to attract staff attention as they passed and so this may create a delay in accessing help. Regular checks referred to as intentional rounding was planned to ensure these patients were checked regularly. However, because of the pressures on the department and on staff, these intentional rounding checks did not always happen.

Staff disposed of clinical waste safely. Clinical waste bins were available and clearly marked. Staff emptied the bins when full. Sharps bins were used for the classified items and were sealed before they were full. This meant that the contents were safe and not accessible.

Assessing and responding to patient risk

Staff in each area of the emergency department could not ensure the safety of all patients. The risks to patients and staff were mostly created by systems outside of the trust's control. Staff attempted risk assessments for each patient on arrival, but these assessments were often delayed. Patients waiting for long periods of time were not able to social distance.

Urgent and emergency services

Work to make improvements in the oversight of patients waiting in the department to ensure they were seen in priority order based on their clinical need and to mitigate the risks associated with this had begun. However, the systems to manage patient risk were not able to be consistently actioned or be managed effectively because of the overwhelming numbers of patients attending the department, the limited capacity to manage patients and the lack of enough staff. Furthermore, the lack of beds in the hospital meant patients in emergency department could not move out of the department and so the environment became overcrowded and unsafe.

Staff risk assessed patients on arrival for COVID-19.

Patients were screened using a 'COVID Screen Process'. When a patient triggered a positive response to the screening process, staff kept the patient where they were and escalated this to the nurse in charge. Tests were sent to the in-house laboratory for processing.

Reception staff did not have training or skills to identify patients at risk.

Reception staff overseeing the waiting area had not received any training to identify signs of a patient's condition deteriorating. Reception staff can raise concerns from alerts on the system, however the reception team are not responsible for the medical condition of the patients in the waiting area, but can pull the alert call bell if a patient collapses for example. Where reception staff identified patients, who may appear to look unwell, these were escalated to the medical staff / doctors within the department, however staff were often too busy to come and see the patient. This was a risk to patients needing prioritisation.

Staff had concerns about patient safety, due to increased delays in patient triage. These concerns had been escalated informally and formally without any improvement action being recognised by staff. The Quality Improvement team were involved, and data was regularly disseminated to all emergency department staff. Staff told us patients were more challenging as waits to be triaged or assessed were often long, this also increased the risk patients may deteriorate.

Staff in each area of the emergency department could not ensure the safety of all patients. The risks to patients and staff was often beyond the trust's control.

The department had developed four routes into the department: the ambulatory entrance, ambulance entrance, Plym (Covid) and paediatric/frailty entrance.

Staff identified and quickly acted to patients at risk of deterioration when they knew about them. However, due to the delays in triage and assessment the staff were not aware of the risks for all patients who had to wait hours to be seen.

<u>Access through the Ambulatory Assessment Unit/Minor injuries department.</u>

The high demand on the service and insufficient staffing affected the time to triage for patients, for example, we saw up to four hour waiting times in the ambulatory assessment/minors to be seen by a triage nurse. The trust had developed START process (Supplemented Triage and Rapid Treatment), this process was to quickly assess patients to try and manage risks and stream patients to the right services. This had been discontinued as there was nowhere to stream patients when the hospital was full. As a result, patients were triaged by nursing staff and waited for medical review. We saw that patients waited for long periods of time for a triage assessment, some were in pain, and all were without initial observations to benchmark their health status.

Where initial assessments had been carried out and a decision to admit the patients was made, this area operated four 'fit to sit' spaces and five cubicle areas for patients to wait. These areas had been occupied by patients overnight. This meant those spaces were no longer free to see and triage the next patients. For example, on the first day of our inspection at 10pm there were 70 patients in the waiting room, 22 patients waiting to be triaged with one person waiting over three hours. The department was overcrowded, there was no seating available, six patients lay on the floor. Social distancing was not possible.

On the second day of our inspection at 8am the ambulatory assessment area had seen 33 patients and there were 70 patients waiting, some from the night before. By 12pm there were 92 patients in the ambulatory/minor's area with patients waiting two hours for triage.

We saw one patient who had been in the department overnight and was being treated/assessed in the 'storeroom' within this area. This was not an appropriate place to be assessed but the department had no space available in clinical areas.

Patients waiting to be triaged or for further review were not consistently checked for the risk of deterioration.

There was a standard operating procedure for checking on patients waiting, but there was no clear procedure or protocol for staff to follow about how often the patients in the waiting room should be checked. Because of this, there was no assurance that staff consistently completed the checks. The checks seen were partially completed. It was not clear how the intermittent information was used to identify patient deterioration. While we observed some staff walking around checking on patients, the intentional rounding documents used to record the wellbeing of patients waiting, were not consistently completed. This meant that patients could deteriorate without staff being aware.

There were safety huddles in the ambulatory assessment area to provide oversight of patients waiting, escalation of waits and admission and discharge decisions. These happened each shift and in between times as needed, to address any demand or risk issues.

Access through the major's entrance and the ambulance entrance.

Some patients had to wait for extended periods of time to access the emergency department which could pose a risk to their health.

High demand on the service meant patients were sometimes held in ambulances. The trust used a hospital ambulance liaison officer (HALO) system, which was a joint working arrangement with the local ambulance trust. The HALO system meant that a corridor was used to hold patients waiting for entry into the department. The corridor could hold up to four patients. However when the department was under high pressure, this was increased to seven patients and a staff member from the department was moved to the HALO corridor to provide support. Even with this increased facility, it was not sufficient to meet the relentless demand on the service. For example, on the first day of our inspection the HALO corridor was opened and accommodating the maximum number of seven patients as the department was full beyond capacity. In addition to the patients being accommodated in the extra seven HALO places and the full department, the ambulance reported six more ambulances inbound and so even with the increased capacity it was not enough to meet demand.

Patients could be waiting for long periods of time to access the department and be seen.

Urgent and emergency services

The emergency department had four resuscitation bays (also used for paediatric resuscitation) with flexibility of a further three bays being used for 'front loaded investigations' (FLIC), these investigations included bloods and electrocardiograph and swabs being taken. This was a pit stop area with little senior clinical input. There were 17 cubicles for major illness and injury.

We saw patients in the major's area having to wait over 12 hours to be seen and decisions made about their pathway through the hospital. On the second day of our inspection 20 patients had waited on trolleys, most in corridors in this area for over 12 hours whilst waiting for a bed in the hospital. These delays meant there was a risk patients would deteriorate while waiting.

Access through the frailty and paediatric entrance.

The paediatric waiting room was not opened during our inspection due to a lack of staff available. This meant that children came in through the ambulatory assessment area and had to walk through crowded areas with patients who may be aggressive or intoxicated.

Access into the Plym unit.

Patients accessed the Plym unit through any of the other doors into the department. After initial assessment, any patients presenting with signs of COVID-19 were transferred directly to this area.

Staff knew about and dealt with any specific risk issues, however due to the pressures in the department this was often delayed.

Staff told us they had 'triage assessment' training. The Australia Triage Tool was the system used. This system sorted patients by urgency and then streamed them to the appropriate area. The trust had planned that two triage trained nurses were always available, but this was not always the case. Staff completed full training and competency assessments had been completed to undertake this role.

Staff used the national early warning score (NEWS2) which recorded patient clinical indicators and required staff to respond when the score reached or passed certain limits. The paediatric early warning score (PEWS) was completed for children. These scores were used to identify signs of deterioration including sepsis. These scores were not immediately evident on the electronic system, so staff had created a write on board which provided staff with an immediate overview of which patients were at risk. This information then had to be transferred to a paper document. Plans were underway to introduce an electronic observations system that would provide alerts and escalations of emergency department patients. Their risk levels would be visible within the new ED operating system and visible to staff on appropriate digital displays. The deployment was in progress currently and planned to be implemented in 2022.

The service had 24-hour access to mental health liaison.

The increased number of patients with mental health concerns presenting at the trust mirrored the national picture.

The triage process for the mental health pathway included a risk assessment and defined the level of observation required. If a high level of observation was determined, staff considered an application to the bed management team to provide further staff. The clinical decision unit regularly cared for patients who were awaiting a mental health assessment.

Urgent and emergency services

There were no personal alarms for staff in the department except for the clinical decisions unit (CDU). If staff in the emergency department were threatened by patient behaviour, they were not able to call for help without using the emergency bell which may be out of reach. For staff on the CDU an alarm was available, but a recent incident showed that due to the immense demands on the emergency unit, the response was not timely. The potential risk of harm to patients presenting with mental health conditions and provision of mental health services was included on the emergency department's risk register as a serious risk.

To address this issue, recruitment of two more security staff had been completed. Further actions taken to promote security included staff trailing the use of a body camera and the use of tanoy alarm systems.

The system for management of patients who persistently presented with challenging behaviour was to issue red or yellow cards with actions related to how that level of disruption should be managed. A panel was held every Friday to discuss the yellow and red cards issued and to identify any learning for the trust.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. There were some delays in patients being seen and transferred out of the emergency department for admission elsewhere.

Mental health patients were not reviewed in a timely manner. The psychiatric liaison team were provided by a partner agency. The psychiatric liaison team office had relocated into the emergency department corridor to support quicker review of mental health patients and provide easier access to the service. Staff told us there were still long waits for patients to be assessed. This was supported by data provided. The data provided noted the time From Psychiatric Referral To Assessment from October 2020 to September 2021". Staff told us a target was for response within 60 minutes, we saw that most months exceeded a two hours delay.

Staffing

Nurse staffing

The level of experienced staff was not always available and the number of staff available was not always safe. The department leaders were not clear about how many nurses of what level of experience should be in the department and as a result junior staff were left in charge of the department. The trust were aware of the difficult position for nursing staff and it was under constant review, but most shifts were short of their planned number. This meant a risk to patient safety and immense pressure on staff. Staff were suffering from the effects of the prolonged pressure on the department and low staffing levels.
The number of nurses and healthcare assistants did not always meet the planned numbers.

An emergency department staffing review for nursing in March 2021, identified current and desired staffing levels for the different departments (paediatrics, minors, majors and education). A review was undertaken of the nursing establishment, the BEST nursing tool was used, this is a workforce planning tool to compare workload to staffing levels.

The number of trained nurses for the whole emergency department was aimed to be 17 trained nurses during the day and 16 at night. The most staff seen were 14 trained nurses on during the day. On the night of our inspection there were only nine trained nurses. The department was extremely busy with at one point over 150 patients in the emergency department and these numbers left the department unsafe. The numbers of health care assistants had improved, but there remained insufficient numbers in the department.

There was poor morale in the emergency department with many staff close to tears.

Urgent and emergency services

Nursing leadership in the emergency department included two matrons as the senior leads and a newly appointed head of nursing for urgent and emergency department. The department was supported by military nursing staff, however the numbers available varied.

The number of paediatric trained nurses working within the department was compliant with Facing the Future Standards for Children in emergency care settings by the Royal College of Paediatrics and Child Health.

Clinical educator posts, one band seven and two band six posts had been recruited to support staff training, although the band seven and one band six nurses were not currently available, leaving one clinical educator to support educational development for staff.

The service did not have enough nursing and support staff to keep patients safe.

The COVID-19 pandemic brought additional pressure to hospitals due to staff either becoming infected by the virus or being required to self-isolate, alongside normally expected sickness absence. The ongoing pressures created by the pandemic meant staff were exhausted and morale was low.

The numbers of patents attending the department had increased beyond capacity and staff were affected by the pressures of increased demand on the service. This ongoing and relentless pressure on staff had become normalised, staff had stopped reporting shortages as they told us nothing happened when they did. This had an impact on staff sickness levels caused by stress and related effects. One staff member told us “we feel destined to fail before we even start the day”.

When staffing levels did not meet planned levels, the trust tried using contingent workforce bank staff or to redeploy nurses into the department from other areas. Sometimes that was not possible, and the department worked below the identified establishment.

Self-rostering had been introduced to help improve a mixture of work life balance; there was a mixed feeling/view on this, however this had only recently been introduced.

The trust had completed a skill mix review of the current emergency department establishment in line with Royal College of Emergency Medicine Standards. This skill mix review was being reviewed by the trust at the time of inspection.

Managers calculated and reviewed the number nurses, nursing assistants and healthcare assistants needed for each shift, but this number was rarely met.

There was no supernumerary nurse in charge over the whole department. It was intended this role would be undertaken at matron or management level nurse; however, we saw they were not always on shift.

The aim for the department was to have one band seven nurse on every shift, working supernumerary to take charge of the department. The staffing of band seven nurses did not enable this to happen. During the night shift the most senior nurse was a band six nurse, and it was unclear how this band six nurse could manage overall responsibility for all areas of the emergency department as well as have knowledge of the patients in their designated work area of the department.

Urgent and emergency services

The department used emergency nurse practitioners (ENP) as part of the nursing team. Once the ENP left at midnight, staff told us it was not uncommon for those patients with injuries needing their attention to be still in the department, still awaiting treatment (applying a plaster cast, wound care etc) when the ENP came back at 8am the next day. Staff told us that when this happened multiple electronic incident records had been submitted to formally record and escalate this.

Staff safety was sometimes compromised by the reduced level of nurses available.

The clinical decisions unit was at the rear of the department and had ten beds and six seated waiting chairs and should be staffed by two trained nurses. The unit had a planned staff level of two trained nurses. This was consistently only staffed by one trained nurse. This meant that one trained nurse had to oversee ten patients in bed and six in the waiting area. There had been occasions when the nurse was at risk by being alone in the unit, because of additional nursing support not being available for challenging patients.

The Plym unit was used when COVID-19 patients attended the department. When this happened, the staff were taken from the main emergency department to staff this area, reducing the amount of emergency department staff available. When numbers of staff in the department were low, this was an increased pressure. Those staff were then required to remain in the Plym unit due to cross infection risks.

Staff were sometimes at risk. Reception staff and staff working on the main doors of the department were vulnerable because of their isolated working with some challenging patients. Reception staff regularly received threats from patients within the department. Reception staff were behind a clear screen, however the side door could only be accessed with a key lock code, therefore not easily accessible to the public in the department. Security alarms were available to the reception staff and had recently been used when staff were at risk but there was no response. Reception staff were seeing an increase of patients with mental health concerns, but they had no mental health training. The reception team were not responsible for the medical condition of the patients in the waiting area and so the trust leadership did not consider they would need mental health training. Safety concerns and incidents had been reported, however, there had been no changes, feedback or improvements to ensure staff safety. We were told that incidents were reviewed and action taken, for example, additional security provision had been allocated to the overall department. A comprehensive action plan was seen to address the issues raised by staff.

The health care assistant at the front door undertaking initial COVID-19 screening process were also at risk of challenging behaviour towards them by patients. This staff member, who worked alone, had no channels of communication/escalation in the event of a medical or security emergency. They had been issued with a body camera, but this was not working and so of little use in ensuring staff safety.

Emergency nurse practitioners (ENPs) worked in an area of isolation with no alarms or ability to call for assistance as required.

The emergency department risk register identified some areas of risk for their staffing. This included the use of a triage system and a suggestion of a more reliable triage system which could be implemented in line with changes to the trust's electronic systems. There was no timescale available for this change. To mitigate this risk, only experienced nurses were identified to undertake triage. However, this was limited as the emergency department had a high number of junior staff and the pressures on the department meant that there was no option but to use junior staff to undertake triage in all areas.

Urgent and emergency services

The service had vacancies it was finding hard to fill. In the April 2021 Trust Integrated Performance report, the trust reported a 2% vacancy rate for nursing staff in the Emergency Department. Recruitment had been ongoing with some post being filled.

Medical staffing

The service had 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. Medical staffing the department had been impacted by the relentless pressure the department was under.

The service had enough medical staff to keep patients safe. Medical staff recruitment was underway and a locum doctor with paediatric competencies was working in the department.

The emergency department and middle grade staff and trainees felt well supported by the consultants, who they said were approachable and well liked in the department. A comprehensive induction plan was given for two days to trainees and additional monthly planned multidisciplinary educational events. Despite the pressures on the department, efforts were clearly made to maintain teaching, supervision and governance where possible.

The department did not have enough consultant medical staff to ensure they were available 24 hours a day, seven days a week.

The ambulatory/minor's area had two registrar level doctors remaining in the department with occasional acute physicians and a consultant on some afternoons. Majors area had two consultants on throughout the day and an on-call consultant at night. There were 16 whole time equivalent consultants.

The clinical decision unit had one junior doctor, with access to senior medical staff from the major's department if needed for advice and support.

Paediatric consultants and paediatric acute care practitioners were rostered effectively to provide equitable cover; working towards providing 24/7 cover for the paediatric department. The department was working towards an additional 35% of staff receiving training in paediatric life support. There was a good relationship between the children wards and the emergency department.

Staffing skill mix

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

The department met the Royal College of Emergency Medicine (RCEM) workforce Recommendations 2018: Consultant Staffing in Emergency Departments in the UK, recommended consultants to be on duty in the department from 8am to midnight in medium and large systems. We saw this was covered in the department. Despite meeting this requirement, there were not always enough medical staff to ensure safe care and treatment. Staff told us the medical rota gave adequate cover on weekdays, but weekends were sometimes variable.

The medical staff matched the planned number.

Urgent and emergency services

In March 2021, the proportion of consultant staff reported to be working at the trust was higher than the England average, although staff still did not feel there were enough consultants. The proportion of junior (foundation year 1-2) staff was slightly lower than the England average. There was a range of differently skilled and experienced junior doctors and trainees. To increase the numbers, there were two advanced clinical practitioners (ACP), who were trained to undertake some medical staff activities.

In the April 2021 Trust Integrated Performance report, the trust reported a 13.3% vacancy rate for medical staff in the Emergency Department. Sickness rates for medical staff were high. The impact of continued high pressure on staff meant that the resilience of the medical staff was compromised, and staff were having to take time off sick to recover.

Records

Staff mostly kept records of patients' care and treatment. Due to the pressures on the department records were not all clear and up to date. Records were stored securely and easily available to all staff providing care.

Patient notes were partially completed.

Due to the very high demand on the service and the reduced staffing levels, patient records were sometimes partially completed.

There were varying degrees of quality of the completion of patient records. The standard of documentation was good. However, there was evidence of only partial completion of observations charts, food and fluid balance charts. This meant there was a risk that decisions made were not fully informed.

Intention rounding documents used to record the wellbeing and safety of patient while waiting in the department and the national emergency department safety checklist were not consistently completed in full every hour. This was due to staff being under pressure because of the high numbers of patients attending the department.

The trust had started an audit process of the intentional rounding documents and the results were being reviewed as part of the trusts governance overview. The audit scores were variable with frailty services showing a mostly good level of compliance. Clinical record keeping audits showed areas for improvement and an action plan had been completed.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. We saw that records were managed safely. The storage of the records were accessible and we always observed staff in the area and so maintaining a level of records security.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff mostly followed systems and processes when safely prescribing, administering, recording and storing medicines.

Medicines were seen to be stored safely and keys were kept in the possession of a dedicated member of staff. The processes for managing the expiry dates of medicines in grab boxes was not always effective and some date expired injections were found in different areas, including paediatrics and resus.

Urgent and emergency services

Staff were not able to access current patient group directions (PGDs). Patient group directions allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. The green file in minors had date expired PGDs and the displayed sheet also referred to date expired directions. On Plym, the nurse could only find an electronic PGD for paracetamol that expired in May 2017.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. Medicines were stored securely in line with the provider's policy and national guidance and access was limited to authorised personnel only. Oxygen was not always stored safely on Plym.

Staff followed current national practice/guidance to check patients had the correct medicines.

Staff were able to access the electronic summary care records to check currently prescribed medicines for patients on admission. We saw for one patient in the major's area that although their medicines had been prescribed, the timing on the electronic prescribing medicines administration (EPMA) system meant that they had not received their regular medicines on the day of our inspection.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The Trust operated an incident reporting system on which staff could record any incidents and medicine safety concerns. Staff told us they would get updates locally about errors and incidents.

Incidents

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.

Staff knew what incidents to report and how to report them.

Not all incidents were being reported due to time pressures and staff not believing they would be addressed. Staff were under such pressure that it was not seen as a high enough priority and there was a degree of apathy noted about actions taken as a response. This remained an issue from our last inspection

Root cause analysis documents showed that incidents had been investigated. Areas of both good practice and where care and service delivery problems had been identified. The investigations looked at any contributing factors and root causes.

All themes from investigations were reviewed at the clinical governance meeting to enable further clinical actions to be taken.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff described a good understanding of the duty of candour. The had a clear understanding of what it meant to them and what action they needed to take.

Is the service effective?

Inspected but not rated

Urgent and emergency services

The service was inspected but not rated.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

The emergency department used a combination of National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines to determine the treatment that was provided. Care, treatment and support was delivered in line with legislation, standards and evidence-based guidance, including the National Institute for Health and Care Excellence (NICE) and other expert professional bodies. Clinical care pathways and proformas included treatment of stroke, sepsis, asthma, fractured neck of femur (broken hip) and mental health problems.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

Patients physical and mental health was delivered using evidence-based guidance. We saw that in most areas of the emergency department, consideration had been given to safety, with ligature risks being removed when possible and risk assessed when not able to be removed.

Patient violence and aggression were managed in line with trust guidance. All staff received training in the management of challenging behaviour, and policies were available to support staff in managing violence and aggressive behaviours from patients.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

Patients told us they had been offered drinks and snacks where appropriate and when not, staff explained what the reason was.

We observed members of the catering team providing water, hot drinks and snacks for patients.

Patients on the Clinical Decisions Unit (CDU) were supplied with meals due to their longer inpatient stay. Before offering any food to patients, staff checked the patient was able to eat and drink.

Staff did not always fully and accurately complete patients' fluid and nutrition charts where needed.

Not all food and drink charts were complete. This was due, mostly to the high numbers of patients in the department and reduced level of staffing. However, intravenous fluids were given when prescribed and were monitored and recorded.

Urgent and emergency services

Pain relief

Staff did not always assess and monitor patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool.

The department used the Abbey pain scale tool for patients unable to verbally communicate about pain and used the same adapted measure for patients living with dementia.

Patients did not always receive pain relief and it was not always identified they needed it.

Pain relief was usually administered during the triage process through a patient group direction (PGD). Delays in triage meant some patients waited for extended periods of time without pain monitoring or pain relief.

However, patients were positive about the way their pain was managed. We observed staff talking with patients about the effectiveness of the pain relief and then further discussion to ensure ongoing pain relief was appropriate.

Patient outcomes

Staff monitored the effectiveness of care and treatment by auditing some aspects of the service. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant trust and national clinical audits.

This included audits of the intentional rounding and national early warning scores (NEWS2), pain management, allergy recording and the friends and family test.

There were outcomes of children's audits for children under the age of three months with a fever which identified key successes and any follow up actions.

NEWS audits were undertaken to ensure that the outcomes and subsequent learning translated into correct actions being taken. Results of sepsis audits showed that between August 2020 and September 2021 of the 664 records audited 99% treatment had been escalated correctly. Sepsis data was reviewed at staff huddles and was reviewed regularly to determine causes when delays in antibiotic administration were identified.

Patients with a traumatic brain injury should receive a CT scan according to the Trauma Audit and Research Network (TARN) within an average of 0.55 hours. From 1st January 2018 to 31st December 2020 the trust achieved an average time of 0.57 hours. The trust responded by increasing diagnostic capacity.

From 1st January 2018 to 31st December 2020 there were an additional 0.4 survivors for every 100 trauma patients at the trust compared to the TARN average.

Unplanned re-attendance rate within seven days

From June 2020 to May 2021 the trust's unplanned re-attendance rate to A&E within seven days was higher than the national standard of 5% at 7% and 8% but generally lower than the England average of 7.7% to 9.0%.

Urgent and emergency services

Outcomes for patients were positive, consistent and met expectations, such as national standards.

Venous thromboembolism (VTE) was audited to ensure patients who needed anticoagulant therapy were risk assessed and treated. Results showed that between September 2021 and August 2021 91% of patients had a VTE risk assessment and 98% were treated.

Competent staff

The service aimed for staff to be competent for their roles. This was not always achieved due to the demand on the service. Managers appraised some staff's work performance and held supervision meetings with them to provide support and development. This was also not always achieved due to the demand on the service.

Managers did not give all new staff a full induction tailored to their role before they started work.

New staff members were planned to receive one-month supernumerary time when core competencies and skills were completed. Staff told us this did not always happen due to the pressures on the service.

The department did not have access to a clinical nurse educator. This meant that due to the intense pressure on the department, learning came from other nursing staff.

Junior preceptorship nurses were no longer employed in the department. This was to enable them to have a wider experience and confidence before working in this pressured environment.

Specific training was given to nurses in the paediatric department and their competency had been assessed. There were always staff who had been assessed as competent to provide treatment to children on duty. However, the staffing levels aimed for were not always met due to staff sickness and absence.

Staff had access to further training to support their role. External and internal courses were available, including human factors training, trauma immediate life support, advanced life support, minor injury and illness, plastering trauma training.

There was planned teaching time for the emergency nurse practitioners (ENP) every Tuesday for one hour. This was dependant on the demand on the department. The sessions supported the ongoing learning and development of new and existing ENP's.

Doctors had protected time for learning. For example, middle-grade doctors had four hours protected teaching time every month. The sessions were led by a consultant and included simulations of emergency scenarios. These events were attended by staff of varying clinical roles. Learning and action points from these simulations could then be fed back to staff. Medical induction was face-to-face with a day to complete mandatory training.

Staff could access training on mental health and the psychiatric liaison team provided bespoke training for non-mental health staff. Staff on the clinical decision unit did not have any specific or focussed mental health training to manage this client group. They could access the psychiatric liaison service for advice.

For band six nursing staff it was planned, but they were yet to receive, two management days a year to undertake a trust leadership programme.

Staff had access to continued personal development opportunities. However, there was no skills passport or framework used for anyone new coming into the organisation who had already completed a preceptorship programme and updated mandatory training.

Clinical staff had not all completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Staff explained that training was available for them but due to the high demand on the service and reduced staffing this was not a priority. Staff told us that they could complete the training in their own time, and they would be recompensed for this.

Staff working in the emergency departments had received training in conflict resolution. However, if a patient became violent, they contacted the hospital's security team who received training in conflict resolution and restraint more regularly (every six months).

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Staff told us that staff huddles were undertaken each day and sometimes throughout the day.

Not all staff had received an appraisal of their work.

The appraisal rates for emergency department staff on 1st October 2021 was 58%. Out of 213 staff in the emergency department, 88 staff had not received a recent appraisal. Staff told us there was no time, due to the demand on the service, or staff available, to undertake regular appraisals.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Effective multidisciplinary working was evident in the emergency department. Staff worked together to prioritise and support patients, with staff across all grades, roles and departments working well together. Ambulance staff worked with the department's staff to ensure patient safety.

Staff attended multidisciplinary discussions about patients in the department and noted decisions were agreed for the patient's plan of care.

We saw medical and nursing staff handover information as shifts changed. Board rounds were held during the day to ensure a cohesive plan was implemented, reviewed and updated as needed. With so many patients, and limitations of the computer system, staff told us it was a challenge to review the patients in the department during board rounds.

The department had a good relationship with a small acute medicine team positioned in the department. This system seemed to work well for both teams.

The frailty teams were proactive in searching for patients whose pathways could be safely optimised.

Urgent and emergency services

The flow of patients through the department was often interrupted as specialty doctors were delayed in attending the department. The quality standard for speciality doctors attending the department was not clear and there was no agreed internal professional standard audit to monitor the time taken. This meant that delays created did not prompt action to address and reduce future delays.

The psychiatric referral team and the child and adolescent mental health service (CAMHS) team contacted the emergency department every day to check if there were any patients with a mental health need.

Porter services worked well within the department. Porters transported patients for diagnostic tests and transferred patients to wards. The department had its own porter available and the Plym area had access to a 'Red' porter to manage any transfers which may pose a risk of cross infection. They were seen to be accessible and helpful.

Security staff were observed to patrol the department and staff told us when needed they could count on security staff to arrive promptly, when they were able to. We spoke with security staff who confirmed two extra staff had been recruited.

The emergency department could access the learning disability team for advice and support. The minor's department had a wide range of resources and documents for staff on the internal information system including 'easy reading leaflets' for patients with extra needs.

Staff did not routinely receive any training in learning disability but could if they requested it.

Seven-day services

Most key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, most were available 24 hours a day, seven days a week.

The department provided some services in line with the NHS seven-day services clinical standards.

Nurses and medical staff provided cover over 24 hours a day, seven days a week. This was either on site or on-call. Junior and middle-grade doctors told us the consultants were always accessible and gave them good support and would attend when they were on call if requested.

Pharmacy services were available either in the department, accessible by telephone or on call. Staff told us should they need specific medicines not stocked in the department; they could access through the on-call pharmacy.

Diagnostic imaging services which included X-ray and scans were available 24 hours a day, seven-days-a-week. These were located next to the department. Once completed, emergency department staff were able to view the images on the department's computers, prior to a formal report being received. Increased access to x-rays and scans had been enabled to support the demand on the service.

Some services had been affected by the COVID-19 pandemic. For example, the diabetes lead explained that they lost 50% of their staff to redeployment during the pandemic. Despite this, they had developed seven-day week services rather than five-day week.

Urgent and emergency services

The emergency department and wider hospital major incident plan had been amended to reflect consideration of COVID-19. The plan had been tested in a recent live situation and the systems involved had been found to be effective.

The emergency department was prepared for incidents which involved hazardous materials, these were known as HAZMAT events. For these events, equipment was stored by the front door and staff confirmed that a practice of the procedure had been completed within the last six months.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The emergency department had relevant information promoting healthy lifestyles and support.

Patients were supported to live healthier lives and health promotion advice information was seen throughout the department and the wider trust. For example, we saw directions on hand washing and social distancing, and we saw more medical based advice about sepsis, which included recognising sepsis in children. There was support advice for patients with autism and those caring for patients with learning disabilities.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

We observed nursing and medical staff talking to patients and relatives about how their health conditions could be managed and improved. For example, we overheard a staff member explaining why it was important to drink enough water and another was explaining why it was good to keep moving.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent, but this was not always recorded. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff followed the trust policy when a patient could not give consent. Staff we spoke with demonstrated a clear understanding of their responsibilities to patients who may lack capacity to make their own decisions. In the adult emergency department, we observed consent being requested, and where consent was refused staff knew to document this, along with confirmation the patient had the mental capacity to make the decision. However, not all records contained written evidence of agreed consent.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions.

For patients who required emergency decisions to be made for them, for example patients who were unconscious, staff made decisions in the patient's best interest and staff described the audit trail of decisions which had been made and these were clearly documented.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Urgent and emergency services

Staff understood Deprivation of Liberty Safeguards (DOLS). Due to patients normally only being in the emergency department for a short time, formal mental capacity and DOLS applications were normally completed by the ward they transferred onto. If in an emergency, a patient refused treatment, staff explained the treatment was in their best interests and if required, the consultant made a best interest decision about what to do in the least restrictive way.

Staff demonstrated good understanding of treating patients under a section 136 order. A 136 order of the Mental Health Act 1983 allows for a patient with a mental health crisis to be removed by the police to a place of safety for a restricted period.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

Staff in the paediatric department described the difficulties in managing children as they approach 18 years of age. They understood that children may prior to 18 years, want to make some health-related decisions and they used the guidelines to ensure best and safest practice.

Is the service caring?

Inspected but not rated

The service was inspected but not rated.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff could not always meet the privacy and dignity needs of all patients.

Staff were discreet and thoughtful when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Staff were courteous when caring for patients. We observed staff introduce themselves and explain who they were and their role. They spoke quietly to patients to try and ensure they maintained a level of patient confidentiality.

We saw staff providing compassionate care when they were able to do so. Most staff apologised for keeping patients waiting, despite it being beyond their control. Staff told us they found it very distressing to have patients in corridors and not being able to provide the dignity and respect they felt they should have.

We saw staff trying very hard to cover patients up and to provide suitable space for patients to use the toilet.

We saw occasions when medical and nursing staff had to discuss diagnosis and treatment to patients on corridors. Staff said they found this distressing and not in line with the care they wanted to provide.

Patients said staff treated them well and with kindness.

Urgent and emergency services

Patients we spoke with told us that the care they received was kind and caring. Several patients told us that they had sympathy for staff as they could see they were busy. One patient told us “It’s not surprising they get a bit fraught, it’s so busy, I feel very sorry for them”.

Another patient told us “it’s all a waiting game and some people get a bit grumpy, but when they do get to you, they are very caring”.

“Staff are very kind, and to be honest, I am just glad to be seen”.

Staff tried to keep patients care and treatment details confidential.

We saw a junior nurse quietly explaining to a patient on a corridor why they needed a procedure. It was impossible for this conversation to remain private, but the nurse worded the conversation to be as discreet as possible while still explaining the treatment. We saw that she held the patient’s hand and reassured them with great kindness.

Patients waiting for long periods of time were not able to social distance and staff could not ensure their dignity.

Due to high numbers of patients attending the emergency department, and the lack of space in the hospital for emergency department patients to transfer to, patients were being held on corridors for extended periods of time. We saw patients held there for up to and above 24 hours. Patients’ privacy and dignity were respected, whenever possible. The emergency department was frequently crowded, and patients could not always be accommodated in the most appropriate area of the department.

When demand exceeded the number of cubicles, some patients were cared for in different corridors/queueing areas. These areas did not always ensure patients’ privacy and dignity could be maintained. Staff pulled curtains shut when undertaking care. However, limitations of the environment for patients being cared for in the corridor meant staff were not always able to provide the dignity and privacy they wanted to provide for patients.

For the patients on trolleys in corridors there was little privacy and dignity and they had no means to alert staff attention should they feel unwell.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Emotional support was provided by staff to patients and relatives, but staff told us they would like more time to be able to do this properly. We saw staff providing explanations, listening and supporting patients and relatives. When patients were visibly distressed, we saw staff take time to reassure and support them.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Urgent and emergency services

Staff made sure patients and those close to them understood their care and treatment.

Staff communicated with patients and relatives, so they understood their care, treatment or condition. Patients and relatives we spoke with were aware of the next stages of their treatment or what they were waiting for. Staff ensured patients and relatives understood the information and were given the opportunity to ask any questions.

We observed that staff provided explanations to patients in a calm and reassuring manner.

Relatives and carers were given timely support and a space to have discussions. Staff directed relatives and carers to a quiet room. These rooms were furnished in a way which was non-clinical and friendly. This provided staff the opportunity to have sometimes difficult conversations and provided a private space for relatives and carers to wait.

We observed staff supporting patients with a mental health issue. They showed understanding about their condition and talked to them with respect and kindness.

Is the service responsive?

Inspected but not rated

The service was inspected but not rated.

Service delivery to meet the needs of local people

The service tried to plan care to meet the needs of local people and the communities served. However, this was not possible to deliver due to the demand on the service and the constraints of the emergency department.

The trust planned services to try to meet the needs of the local population, but the emergency department was too small to meet the demand.

Facilities and premises were limited in size and struggled to meet the demands created by the wider health system. The demand was created by limited availability of alternative health and social care services in the community and a reduced ability to discharge patients safely back into the community. The trust worked well with the wider health and social care system, but this was not effective or responsive enough to enable the emergency department to cope with the surges through the front door and the lack of beds to admit patients to in the wider hospital. The trust tried multiple ways within the constraints of the department but could not meet the relentless demand.

The department provided separate entrances for ambulance patients and those who make their own way to the department. The ambulatory assessment unit/minor's unit had a reception and a seated waiting area for patients requiring assessment and treatment of minor illness or injury.

As a result of the COVID-19 pandemic a further area "Plym" had been provided as a nine bedded area for the streaming of patients considered at risk of having COVID-19.

The hospital also had a front door frailty assessment unit. This was designed to deliver timely care in collaboration with primary care partners and avoid whenever possible hospital admission for elderly frail patients. The access to the frailty

team was seen by staff in the department as an asset. By increasing the access into the department, staff confirmed this had reduced the volume of patients in the waiting areas and improved patient visibility. This reorganisation was also hoped to reduced ambulance handover times, help staff manage triage times and reduced overcrowding during times of surge in attendances.

Staff could access support 24 hours a day, 7 days a week for patients with mental health problems and for those with a diagnosis of dementia.

There was a mental health assessment room in the observation unit. The room was well equipped to meet the needs of patients and staff needing a quiet safe space to undertake mental health assessments.

Meeting people's individual needs

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

Staff understood and respected the personal, cultural, religious and social needs of patients in the department. Staff tried to meet those needs as far as was possible within the constraints of the department and the pressures currently ongoing.

The trust had a learning disability team who could provide support to patients within the department when needed. Patients with known learning disability could be alerted to the team when they arrived in the department.

We saw that consideration had been given to patients with visual impairment and those living with a diagnosis of dementia. There were contrasting colours used for toilet seats, doors and door frames to provide visual aid. Call bells to call for help were available near the toilets and clear signage was available.

Patients living with dementia were seen to find the department a challenge and sometimes they found it to be very distressing. The pressures on the department meant that some patients with dementia waited for a long time in corridors. This was distressing for them and for staff.

Managers made sure that anyone needing language support could get help from interpreters or people who could use sign language. Staff were able to access interpreters for patients whose first language was not English. This could be arranged via telephone or electronic tablet. Patients with hearing impairment could request staff to access a person who could use sign language for them.

Access and flow

The trust faced challenges with access and flow which meant they could not always ensure patients accessed the emergency department when needed, or ensure they received timely treatment. Some of the challenges were beyond the control of the emergency department. Delays were seen in patients accessing the emergency department, waiting to be seen and treated, and admission into the hospital.

Patients did not have access to timely care and treatment.

Since our last inspection action had been taken to resolve triage delays. The emergency department entrance had been reorganised, creating one entrance for ambulant patients and one for ambulance patients. Standard operating

procedures were reviewed to provide assurance of clinical oversight and define responsibilities for actions to be taken. Patients were being triaged by clinical priority with oversight of the risks of patients deteriorating while they waited. Further monitoring was noted to be needed to provide the trust with assurance of embedded process and compliance with national targets.

The emergency department remained under significant pressure while the issues driving that pressure were beyond the control of the both the emergency department and the trust. Staff in the department felt the risk of patient harm was held in the emergency department. The trust declared an internal critical incident the night before the inspection, and this continued throughout the inspection. This meant that the trust recognised these pressures as an event outside of the range of what would be considered normal activity. Staff told us that declaring a critical incident did not generate any visible improvement in working conditions for them.

We also visited the department two weeks later and this position remained unchanged. The department continued to receive patients at a level which was greater than capacity due to the level of demand, with patients delayed in the department for over 24 hours.

Escalation was working effectively, but despite these efforts the surge of patients to the department and the lack of beds for hospital admissions meant that the department remained under severe pressure and was overcrowded with patients.

Flow challenges to move patients in and out of the department were exacerbated by workforce shortages which were deteriorating as staff became exhausted and stressed by the pressure. A workforce review was undertaken, and a recruitment campaign was in progress.

Patients waited long periods of time to be seen and treated.

On the first day of our inspection 316 patients had attended the department. This resulted in 130 of those patients being admitted to the hospital. The trust discharged 84 patients and the capacity of the hospital was running at 102%. Some patients had been waiting in the emergency department for over 24 hours for admission to the hospital.

Performance data showed delays in patients both accessing the emergency department and waiting to be seen by medical and nursing staff. This posed a risk that patients were unable to access care and treatment in a timely way.

The wider hospital flow was impacting on the emergency department. To improve the patient flow into the emergency department the trust implemented a senior triage and rapid treatment (START) process in October 2020. This process had since been altered so that the senior clinician is no longer involved with this process.

When patients were waiting review by speciality consultants, this could cause delays in care and treatment. To improve the delays previously seen by waiting for medical review, a small team of medicine staff were in the department, assessing and planning care for some medical patients awaiting admission.

Patients receiving care and treatment for cancer or end of life had a faster pathway into the hospitals to avoid them staying in the emergency department for longer than was necessary.

Some patients attended the department for non-emergency reasons.

Urgent and emergency services

Patients attended for many reasons outside of the remit of the department. For example, patients had attended because they couldn't get a doctor's appointment to change a wound dressing. Staff told us this kind of attendance was becoming a regular occurrence.

Staff said that when there was a primary care GP within the department, this was proved to be beneficial in assisting patient care and flow. However, there was no evidence of this role within the department during the inspection. Nursing staff said this was only provided one day a week when the GP was available.

Escalation procedures were responsive but could not meet the demand on the service.

Escalation systems in the trust worked on a bronze/silver/gold schedule, this meant that throughout each day meetings were held, flow reviewed, and actions taken forward to promote the flow of patients throughout the emergency department and wider hospital. The actions were then reviewed and amended as needed. This escalation process was continuous throughout the day and ensured that staff at department, management and board level were aware of the current flow situation.

Escalation actions could not create sustained flow through the emergency department. On the 18 October 2021 at 8am we saw patients in the ambulatory care area and on a trolley in the major's area who had been waiting for admission to the hospital since the morning of the previous day. Across the trust there were 146 patients fit for discharge. Of those 116 had been delayed because of lack of ability to safely discharge them into the community.

The average length of delay had a trust target of one day but was running at eight days. This length of delay varied and had been at a higher level since September 2021. The patients with the longest length of delay were discussed three times each day to try and address the causes of the delays. The delays were mostly related to social care capacity, mostly for patients requiring dementia and nursing care.

When the department was under severe pressure as it was during our inspection, decisions made to help the department did not visibly translate to a reduction in pressure on staff in the department and communication about actions was not maintained. This meant staff felt isolated and the risk of patient flow remained mainly with the emergency department.

The emergency department monitored the attendance data, but this was not used to help with service planning.

The departments used a predictor tool to review the same level of activity 12 months previously to provide insight into the demand on the service that day. The trust regularly looked at patient patterns of attendance when planning models of care. The trust used attendance data to plan medical rotas. The trust leadership aimed to get additional nurses on shift for the evening busy period. Staff rotas should be adapted to meet demand and potential surges, but this was not possible because there were not enough staff to meet the level of demand.

At our previous inspection in March 2021, we told senior members of the trust they should look at developing or enabling systems to give a real-time presentation of performance to provide staff with an understanding of how well the system or department was working and to give motivation for staff when used effectively. This had not yet become available to staff.

The hospital monitored the demand on its service.

Urgent and emergency services

For acute trusts, NHS England's operational pressures escalation levels (OPEL) had been nationally defined as being levels one to four, with four being the highest level of operational pressure. This detailed how the trust identified and responded to pressures within its system daily, as well as at times of extraordinary pressure. This framework relates to adult beds. Each day bed meetings took place at 8:30am and 4pm, to review the flow of patients through the hospital. Those meetings were attended by bed managers and department nurses in charge. Some staff attended virtually.

Data provided by the trust showed that demand on the service had significantly increased. Data from March to July 2019 and March to July 2021, demonstrated a significant increase in days the trust spent in OPEL 4. For example, in May 2019 the trust spent 19.4% of the month in OPEL 4. In May 2021 the trust spent 58% of the month in OPEL 4. This significant increase showed a continued pattern through June and July 2021.

Very few staff were aware of the OPEL level of the trust or the actions that were involved or resulted in. The department clearly had accepted and 'normalised' a level of busy activity that meant it was not being responsive or proactive to patient needs or promoting flow within the trust.

There was no full capacity protocol available for staff to reference. A hospital full policy was in draft form. This policy described the process of sharing risk across the organisation when the emergency department had more patients than it could safely care for.

Although the trust had recently updated their discharge lounge policy and introduced the Discharge-Exchange policy, there was no effective full capacity protocol available to staff to follow.

The hospital had implemented admitting patients to wards in excess of the ward capacity while waiting for patients to be discharged. (Discharge-Exchange policy, also referred to as boarding). Work had been undertaken to prepare for any potential discharges for example by completing prescriptions for take home medicines and letters for discharge. This meant that when the patient was told they could leave there were no delays and so the bed could be refilled as soon as possible.

On one day of inspection, this system was used twice throughout the day to try and create some flow through the emergency department. The flow was brief and not sustained.

We saw the minor injury unit run by the trust but located in the community was also overwhelmed by demand and had to close its doors to enable it to catch up and so diverted patients to the main emergency department. This increased demand on the emergency department.

At the time of inspection there was excessive demand on the service and the trust took action to provide extra bed space. A COVID–19 ward was cleaned and opened to accommodate the excess patients waiting in the emergency department. The newly opened ward during our inspection was struggling to be staffed safely.

Medically expected patients were managed through the emergency department, which increased pressure and reduced capacity through the department.

The patients who arrived by ambulance or individually following referral by their GP came through the emergency department. This increased the demand on the service. The senior leadership team confirmed that whilst not ideal, at this time there was no other point of admission available for them.

Patients had long waits in ambulances due to increased demand on services.

Urgent and emergency services

Throughout our inspection, there were long ambulance waits with ambulances queuing for several hours. There was confusion amongst staff as to who had ultimate responsibility for the patients in the ambulance queue outside in the car park and the standard operating procedure was not immediately clear for staff.

The standard operating procedure for the trust stated "Acute trusts have a responsibility towards the patient from the moment that the ambulance arrives outside of the emergency department. However, the duty of care that ambulance clinicians have to their patients is not altered by being outside or within the emergency department. This duty does not transfer to the hospital until a physical handover has been completed and the hospital has accepted the patient".

Ambulance handovers were not in line with standards for an ambulance handover (clinical handover and offload) to be reliably completed within 15 minutes of arrival. Compared to other hospitals the handover performance showed this issue was not unique to Derriford Hospital.

The median average time from arrival to initial assessment was higher than the overall England median average over the 12-month period from August 2020 to September 2021. Data indicated that the highest waiting times were over winter between December 2020 and March 2021. This would concur with the winter pressures felt at the hospital.

The trust had reported a higher proportion of ambulance handovers over 60 minutes compared to the England average. Again, compared to other hospitals the handover performance showed this issue was not unique to Derriford Hospital.

Patients often waited over the recommended time which was not in line with national guidance to receive treatment.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard in any of the last 12 months from June 2020 to May 2021 and in 11 months the median time to treatment had been over 90 minutes. The England average was 43 minutes, there was no target, but this was worse when compared to other trusts.

The trust was part of the rapid care assessment pilot trialling the four new standards set out in the NHS review of clinical standards. The NHS constitutional standard to see, treat, admit or discharge 95% of patients within four hours was therefore not required to be reported on. The performance data from the new target was not readily available to the emergency department staff, which had an effect on the ability for the trust to compare performance.

The systems to promote flow were not always effective, with the increasing demand for the emergency department outweighing the capacity available within the trust.

To aid flow from ambulances the local NHS ambulance provider had placed a hospital ambulance liaison officer (HALO), in the entrance to the emergency department. The HALO was onsite from 11am to 11pm seven days a week. Their role was to ensure the smooth offload of patients into the department, to look after ambulance crew welfare, to liaise with the emergency department about patients waiting in ambulances and help manage the flow of ambulance patients into the emergency department.

The HALO standard operating procedure identified that the trust was responsible for these patients and those being held on ambulances in the hospital car park, with the ambulance trust providing immediate care until they were formally handed over to the emergency department. We saw this time could range from a matter of minutes to hours.

Consultant doctors went out to the ambulances and check on patients every couple of hours. This checks and decision making were not recorded. There was no reference to this review on the HALO standard operating procedure. This meant there was no record or audit of this practice and the trust could not be assured, especially under periods of consistent and ongoing pressure, that staff were maintaining this practice. This meant patients waiting for extended periods of time may not be correctly prioritised for entry into the department.

There was a patient booking system, registering patients arriving by ambulance. These patients were visible on a separate screen prior to being triaged. This alerted staff within the department of the number of patients waiting in the ambulances.

The HALO had access to the electronic system used by the ambulance service and could see crews due to enter the department, allowing collaboration with the emergency department team prior to the patient's arrival. The ambulance service also collated their own data daily capturing delays and lost unit hours incurred within the department and escalating these through their electronic reporting system.

If there was capacity within the department the patient was handed over to the sister in charge, then the care of the patient was formally relinquished by the ambulance crew. If there was no bed capacity the HALO and the nursing sister would receive handover of the patient. The patient was then be transferred onto a hospital trolley, where they would be wait within the emergency department corridor.

Between the hours of 11pm and 11am, there was no commissioned HALO service, which meant ambulances would queue, and as a direct result the ambulance service would have to take ambulances off the road to deliver this service. We observed that this had an impact on the ability of the ambulance trust to respond to other emergency calls.

Same day emergency care (SDEC) for patients was not seen to be responsive to the demand on the department.

Many staff told us the numbers of patients who could be seen, treated and discharged within the department was high. The same day service took patients away from the overcrowded department. Most staff said this was not used effectively. The same day emergency care provision was not focussed at the front door and was spilt across a variety of specialities.

So far in 2021 there had been 1768 Same day Emergency Care (SDEC) visits which resulted in no admission, this was 53 more than the whole of 2020, and was 256 and 342 more than 2018 and 2019 respectively (as at end of September 2021). Patients attending the same day emergency care service were treated throughout the hospital and not just in the ambulatory assessment unit.

These SDEC pathways were not considered by staff to be easy to access as a simple pathway or process. The total amount of SDEC slots available to emergency department clinicians were insufficient for the volume of patients attending. The available slots and performance were not visible to emergency department staff. Five morning slots were given to the emergency department. This was described more as an offload than a proper process or easily accessed pathway by department staff.

Other providers supported the flow in the emergency department, but this was not consistent. We were told that there was a general practitioner (GP) at the front door of the emergency department providing some primary care streaming and same day emergency care. On each day of our inspection there was no GP working in the department. There was no consistent provision for GPs to work in the department and be able to provide a same day emergency care service.

Urgent and emergency services

From July 2020 to June 2021, the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was lower than the England average.

Over the 12 months from July 2020 to June 2021, 434 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers were during January and February 2021, which was reflective of the winter pressures felt by the trust. The department consistently had 12-hour trolley breaches with the highest number of 115 being recorded in September 2021.

Patients could not all access the emergency department in a timely way and the trust faced known challenges with access and flow. From June 2020 to May 2021 the monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was higher than the England average. The trust's performance ranged from 2.9% to 7.2% of patients leaving the department before being seen, compared to the England average of between 1.9% and 3.5%. The highest point when patients left before being seen was August 2020 during a high point of pandemic activity at the trust and June, July and September 2021 which was a high period of activity at the trust. This was reflective of our observations, when patients had to wait for long periods to be seen

Managers and staff worked to try to ensure patients did not stay longer than they needed to, but the demands on the service and challenges with access and flow did not ensure this was consistently managed.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns.

Complainants were directed to the patient advice and liaison service (PALS) and complaints team . The service clearly displayed information about how to raise a concern in patient areas. Information about how to raise a complaint was available from staff in the department and on the trust's website.

The emergency department received 109 complaints from 01 September 2020 to 30 September 2021. Of those, 85 related to the emergency department, eight to the paediatric area and six to the clinical decision unit.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service.

Learning from complaints was discussed at governance meetings, team meetings and, if safety related, during safety briefings. Staff involved were included in the investigation process and given appropriate support where necessary. Staff told us they sometimes received feedback to any complaints they were involved with.

Is the service well-led?

Inspected but not rated

The service was inspected but not rated.

Urgent and emergency services

Leadership

Emergency department leaders had the skills and abilities to run the service, however they were not all visible and approachable in the service for patients and staff. There were plans for staff to develop their skills and take on more senior roles, but current service pressures were preventing this from happening.

Staff told us department leadership was good and they mostly felt supported. The senior trust leadership was not clear to all staff.

The leadership team included medical leadership from a consultant clinical lead and nursing leadership from two matrons and a newly appointed head of nursing for urgent and emergency care. Staff said that emergency department nursing and medical staff leaders were mostly visible and approachable.

The department remained under significant and relentless pressure, with normalised low staffing levels and with staff feeling unseen and unheard. Staff told us that there was some engagement from deputy nurse and chief nurse when the department was under severe pressure. Staff said the focus on operations to manage capacity and flow was so enormous that conversations around development of leadership were challenging as department leaders and staff were constantly pulled back to operational issues. Staff explained that this had an impact on their resilience and morale.

Staff told us that while they knew changes at a senior trust level had been implemented, these had not yet translated into any visible changes in the department.

Considerable work had been undertaken to develop and promote good communications and relationships between the emergency department and the trust leadership. However, staff did not have regular visibility of the senior management team and staff told us that the changes do not translate to improvement at department level.

There was a plan for a nursing development programme, to support band six staff to develop their management skills.

During the inspection we noted that the band seven staff managed the band six staff, but there was no clarity about who managed the band five staff. The band six nurses did not have any managerial responsibility towards the band five nurses and while a band six development programme was planned, the systems in the interim were unclear.

Vision and Strategy

The service had a vision for what it wanted to achieve. The vision and strategy were focused on sustainability of services and were dependant on plans within the wider health economy. The pressures on the department were related to the wider health systems and economy and this had impacted on how the vision could be achieved.

Leaders and staff understood and knew how to develop the plan and monitor progress but were delayed by the external pressures on the department.

Leaders sought external support, but they found restrictions in the improvements they could make as this required a trust and system-wide approach alongside changes to the emergency department. Several new initiatives were being trialled to promote flow and reduce unnecessary attendance. Staff told us that because of the pressures on the department, new operating procedures were implemented but were not sustained and so the vision and strategy was not successful. Staff found this frustrating as some felt that there was a lack of commitment by leadership to putting in a strong enough infrastructure to sustain the changes.

Urgent and emergency services

The emergency department leadership team told us they were focused on improving performance. They had reinstated safety huddles, which were now held three times a day. There was a recovery plan that involved investing in the departments workforce and structure.

Culture

Staff did not feel supported and valued. They were focused on the needs of patients receiving care and felt that they were isolated. The service had an open culture where patients, their families and staff could raise concerns without fear. The service promoted equality and diversity in daily work and provided some opportunities for career development.

There were long standing cultural issues within urgent care which were being addressed. Staff were a strong team who focused on the needs of patients receiving care.

Staff were working under relentless pressure with reduced staffing numbers and increased demand on the service. We saw they were a strong team, working to support each other and with a dedicated work ethic which meant they looked after each other during and after challenging and exhausting shifts. The impact of this was that they were exhausted and demoralised. Staff morale across all staff grades was low.

Despite these pressures, we saw doctors and nurses, receptionists, ambulance staff, therapists and porters, trying to do the best for patients despite the crowding and the intense pressures and very high numbers of patients in the emergency department. Staff worked together as a team despite the difficult circumstances to try and reduce these risks and to try and deliver safe patient care.

Staff told us the department had lost a significant number of staff at all levels to staff sickness and resignations. The very real issues of staff burnout were recognised and had been tackled with a variety of initiatives within the trust including surveys, a wellbeing room and psychological support.

The trust had implemented strategies to develop better relationships with the emergency department and the senior trust leadership.

The trust and NHS England and Improvement had commissioned an external review which focussed on cultural and relationship challenges. The review took place in December 2020, and since then a piece of work had been carried out looking at the culture of the department, involving the emergency department clinical leaders, the care group and the trust executive team. Staff felt that actions resulting from this piece of work had helped and that relationships in the department and with leaders were in a better place.

A culture group had been developed with both internal and external facilitators to develop workforce inclusion. A staff council was introduced following the external review, to encourage staff to speak openly.

There were dedicated freedom to speak up listening events set up and being held for the department. Staff were not all aware of access to the Freedom to Speak-up Guardian role and how it could support them if needed.

There were planned mechanisms for sharing risk across the organisation.

Staff felt there was a lack of a shared culture across the whole hospital. There was view that if the wider hospital made a bigger effort to support the department in practical terms, the load and risk would be shared, and patient care would improve.

Urgent and emergency services

Governance

Governance processes were in development and some areas required strengthening to improve patient safety. Staff at all levels were clear about their roles and accountabilities and had opportunities to meet, discuss and learn from the performance of the service.

There were developing structures, processes and systems of accountability to support the delivery of the strategy.

Governance was being addressed to improve oversight of the service. The nursing leadership had implemented governance improvements across the trust, for example introducing key performance indicators to demonstrate effectiveness of each area. However, the emergency department had not yet been through this process.

Staff told us there had been a lot of change in the previous year around the governance of the emergency department. The trust had implemented system improvement work, looking at the emergency department pathways.

A quarterly learning from deaths report was presented to the board which looked at mortality performance and actions taken to ensure learning from deaths was recognised. A mortality review group was relaunched in April 2021.

Every board meeting included an update on the emergency department situation and governance. Every month the board was updated about the emergency department, including emerging issues, for example ambulance delays.

There were areas of governance which were not being used to develop the specific areas identified at the inspection.

There was limited oversight and governance to identify patients at highest risk. There was no live data available to staff to see which patients were in the poorest health or the highest priority. There were insufficient information technology systems to allow staff to see which patients were the highest priority. Staff had implemented a National Early Warning score board which needed to be cross referenced to the paper record system. This was an effective system as a short-term measure but relied on staff understanding that the boards and records needed to be updated together.

There was limited governance to monitor the safety of equipment and routine checks in the emergency department. Due to the lack of staff, increased capacity pressure and poor process management, equipment checks were not consistently completed. There were insufficient governance systems to ensure consistent checks were undertaken.

Staff described a lack of sustained practice and limited governance oversight of protocols. This meant that lines of clear communication were not used, and so newly implemented systems were not all successful. For example, there was no auditing of interventional rounding to establish patient safety.

There were no audits or governance overview of quality standards. The use of paper records for patients created a reduced opportunity to automate processes, audit records, systems and processes quickly, and to be more responsive to safety and flow issues. The department was planning to move to an electronic paper record later in the summer 2021, but this had been delayed to the end of 2021.

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. However, these actions were not all successful due to the pressure on the service. They had plans to cope with unexpected events but were restricted by the demands on the service.

There were assurance systems used to monitor risks and these were regularly reviewed and improved.

Risk registers were used in each department, and there were further risk registers at divisional and trust level to oversee, monitor and review risks. The risks recorded on the registers reflected the concerns staff and managers told us about. The department had a local risk register, which was reviewed by the clinical governance lead and matrons on a quarterly basis, or sooner if something had significantly changed.

The department risk register included concerns about staffing, the environment and crowding in the department. Some of these were escalated to the corporate risk register.

The trust used a board assurance framework to provide information about severe and very likely risks. These included risks related to COVID-19.

Information provided by the trust demonstrated a clear recognition of the difficulties ahead.

The trust were planning for a surge in demand over the winter and were being creative in looking at ways to increase discharge capacity and so promote the flow of patients through the hospital.

Risk assessments were used to review and monitor ongoing department risks. Some risk assessments were not well completed.

Risk assessments were not all well completed or informative. The trust provided managers and staff with comprehensive guidance on the process, including virtual risk assessment interactive briefing sessions.

The risk assessment associated with crowding in the emergency department and the risks of COVID-19 transmission, the risks to patients of delays in triage and the overall impact of working in these conditions for staff; did not have control measures which identified all areas of risk and were limited in content.

There were areas of risk to patient safety which did not always have appropriate actions taken to reduce their impact.

The welfare and safety of the COVID triage health care assistant (HCA) had not been fully considered by the trust. This individual was patient facing and solo working, with no access to alert security or clinical staff if there was an emergency or security situation.

Information Management

The service collected some data and analysed it. The information systems were secure but lacked the scope to inform staff about real time activity. Data or notifications were consistently submitted to external organisations as required.

Staff did not have enough access to information about patients or systems used. There was no access to technology systems to inform staff and effectively monitor and improve the quality of care.

The department did not have a means to monitor patient acuity and the department's ongoing performance. There was a lack of access for the department to real time data. The computer system used was unable to convey how the department was performing against key performance indicators. There was no dashboard or other means that enabled staff to see a live display of performance, acuity or activity.

The computer system did not have capacity to inform staff which patients were the sickest and those at high risk of deterioration. Neither national early warning scores nor pain scores were visible on the system. However, a new system was due to be implemented in the next year. The trust have since advised us that emergency department dashboard discussed during inspection, was now being used daily to help run the department.

Data systems were secured and monitored.

Processes were followed when there was any breach of data, which led to learning and if needed change of practice.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

Staff views were considered but not always seen by staff to be reflected in the planning and delivery of services.

Communication and the relationships between senior managers and frontline staff were being addressed as part of an ongoing piece of work. There had been a recognised breakdown in trust between senior managers and the emergency department staff.

Although during our visit, members of the executive team were very much visible in the department, most staff said that it this could be improved. Several trust initiatives had not filtered down to all the emergency department staff. For example, the discharge exchange policy or access to same day emergency care slots in various specialties were not known by all staff.

There was no facility currently for patients or relatives to provide feedback other than the friends and family test.

We heard about positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population.

We spoke with the hepatology lead who explained they wanted to reduce emergency department presentations by trying to stop patients becoming so unwell that they presented at the department. They had been looking at their pathways into the hospital and to try to reduce admissions and they were providing services such as ‘same day care’.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services but was impacted by the pressures on the service. Leaders encouraged innovation and participation in research.

Leaders and staff strived for continuous learning, improvement and innovation. The trust had an education programme which focussed on the promotion of development and improvement. The development of champions in areas identified for development were being used to help make those connections. These champions included dementia champions and freedom to speak up champions.

The trust was developing plans to improve the flow of patients through the hospital. The trust identified that an increase in portering staff would facilitate a higher number of patients accessing scans and reduce delays in discharge. Recruitment was ongoing and porters from other areas of the hospital were being used to start the plan.

Urgent and emergency services

Plans were being considered to cohort outlier patients on non-medical wards and support them with extra outlier medical teams. This would enable patients to receive the right medical care when not in the right speciality ward.

Staff had been to other hospitals looking at how other trusts utilised the discharge lounge to promote discharge of patients and allow earlier new patients access to the wards.

Medical care (including older people's care)

Requires Improvement ➔➔

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 and made sure everyone completed it.

Mandatory training compliance had improved since the last inspection in August/September 2019. In the trust's July 2021 integrated performance report, the trust reported mandatory training completion had improved to 86%. Resus and manual handling had improved at 89% and 53% respectively, with service line managers accountable for maintaining this improvement. The care group was working towards at least 90% compliance with oversight of this target at care group board level.

Nursing staff received and kept up to date with their mandatory training. Despite the impact of the COVID-19 pandemic on accessibility of training, nursing staff achieved very close to, or above, the trust target for mandatory training. Most staff were up to date with the trust's mandatory training programme or had dates booked to attend training in the near future. This meant that most staff were up to date with their skills and knowledge to enable them to care for patients appropriately.

Medical staff received and kept up to date with their mandatory training. Medical staff achieved very close to, or above, the trust target for mandatory training. However, there were challenges with achieving the trust target for child protection training (52% in July) due to the escalation in patient numbers over the last year and not having capacity to protect time to complete the external training.

The mandatory training was comprehensive and met the needs of patients and staff. Most staff told us mandatory training updates were delivered to meet their needs and they were able to access training as they needed it. Efforts were made to ensure training was not cancelled although we heard staff had on occasions had training cancelled at the last minute.

Training was available using a range of methods to maximise accessibility, including face-to-face sessions and e-learning.

Sepsis training was included within the trust induction and yearly update training. Staff were aware of the signs of sepsis and how to begin treatment using the 'sepsis six' pathway. Sepsis training was also included in medical resus day training, recently introduced by the sepsis nursing lead in the emergency department

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. During our last inspection staff described the mental health content as minimal. During this inspection staff could discuss mental health training with confidence. Training on mental health, learning disabilities and autism was included in the mandatory trust annual update training.

Staff received additional training support for supporting people with dementia in the acute hospital setting. There was a regular scheduled monthly study day they could attend. This supported study day was open to nurses, nursing associates, student nurses and allied health care professionals.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers monitored mandatory training compliance through monthly performance reports. Ward managers discussed performance reports with matrons every month at performance reviews to address gaps in staff mandatory training.

Staff told us they received emails to alert them when they needed to update their training and their managers were supporting them to complete essential learning that had been missed due to the COVID-19 pandemic and the increased demand on services.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. Medical and nursing staff completed training specific for their role. The trust set a target of 90% for completion of safeguarding training. Safeguarding adults' and safeguarding children were included in the trust update training module. Level one safeguarding formed part of training for all staff and compliance was monitored on the performance review framework, compliance was 99%.

Data showed 94% of nursing staff had completed level two safeguarding adults' training with 64% of nursing staff having completed level three child protection training. This had declined from the 75% compliance at the last inspection.

Safeguarding training in medical staff had improved with 87% of medical staff in the medicine care group having completed it(July 2021). Data also showed 76% of medical staff had completed child protection training level three.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff told us they felt confident in identifying adults and children at risk and gave examples where referrals had been made to other agencies. We saw safeguarding risks were discussed during handover meetings. For example, we observed a handover meeting where a consultant agreed to follow up a safeguarding referral after concerns were identified.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. 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.

Staff followed safe procedures for children visiting the ward. The trust provided information to staff within safeguarding policies and procedures. This included the action to take when staff had concerns regarding child protection and domestic abuse.

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.

The safeguarding policy was underpinned by other policies and resources that reflected the wider system approach to protecting people's human rights. These policies included the domestic abuse policy, safeguarding children's policy and the Mental Capacity Act (2005). Staff had access to the Preventing Exploitation Toolkit (Devon Safeguarding Adults Board) and safeguarding adults' flashcards to help protect patients from harassment and discrimination.

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. All patients reported wards being clean and several patients said the wards were "spotless". However, some corridors were cluttered with equipment.

Cleaning records had improved. 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 and they were fully integrated with the clinical teams. 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. Workloads were high in all areas as a result of the increased cleaning programmes due to COVID-19 requirements.

The service generally performed well for cleanliness. Regular audits were completed for hand hygiene and care of biomedical devices (cannulas, central lines, catheters). All results were available for individual areas and were included in service line reports to infection control.

There was an annual hand hygiene assessment of technique using the glo box. Results were recorded and between April 2020 and March 2021 average compliance was 84% across the medical care group. Hand hygiene audits were performed on a monthly basis. Any department that failed to achieve 95% was required to undertake weekly hand hygiene audits until two consecutive audits scores were greater than 95%.

Staff were updated regularly with information on COVID-19. They had access to a range of resources on the intranet and changes to guidance were communicated by email and at daily matrons' huddles.

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 in green/amber and red areas, which staff followed.

We also saw staff bulletins advising colleagues of changes in policy following government updates and signposting colleagues for further support. PPE posters were visible in all areas advising staff what PPE was required in each area.

There were good quantities of PPE available, including face masks, gloves and aprons. These were readily available to staff.

Hand sanitiser gel was readily available in all areas visited and we observed patients, families and staff sanitising regularly.

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.

Patients were screened at the emergency department (ED) front door to assess their risk. If there was any clinical suspicion of COVID-19, they were transferred to Plym (within ED) for assessment and had a rapid PCR test.

Patients were screened on day one, three and five and weekly thereafter and all patients had a COVID-19 passport at the front of their paper record. If more than one patient was positive the ward was closed to admissions for a minimum of two weeks. The infection control team undertook a review and if the ward could be deep cleaned, it could be reopened. This was assessed on a ward by ward basis taking into consideration the patient group's vulnerabilities.

Staff discussed patient's infection status as part of handover meetings.

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.

On most wards patients could reach call bells and staff responded quickly when called. However, call bells in the acute assessment unit were on the wall and could not be reached by patients. We observed staff responded to calls bells within good time on most wards. However, we did note two occasions where call bells were not answered for over five minutes.

Data from the matrons' ward inspections for the period from 1 August 2020 to 30 September 2021 showed an overall score of 98% of call bells were in reach for all patients and 95% of call bells were answered in less than five minutes.

The design of the environment followed national guidance in most ward areas. In response to COVID-19, risk assessments had been completed for all environments to ensure staff and patient safety. Non clinical areas had signage indicating how many people could safely share the space.

Environmental ligature risk assessments were also completed in ward areas.

We saw an improvement in the safety checks of specialist equipment. Staff carried out daily safety checks of specialist equipment. This had improved since our last inspection with daily checks being clearly undertaken.

There was access to emergency equipment. The emergency trolleys were clean, tamper evident and ready to use. Staff carried out daily and weekly checks of the equipment and medicines to ensure they were ready to use and in date. This was evidenced by the signature of the staff member carrying out the check. From the records we reviewed during a three-month period there were no gaps in the log.

We noticed an unattended defibrillator that was not locked away. Daily checklists had not been consistently completed. This was reported to the chief nurse at the inspection who agreed to investigate further and provide assurance of its safe use.

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 in all specialties. For example, pressure relieving mattresses.

Equipment was clearly labelled as being ready to use and dates of the next service were noted on the equipment. We checked a number of pieces of equipment throughout the hospital and saw they were within service date. There were regular inspections to identify any faulty equipment and this was removed from use and the fault reported.

Bariatric equipment such as chairs and trolleys could be accessed through the medical equipment library. The manual handling team carried out risk assessments for the use of this equipment.

There was non-slip flooring in the frailty unit and dementia friendly differently coloured chairs in the care for the elderly wards.

The service had suitable facilities to meet the needs of patients' families. Visiting had been restricted during the COVID-19 pandemic. Some wards had reintroduced visiting in line with government guidelines, this was limited to one nominated visitor at any time within a four bedded bay.

Staff disposed of clinical waste safely. Disposable items of equipment were discarded appropriately, either in clinical waste bins or sharp instrument containers. Staff signed and dated sharps bins and stored them appropriately. Nursing staff said these were emptied regularly and none of the bins or containers we saw were unacceptably full.

Substances hazardous to health were kept securely. We saw sluice doors were closed and locked.

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.

The hospital used a paper system for recording NEWS2 scores which meant data collection took more time than if an electronic system was used. However, the service had worked on developing an electronic observations package to track patients with suspected sepsis throughout the hospital. The service recognised how this could improve the accuracy of the calculation of NEWS2 and provide alerts directly to an appropriate clinician to act on the deterioration more rapidly.

We reviewed 36 patient notes and saw all NEWS2 scores were calculated correctly and escalated to act on any risk of deterioration.

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. For example, records we reviewed showed that an individual had been monitored and their oxygen levels rechecked after 20 minutes, after they had scored highly on NEWS2 due to low oxygen saturation levels.

Medical care (including older people's care)

The sepsis protocol was embedded within the service, which was an improvement from our last inspection. There was a dedicated sepsis policy within the escalation and reporting adults' policy.

Sepsis audit data collection had improved and the service audited compliance with sepsis pathway timelines for medical patients, including the administration antibiotics within one hour.

The team recognised opportunities that still existed for improvement and were working to develop their sepsis strategy. Currently the sepsis programme was being supported by members from the military service, which could be disruptive when these members were on service.

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.

There had been an improvement in the risk assessment of patients for VTE. All patients were risk assessed on admission. We reviewed 32 records and noted completion of VTE assessment in line with guidelines. Prophylactic medicine was prescribed.

We saw records which clearly showed risk assessments for patients at risk of developing pressure ulcers. With each risk assessment there was a clear care plan of what needed to occur to prevent ulcers from occurring.

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. Staff completed a frailty score for each patient on an electronic system on admissions. Frailty scoring was used to assess older people's mobility and ability to live independently and complete the tasks of daily living.

During our inspection we were advised the trust falls lead had been redeployed due to staff shortages. During this time oversight of falls and their cause was managed by the healthcare of the elderly matron.

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. The recording and quality of handovers when patients moved wards had improved. 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 twice 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 and COVID-19; 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.

Risk management performance was presented to the care group quality assurance group (QAG) as part of a rolling schedule where teams presented to the committee. QAG was also where serious risks were approved.

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.

Medical care (including older people's care)

The service did not always have enough nursing and support staff to keep patients safe. The service had enough nursing staff of relevant grades to keep patients safe most of the time. However, the service had a high number of nursing vacancies.

An annual nursing establishment review was completed earlier in 2021 and board approval had been gained for a nursing investment plan over three years.

Staffing ratios were closely monitored and risk was balanced across the care group to all areas based on patient risk profiles and acuity. Incidents and complaints were screened to assess any issues relating to patient safety/experience and staff safety/well-being. However, staff said not all staffing shortages were entered onto the incident reporting system.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants 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 number of nurses and healthcare assistants did not always match the planned numbers. We attended the 9.15 am matrons' staffing meeting for the medicine care group. Nurse and health care assistant staffing was discussed for the late and evening shifts that day and there were a number of unfilled shifts. Late shifts were covered by moving nursing and health care assistant staff around.

There was a mix of skilled and experienced nurses and healthcare assistants across the care group. There were senior nursing staff in band eight (matrons), band seven (senior sister) band six (sisters) and supporting band five (nurses).

The service had increasing vacancy rates for nursing staff. The service had a challenging year with vacancies increasing steadily across the year. The vacancy rate had increased from -0.9% in March 2021 to 7% in August 2021.

Vacancy rates for the specialties reported in the trust's April 2021 integrated performance report showed gastroenterology had the lowest rate at 2% and endoscopy was the highest at 25%. For the period from March to August 2021 the average vacancy rate for these specialities was 4%.

The trust had a recruitment strategy and investment plan for actively recruiting nursing staff particularly for stroke, renal, care of the elderly and oncology. The service was increasingly looking at international nurses to fill vacancies. This was a successful route to recruitment and international nurses were valued and respected by all staff.

Hospital staffing was established for 85% occupancy, with plans to increase this to 95% in the future. The number of staff required to staff the wards was in line with agreed National Quality Board ratios. Further to this, the uplift for annual leave, maternity and absence had also been increased this year and next year. The wards were funded and established to meet the skill mix ratios for the number of beds open.

Medical care (including older people's care)

Staff said they had been stretched at times during the last year when capacity and demand had been consistently high as a result of COVID-19. Staffing levels were an ongoing concerns. They knew there were the number of staff they needed, but this often meant bringing in staff from other wards and relying on bank staff. They said they often came to work expecting to be moved to other wards due to low staffing levels. This had created a high level of uncertainty and further dip in staff morale.

Nursing staff told us they felt able and supported to raise incidents where they felt the staffing levels on wards were not safe.

The service had increasing sickness rates. In the trust's April 2021 integrated performance report, the trust reported nursing staff within medicine had an average sickness rate ranging from the highest in endoscopy at 7% to the lowest at 2.1% in diabetic medicine and endocrinology, and hepatology.

In the trust's July 2021 integrated performance report it was highlighted that at trust level annual sickness absence had increased over the past 12 months from 4.87% in June 2020 to 4.9% in June 2021. There were a number of reasons for sickness rates increasing, including staff being required to isolate in line with COVID-10 regulations and as a result of track and trace, and the stresses incurred during the pandemic.

An absence hub was created for clinical staff who could not work in the hospital during waves one and two. The absence hub updated the roster and contacted the ward manager when staff called in sick. The absence hub submitted the shifts required to the matrons.

The trust did not use agency nursing staff and instead, preferred to use existing staff. Monetary incentives had been offered to staff for working a required number of shifts.

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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service did not always have enough medical staff to keep patients safe. At the time of the inspection, there were 388.71 full time equivalent (FTE) medical staff employed by the medicine and specialised services divisions against a budget of 410.44 FTE.

In March 2021, the proportion of consultant staff and junior (foundation year 1-2) staff reported to be working at the trust was similar to the England average. Staffing skill mix for the 241 whole time equivalent staff working in medicine was consultant 46%, middle career 7%, Registrar 25% and junior 22%.

Leaders monitored where there were gaps within medical staffing and identified areas of risk. There were rolling recruitment campaigns and staff were being supported to develop into roles.

The service had reducing vacancy rates for medical staff. Over the year the service had worked hard to reduce vacancy rates. They had reduced the vacancy rate from 8% in March 2021 to 5% in August 2021. The service was continuing to recruit to the remaining vacancies.

Junior doctors said they were redeployed on a day by day basis to support medical escalation beds and to support other medical specialties that were running below core numbers. Rotas were changed at short notice and some junior doctors

stayed in areas for longer than was expected or in specialities that had not been planned. Staff outlined a number of recent examples where there was poor cover. Four out of five shifts were unfilled for the coming Friday (24 September) and junior doctors felt pressure to cancel leave / rest days to fill empty shifts. Registrars often stepped down to fill any gaps, although managers agreed this was not a long-term solution. The cover for the junior doctor rota had been identified as a risk of patient harm and service delivery on the risk register.

Over 50% of junior doctors had not completed exception reports. These were reports where work that varied from the agreed work schedule was flagged. There was a reluctance amongst junior doctors to exception report as they felt nothing would happen as a result.

Some junior doctors felt supported by senior doctors although others said there was poor interaction and training opportunities with senior colleagues.

Managers could access locums when they needed additional medical staff. The agency usage of medical staff was for 2.86 full time equivalent in April 2021.

Medical staff had an average sickness rate of 1% and rates were consistently lower than the England and trust overall rates.

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.

The clarity and organisation of record keeping had improved. Patient notes were comprehensive and all staff could access them easily. Staff used paper records for medical and nursing notes. They also had access to an electronic system.

We reviewed 32 patient nursing and medical records. They had a standard layout and format which assisted the clinician to locate the information they needed specific to the patient's condition. Each set of records provided detail of the care and treatment plan and included risk assessments and all were signed and dated. Completion of records was regularly audited and actions taken to address any shortfalls.

There was an improvement in medical staff printing their name, role and GMC number (identification number from the General Medical Council) in medical records. Most medical staff completed this.

Records were stored securely. There was an improvement in the secure storage of medical records, most were stored securely. If the record cupboard was unlocked a staff member was very close by and the record cupboard was accessed regularly.

We observed two patient notes in the same folder. This was raised at the time of the inspection with staff on the ward who raised it as an incident on the reporting system.

Senior nurses audited the quality of completion of records every month using the fundamentals of care audit.

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.

Medical care (including older people's care)

Medicines

The service had systems and processes to safely administer and record medicines use, but they did not always reflect local practice and staff did not always follow them.

Staff mostly followed systems and processes when safely prescribing, administering, recording and storing medicines. 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.

Medicines advice and supply were available seven days a week. There was a dedicated medicines information telephone line between 9am and 5pm for staff and patients should they have any medicines queries. An out of hours service was available through the switchboard. Staff were well-informed of this and knew the routes to contact pharmacy at all times of the day.

On the wards, medicines were stored safely in dedicated secure storage areas with access restricted to authorised staff. Keys were kept in the possession of a dedicated member of staff. Medicine trolleys and patient's bedside lockers were also used.

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. The process for managing the expiry dates of medicines once opened was not effective. This had resulted in a patient being administered date expired medicines without this having been identified.

Whilst there were orange Hypoglycaemia grab boxes on all the wards we visited, there were differences in the items stored within them. For example, Glucagon® was mostly stored in a fridge when it was indicated it was stored in the box. On two wards there was a notice stating it was stored in the fridge.

Oxygen cylinders were not always stored securely and in accordance with current guidance. We informed the ward manager about the storage of two cylinders and they immediately requested stands from the estates department to secure them.

When pain relief patches were applied to patients there was no ongoing monitoring recorded to show the patches remained in place. Not all patients reviewed would have been able to tell staff where their patches were applied.

We received assurances after the inspection that action had been taken to address the discrepancies and review the monitoring system.

Staff followed current national practice/guidance to check patients had the correct medicines. Policies and procedures were available and accessible to staff on the trust intranet. Policies we viewed as part of our inspection were in date and in line with best practice and national guidelines.

We reviewed 35 patient medicines records which clearly demonstrated patient medication history, including allergies, and drug sensitivities. Medicines reconciliation was completed within 24 hours.

Medical care (including older people's care)

Antibiotic audits demonstrated that the trust was mainly compliant with prescribing in line with national and local guidance. However, the reason for prescribing an antibiotic was not always recorded on prescription charts.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Where patients had specific medicines administration needs, these were clearly documented and staff followed protocols to administer medicines safely, for example by a feeding tube.

Patients on wards were supported to self-administer their medicines if a risk assessment showed it was safe for them to do so. Patients waiting to go home in the discharge lounge were encouraged to self-administer medicines to promote independence. Any medicines administration in the discharge lounge were recorded on patients' prescription charts.

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.

There were decision making processes to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. We did not see any patients being given medicines hidden in food or drink (covert administration), however, staff could explain the requirements of the Mental Capacity Act (2005) and how patients would be assessed, and best interest decisions made. Pharmacy advice was available to make sure if medicines were given covertly, they were safe and would be effective.

When a medicine was administered to manage agitation or aggression (rapid tranquilisation), there was a policy to enable medicines to be appropriately prescribed and monitored. Staff we spoke with understood the requirements within the policy.

The pharmacy department technical services team worked closely with clinicians to ensure that chemotherapy products were prepared to meet the patient's need and were delivered to ensure timely treatment. This team prepared high risk injectable products such as chemotherapy and parenteral nutrition (PN) in response to a prescriber's request. This used an aseptic clean room to ensure products were made to the best possible quality, safety and efficacy. The team's apheresis service provided 24-hour provision of chemotherapy should the need arise. The team ensured the latest cancer treatment protocols were entered and validated onto the chemotherapy electronic prescribing system and pharmacy staff worked directly with the oncology day unit to ensure these were implemented.

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.

Medical care (including older people's care)

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 the duty of candour. Staff we spoke with demonstrated a clear understanding of the duty of candour and discussed how they would be open and honest with patients when things went wrong. The 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.

Although we did not see any examples where duty of candour had been applied, 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.

The timeliness of serious incident investigation had improved. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The incident reporting policy set out the processes for reporting and managing incidents and described the root cause analysis investigation process and the roles and responsibilities of staff involved in the process.

Managers debriefed and supported staff after any serious incident. Staff confirmed they received feedback after reporting an incident and an action plan was shared. Learning was shared using a variety of methods. Firstly, 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 learnings from events.

Is the service effective?

Good

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Medical care (including older people's care)

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies, care and treatment pathways, and clinical protocols had been developed in line with national best practice recommendations. These included the National Institute for Health and Care Excellence (NICE) guidelines and quality standards. Updates were circulated to clinical leads and senior leads to review within three months. After review guidelines received compliance status and registers were updated each month.

The trust conducted audits to ensure NICE guidelines and quality standards were being followed.

Policies were available to all staff on the trust intranet system and staff demonstrated they knew how to access them.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Most patients told us food was of a good quality and food choices were available, One patient said meals were "well cooked and hot and nicely presented". Overall, patients were satisfied with the size and choice of meals offered.

Oncology patients were offered a choice of food from nine menus to meet their increased needs.

We observed nursing teams supporting housekeeping staff to provide meals and food was served hot. Mealtimes were protected to encourage patients to eat in a calm environment without distraction.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. We reviewed 32 patient records and saw fluid and nutrition charts completed accurately including where specialist feeding and hydration techniques were needed. Staff were able to quickly determine input and output.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition A malnutrition universal screening tool (MUST) was used by the trust to determine individual hydration and nutritional risks. This was completed on admission and once a week thereafter. Where patients were not eating or drinking well, we saw fluid and food charts were being used.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Staff told us specialists could be referred to easily through the trust computer systems. We saw documentation completed by dietitians who had prescribed a clear dietary regime. The name and registration number of the dietitian were clear and legible.

Refreshments were available for patients in day case areas, for example, tea, coffee, juice, sandwiches and cakes.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. A nationally recognised tool was used to assess patients' pain. In addition to this, a pain score was used for patients who were unable to communicate their experience of pain verbally. The tool was based on using facial expressions and body language to determine pain levels. We saw staff making observations and completing pain assessments regularly on all wards we visited.

There was guidance in care plans about pain management for patients where it was appropriate. Patients had their pain assessed and appropriate methods of reducing pain were offered.

Patients received pain relief soon after requesting it. Patients told us and we observed staff on all wards asking about levels of pain and assessing patient comfort levels. Patients told us they received medication promptly and were not left in pain.

Staff prescribed, administered and recorded pain relief accurately. Staff discussed patients' pain management needs during handovers to ensure pain was managed appropriately. We reviewed 32 patients' medical records and found pain relief to be appropriately prescribed and recorded accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes

The service participated in relevant national clinical audits. There was an annual audit plan which enabled the service to benchmark the standard of care against local and national standards.

The National Clinical Audit & Patient Outcome Programme (NCAPOP) was mostly suspended during periods of the COVID-19 pandemic. Due to the challenges of the pandemic, audit work had been limited in 2020 and the team were starting to resubmit audits to establish their latest benchmarks at the time of inspection.

The trust continued to submit data to the national audit programme throughout the pandemic for adult services.

Managers used information from the audits to improve care and treatment. Audits were monitored and action plans to address areas of improvement were regularly reviewed.

Improvement was checked and monitored. Staff could tell us of improvements made. For example, frailty had been assessed, from both a patient and staff experience perspective, and an action plan had been implemented based on the results. This led to timely decision making and an increase in direct access for the patient. Other examples included endoscopy utilising digital tools to improve governance and efficiency.

During the pandemic the respiratory team purchased oximeters to enable patients to manage their own conditions, with the support of the respiratory team. We were told this had worked well and created an independence for patients as well as a reduction in visits to the hospital. All results were reviewed by the clinical team and if trigger points were reached the patient would be contacted. This meant unnecessary admission were avoided.

Managers shared and made sure staff understood information from the audits. Information was shared and discussed at ward meetings and by email. Staff confirmed they were kept up to date with results and any actions required, and were also encouraged to discuss information if they had any questions or concerns.

Through the cancer alliance the trust was taking part in a patient survey for Black, Asian and minority ethnic (BAME) cancer patients to increase the numbers returned for the region in the national cancer survey. There was also participation in the national site-specific cancer audits for oesophago-gastric, lung, bowel and prostate.

Data was captured on the cancer register including ethnicity and age, new diagnosis of cancer and the waiting times and this was submitted to the Public Health England through monthly submissions.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service made sure staff were competent for their roles. Managers appraised staff's performance and held supervision meetings to provide support and monitor the effectiveness of the service.

The updated appraisal compliance identified that the service was close to the trust target for most staff. There had been a slight drop in compliance during August due to staff isolating and annual leave being taken. Overall, most staff reported having yearly appraisals or had dates booked in the near future, with effective development plans.

Managers gave most new staff a full induction tailored to their role before they started work. Staff confirmed they received a comprehensive induction. They felt confident and prepared to work in the departments.

A group of staff had been redeployed at the start of the pandemic, due to their clinical vulnerable status, and had received appropriate training and access to a manager who provided support for their ongoing personal development whilst returning to their clinical area was not an option.

Staff who had skills and experience in critical care who were working in other roles, were redeployed to critical care to support the team during times of surge. This redeployment was accompanied with support from the critical care matron and 'turbo teaching' to ensure staff carried out their roles safely and effectively.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Clinical supervision enabled staff and managers to identify training needs, develop competence and enhance clinical practice. Most staff were positive about the frequency of clinical supervision they received.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. However, in March 2020, in response to the COVID-19 pandemic, the trust followed the NHS England recommendation to suspend medical appraisal for the first six months of the year. Missed appraisals were automatically postponed to the same month of 2021, and medical practitioners were not required to catch-up. From October 2020 medical practitioners were advised to complete appraisal where possible, but that they may defer, delay or postpone their appraisals, if their clinical commitments did not allow. These postponements meant it was not possible to achieve the usual 91% completion rate for medical appraisal. The completion rate was 27% for those in the medical care group.

The clinical educators supported the learning and development needs of staff. Staff were encouraged to complete specialist training. A nurse educator supported staff to continue to learn within their own specialty and services and provided training on the wards for nurses, associate practitioners and health care assistants.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Minutes of meetings were emailed to all staff and a paper version was available for staff to read.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. There was a commitment to training and education within the service. Staff told us they were encouraged and supported with training and there was good teamwork. Staff were encouraged to keep up to date with their continuing professional development and there were opportunities to attend external training and development in specific areas.

There was a trust-wide electronic staff record where all training attended was documented. Managers were informed of training completed and alerted staff requiring updates for mandatory training through regular competency reports.

Managers made sure staff received any specialist training for their role. The service undertook a range of education and practice development activities aimed at enhancing the knowledge, skills and awareness and development of the staff. For example, a dementia accreditation system and three tiers of frailty training which provided different levels of training, from a general awareness of frailty to expert care and lead services for patients living with frailty.

There were clinical supervisors for the foundation doctors. Clinical supervisory information from the departments across the care group was requested a month before a trainee rotated to the department and details were added to the trainee e-portfolio. Supervision of junior doctors out of hours was achieved through the senior medical registrar with escalation to the general take physician on call. Issues requiring direct subspecialty input (e.g. interventional cardiology, endoscopy, etc) were escalated to the specialty consultant on call. Rotas for the general take and cover streams (for all grades) were published, as were consultant rotas for the medical specialties. All were visible to the hospital switchboard.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Nursing, medical and therapy staff worked together well and were all involved in the support and treatment of patients to improve their care. There were multidisciplinary integrated clinical pathways to improve the patient outcomes. Staff worked across health care disciplines and with other agencies when required to care for patients.

Ward rounds throughout the service, included discussions amongst members of the whole multidisciplinary team to support patients. Consultants, doctors, therapists and nursing staff were all in attendance. Discharge plans being discussed with clear plans and members of the team were able to communicate freely. For example, during a meeting we saw discussions about a patient who was awaiting discharge, where an occupational therapist gave updates on equipment needs. Staff told us they worked well across disciplines and all staff participated in discussions about patient care.

Staff worked across health care disciplines and with other agencies when required to care for patients. We saw evidence of multidisciplinary working throughout the inspection. Care records demonstrated clear management plans by medical staff as well as involvement from the wider multidisciplinary team. We observed conversations taking place on wards between nurse specialists, pharmacists and psychiatric liaison staff.

Staff referred patients for mental health assessments when they showed signs of mental ill health. Psychiatric liaison was provided by an external team which could be accessed by ward staff, 24 hours a day, seven days a week. Staff said the referral process was easy to follow and the response was quick and efficient.

Seven-day services

Most Key services were available seven days a week to support timely patient care.

Consultants led ward rounds on acute wards on average on two or three days a week. Patients were reviewed by relevant consultants depending on the care pathway. All patients had a clinical assessment once admitted by a consultant or registrar. This was undertaken in line with the standard within 14-hour review which was outlined in the standard operating process.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Therapy services on respiratory wards were available on-site Monday to Friday and were on call over the weekends.

However, there was a lack of a seven-day therapy service on other wards and this had been highlighted as a risk on the risk register. There was a phased approach to a seven-day service with the data from the first phase demonstrating a reduction in length of stay by a minimum of two days and the need for an established physiotherapy, occupational therapy. speech and language therapy and dietetic seven-day services to optimise acute care, discharge planning and operational flow.

There were plans to expand the frailty service to a seven-day service and funding had been secured.

Medicines advice and supply were available seven days a week. An on-call pharmacist was available outside of core working hours.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards and units. Staff provided health promotion information for patients on all wards we visited. For example, we saw information about lifestyle changes as well as infection control in light of COVID-19. Staff offered nicotine replacement patches to relevant patients.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Health promotion was a routine part of all care provided to patients. All staff worked collaboratively to assess aspects of general health and to provide support and advice to promote healthy lifestyles. Staff completed smoking and alcohol risk assessments on admission.

The endoscopy service participated in a bowel cancer screening programme to support the early detection of bowel cancer. Cancer patients had access to a range of complementary therapies, such as massage and manicures at a local cancer centre.

Medical care (including older people's care)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were trained in the need to obtain consent from patients in relation to any intervention or in relation to decisions about their care (or their next of kin if they lacked capacity). Staff said they were confident in making capacity assessments.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Throughout the inspection we saw staff explaining the assessment and consent process to patients and any need to share information with other professionals such as GPs, before obtaining written consent.

Staff told us restraint was used as a last resort and only applied in cases where it was deemed necessary to prevent harm to patients or others. Information was available for staff, patients and carers to confirm what was meant by restraint (e.g. mitts/closing doors). Specialist advice was always sought and restraint was monitored closely to ensure it was stepped down as soon as it was no longer required.

Any incident involving physical restraint was reported to the internal reporting system. The physical interventions team monitored instances of restraint by reviewing reported incidents. They worked with the safeguarding team to identify and investigate any concerns surrounding the use of inappropriate patient restraint, or the use of inappropriate restraint techniques.

Staff working in high risk areas received annual refresher training on restraint techniques guidelines, and risks in accordance with trust policies and national frameworks. However, staff we spoke with on some wards had not received physical intervention or restraint training but had training booked in the near future.

When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. When patients could not give consent, staff made decisions in their best interests, taking into account patients’ wishes, culture and traditions.

There was improved consistency in how patients’ mental capacity was assessed. Consent was recorded in line with relevant guidance and legislation. Nursing staff knew their responsibilities in terms of what action should be taken if a person did not have the capacity to make decisions about their care. Staff were aware of the need to make a written record of mental capacity assessments and to make best interest decisions in line with legislation.

Staff made sure patients consented to treatment based on all the information available. Staff said they obtained consent from patients prior to commencing care or treatment. They said patients were given choices when they accessed their service. Staff clearly recorded consent in the patients’ records. The trust had policies regarding consent, assessment of mental capacity and the use of deprivation of liberty safeguards. Staff told us they were aware of these policies, and we saw evidence of completed mental capacity assessments in care records we reviewed.

Patients were given the opportunity to ask questions about their care, staff assessed their understanding and supported patients to make informed decisions about their care.

Staff clearly recorded consent in the patients’ records.

Medical care (including older people's care)

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff were aware there were additional steps to consider if the patient did not consent to treatment.

Managers monitored the use of Deprivation of Liberty Safeguards (DoLS) and made sure staff knew how to complete them. The care group made a total of 909 applications in the 12 months prior to the inspection. The applications were triaged by the safeguarding team before being submitted to the local authority to ensure that applications were of good quality. No applications had been returned or rejected within the last 12 months. The safeguarding team worked with the wards to share good practice, and noted two care of the elderly wards, Marlborough and Monkswell had completed their applications to a very high standard.

The DoLS administration team undertook regular reviews on wards with the physical interventions team and/or psychiatry liaison team and occasionally the learning disability team and advised on whether a legal framework was needed. The team also reviewed all incident forms and followed up directly with the ward. They gave advice if there were concerns around the proportionality of any intervention, or if the legal or human rights of the patient were at risk of being breached.

The trust intranet had resources to support staff with timely discussions around treatment escalation plans (TEP) and do not attempt cardiopulmonary resuscitation (DNACPR). The guidance focused around appointing a senior decision maker who could involve the patient and their family in discussions. This ensured patient's wishes were accurately represented, discrimination was avoided and assumptions were not made about quality of life. Staff were advised to access specialists e.g. lasting power of attorney, independent mental capacity advocate or court of protection in cases where decision making was more complex.

Twice a year an audit was conducted by the resuscitation team. Five sets of notes on every adult ward were chosen at random and checked for TEP completion. This was completed in March 2021 and showed there was good compliance on the completion of TEP forms and that there was nearly always a rationale stated. However, it had been identified that capacity assessment had not always been clearly assessed by the medical teams when completing the patients form. Action plans had been devised and were monitored to mitigate this through awareness and training.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. During our inspection we observed positive interactions between staff and patients. Staff were open, friendly and approachable and interactions were very caring, respectful and compassionate.

Medical care (including older people's care)

Patients said staff treated them well and with kindness. Care from the nursing, medical staff and support staff was delivered with kindness and patience. The atmosphere was calm and professional, without losing warmth. Staff were focused on the needs of the patients and ensured they felt respected and valued as individuals.

Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed a health care assistant ask a patient if they could check their dressing and explained to them what they would be doing. They also used this time to speak with the patient about any pain or discomfort they may be experiencing.

Staff followed policy to keep patient care and treatment confidential. During the inspection we saw staff lowering their voices and using curtains to maintain confidentiality when providing patient care.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. They were knowledgeable about the trust framework to support communication with families who were non-English speakers, or for whom English was a second language. Support was also available for patients with hearing or visual impairment, or who had learning disabilities.

The comments we received from patients were unanimously positive. They spoke positively about their experience in the hospital from staff at the front door, the reception staff and consultants and nurses. They confirmed the staff were kind and helpful to them. We observed medical and nursing staff interacting and engaging with patients. On most wards we saw an array of thank you cards from patients following discharge from hospital.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. During the inspection we observed a patient waiting to have a procedure. We saw staff providing reassurance, talking with them and keeping them updated about what would be happening.

We saw numerous examples of staff providing reassurance to patients who may need additional support. For example, walking with patients who may have mental health needs to ensure their safety and minimise any distress.

All staff we spoke with were aware of the enhanced care team. There was a team of 10 staff in the team working across the medical care group who provided provide one-to-one support for those patients with complex needs. Staff saw the benefit of having this support, in terms of being able to monitor and understand an individual's behaviour to be better able to provide individualised care.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff providing emotional support to patients. Individual concerns were promptly identified and responded to in a positive and reassuring way. Patients told us staff offered increased emotional support as a result of current visiting restrictions by facilitating time away from wards to see family and friends.

Medical care (including older people's care)

Since 12 April 2021 the trust had amended visiting to support patient's health and well-being by allowing one visitor for one hour, once a day. We saw additional emotional support provided to several patients who had found this challenging. We observed ward staff demonstrating flexibility by rearranging and swapping visiting appointments to accommodate family requests. Visiting was also supported on a case by case basis for patients who may require more contact with loved ones to support their wellbeing.

We observed board rounds on a number of different wards and saw staff discussed the entirety of the needs of patients including physical, social and emotional. We heard from staff how the emotional needs of older people in particular were being considered and the impact of bed moves on their recovery was well understood.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Throughout our inspection, we saw patients being treated with dignity and respect. Voices were lowered to avoid confidential or private information being overheard despite the difficulties of COVID-19 measures i.e. wearing face masks and having perspex screens at reception desks. All patients said their privacy and dignity was maintained.

Patients with mental health needs were admitted to side rooms where possible. Staff we spoke with reported increased support for patients who required one to one observations by the enhanced care team who were able to provide immediate assistance.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Difficult information was discussed in a sensitive manner and a patient told us how supportive the entire team had been when they delivered such information.

Staff told us they had dealt with very difficult situations during the COVID-19 pandemic and they had developed increased empathy with patients. Several staff had contracted COVID-19 and understood patient's experiences and anxieties.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We saw wellbeing boards in staff rooms and ward areas to provide supportive prompts for staff and patients when dealing with difficult situations.

Patients were spoken with in an unhurried manner and staff checked if information was understood. Staff talked about patients compassionately and with knowledge of their circumstances and those of their families. A patient told us they felt well looked after and their needs were fully met, with additional support provided for personal care.

There was good support from the hospital's pastoral and spiritual care team. They were available to patients and their families of all religious faiths and traditions, or none.

Staff were conscious of the impact of visiting restrictions on patient's wellbeing. Staff were aware of the need to make exceptions, for example patients at the end of their life or with additional needs. Staff supported patients to speak with relatives over the telephone and were glad to receive more visitors when restrictions had been lifted.

Staff told us they supported families who were unable to visit during the COVID-19 pandemic. This was especially difficult for those patients reaching the end of their life where families were unable to be with them. Staff had been determined to provide as much emotional support and reassurance as they could muster in the absence of family or friends.

Medical care (including older people's care)

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients were involved with their care and decisions taken. Patients said all procedures had been explained and they felt included in the treatment plan and were well informed. We observed staff explaining the process by which nurses carried out regular checks such as positioning, pain and personal care.

The ethos of putting patients first ensured patients and their families were well informed about the risks or benefits of treatment to enable them to make decisions about their care and treatment. Any concerns raised were fully investigated and used to support staff reflection and service improvement.

Patients told us there were clear plans for their care and staff kept them informed about any changes. We saw on numerous occasions nursing staff contacting families to give updates on their relative's progress. For example, a health care assistant giving a detailed update on a patient's condition and well-being to a family member over the telephone in a polite and friendly manner.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We observed staff explaining things to patients in a way they could understand to help them become partners in their care and treatment. Staff were aware of the types of communication aids that could be used to support patients. Staff were clear about how to access interpreting services and where to go for additional support if needed. Patients told us staff were clear when speaking with them and they could understand what care and treatment was being provided.

Communication boxes had been launched and rolled out across the care group to help patients communicate with staff. (Details of the contents of the boxes are included in the Responsive section of the report below).

Staff supported patients to make informed decisions about their care. Patients were encouraged to be involved in their care as much as they felt able to. Staff recognised when patients needed additional support to help them understand and be involved in their care and treatment.

Staff showed understanding and a non-judgmental attitude when caring for or talking about patients with mental health needs, learning disabilities or autism. We saw a patient being supported in their choice of treatment. The individual was provided with information about the types of treatment available and why a certain treatment would be beneficial. Staff knew how to access advocacy services and supported patients to achieve this when required.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The trust used a national patient survey run by NHS England called the Friends and Family Test, to gather feedback on the service. The national survey was paused in February 2020 due to the COVID-19 pandemic but relaunched on 1 December 2020. From December 2020 to May 2021 the results were positive with a high percentage (95%) of those asked stating they would recommend the hospital.

Patients gave positive feedback about the service. All patients we spoke with were positive about the service they had received. One patient told us their care had been "exceptional" and another that the nurses and doctors had been "very professional" and their experience had been "incredible despite the complications of the pandemic".

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.

The service mostly 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 mostly planned and organised services so they met the changing needs of the local population. All aspects of performance continued to be heavily affected by COVID-19. Initially capacity was lost due to repurposing of wards to manage inpatients, additional infection prevention and control measures, a shortfall of staff, social distancing and patient choice not to attend. As a result, services did not always meet people's needs.

Managers were planning and organising services to meet the needs of the local population and the changing COVID-19 situation. The trust launched a restoration programme in April 2021, led by members of the senior leadership team, to coordinate recovery activities based on the core priorities of patient safety, workforce, capacity and capability.

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.

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.

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. There were arrangements for staff to access urgent mental health support. Staff told us they knew how to request services and there was not an issue with accessing these in a timely manner.

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.

Managers monitored and took action to minimise missed appointments. Where patients cancelled an appointment for an endoscopy at the last minute, where possible, a same day appointment could be offered to other local patients who were available at short notice.

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.

Medical care (including older people's care)

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.

Patients' particular needs were flagged on the electronic patient records to ensure staff were aware of the need to make adjustments where necessary.

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.

There were individualised and holistic medical and nursing assessments to determine what strategies were required for patients living with dementia. Compassionate visiting arrangements enabled carers/relatives to spend time with the patient to manage their stress. The enhanced care team were also available to support staff with patients experiencing challenges such as distress and communication difficulties.

There were plans to appoint an acute mental health matron to undertake regular audit cycles of the use of mental health referral and mental health passports until its use was fully embedded and established in clinical practice.

There was a focus on mental health training needs to ensure all staff felt confident and competent in managing and supporting patients with mental health difficulties. Care planning at all stages of the patient journey included physical and mental health care.

Most 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.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. We reviewed 32 records and found examples of hospital passports being used for people with a learning disability, to support their care when an inpatient. Records showed people with a learning disability being referred to the trust's learning disability and autism team within 48 hours of admission. Hospital passports for these patients identified their communication and support needs. This allowed staff to be aware of individual needs and ensure care was personalised.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Communications boxes had been launched and rolled out across the care group to help patients communicate with staff. The contents of the box included a hospital communication book, which contained pictures to explain what was going to happen, a magnification sheet, guidance for accessing interpreters, finger spelling help sheets, sign language information, a mini echo tech hearing loop, dyslexia overlay sheets and other useful tools for staff and patients.

The service had information leaflets available in languages spoken by the patients and local community. This ensured patients and their families and carers had access to written information about their illness and/or conditions in a language they understood.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Support was available for communication with patients and carers for whom English was a second language, people with hearing or visual impairment, or who had learning disabilities. There was telephone interpreting, video conferencing and written translation services. Face-to-face interpretation had been suspended as a result of COVID-19 working arrangements. Information could also be provided in large print, in braille, or a British Sign Language interpreter was available.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff completed admission assessments to identify food preferences including vegan, gluten-free, vegetarian and halal.

Staff provided support to patients to inform them about their medicines, allow them to raise concerns and ask questions. Staff took account of patients' personal, cultural and religious needs. People were supported to continue taking over the counter or complementary medicines if they were safe to do so.

The hospital's pastoral and spiritual care team provided pastoral support and spiritual care to patients and their families. They provided support for all faiths (and none) and maintained close contact with faith leaders in the community. There was a chapel on the hospital site open at all times, a **multi-faith prayer room available in office hours and a quiet room was a private space for patients and families to meet with one of the team or to be alone.**

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. 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. Bed meetings were held through video conferencing and this had resulted in better attendance and participation.

From September 2020 to August 2021 the OPEL framework had reached level three for 33 days and the highest level, OPEL level four, on eight days. 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, COVID-19 third wave and system wide issues relating to staff absence as a result of COVID-19 sickness and isolation.

The team were committed to identifying the best way of doing things and standardising processes. Staff consistently told us they "want it (flow) to be better." The team were committed to getting the right patient in the right place.

Medical care (including older people's care)

A clinical site team managed flow throughout the hospital and met regularly during the day to ensure oversight of patient numbers and staffing levels. The clinical site team also liaised with the wider healthcare system to monitor demand and gain support.

The site team had expanded and continuity had improved. The complex discharge team were part of the site team. However, staff said communication and engagement needed to improve to ensure the team were fully involved in decisions.

Links had been made with other trusts and the team had visited other hospitals who were performing well to discuss their processes with a view to adapting them.

There were three task and finish groups with focus around improved flow. These included the front door triage; the discharge lounge and prescribing and dispensing discharge medicines earlier in a patient's stay. Discharge forms were completed for all patients being discharged from hospital. The work to improve patient flow had relied on patient experience data and staff expertise to design and implement a more efficient triage process that would improve both patient and staff experience.

Managers and staff worked to make sure that they started discharge planning as early as possible. We observed discharge planning was discussed during handover meetings and the discharge lounge was well used. There were extended opening hours in the discharge lounge. Staff from the lounge visited wards to support the discharge of patients every morning.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. Patient numbers in the discharge lounge were regularly monitored and delays were challenged by the matrons. Reasons for delays included completion of assessment, care package in patient's own home, community equipment/adaptions. Delays were escalated at daily huddles. The emergency department was included as part of the huddles to share information. There were also daily calls with system partners.

Staff were looking at how to maximise the potential use of the discharge lounge. They had visited other hospitals to understand how this facility was used.

An "exchange of patient process" had been introduced on wards to improve patient flow. Patients ready for discharge from a ward were highlighted at early morning meetings and briefly boarded pending a discharge. Another patient waiting to be admitted to the ward was moved to the vacant bed space. This meant there were no delays when a patient was told they could leave and the bed could be refilled as soon as possible.

The standard operating procedure had been reviewed to adapt the criteria for patients suitable for the exchange.

The service line manager of the day was assigned to discharge and to get discharge medication prepared the day before. The emphasis was on prompt and comprehensive completion to ensure discharge was not delayed and care was handed over to primary or other secondary care.

Staff said the current system was outdated and needed replacing and no training and guidance was available or clear time protected to prepare discharge medication.

Medical care (including older people's care)

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed time frames and national targets. Endoscopy targets were currently being met. Each team was working towards reducing backlogs where they existed with an action plan. This included recruitment of staff and the introduction of clinical pathways. The backlog was monitored daily and actions noted on the cancer long waiter report which was sent out three times per week to managers.

The care group did not step-down cancer services during the pandemic. In the first wave of COVID-19 oncology and chemotherapy was moved to an alternative site. In other waves the same services had been protected.

There had been a dip in performance and activity levels during the pandemic, including less two week waits for suspected cancer referrals. A cancer recovery action plan and a rapid diagnostic cancer pathway were being implemented, in line with the cancer alliance strategy.

Managers and staff worked to make sure patients did not stay longer than they needed to. From May 2020 to April 2021 the average length of stay for medical elective patients was 5.4 days, which was lower than England average of 6.3 days. For medical non-elective patients, the average length of stay was 6.1 days, which was higher than England average of 5.7 days.

The average length of stay for elective patients in cardiology, clinical haematology was lower than the England average. The average length of stay for elective patients in clinical oncology was slightly higher than the England average.

The average length of stay for elective patients in general medicine and geriatric medicine was higher than the England average. The average length of stay for elective patients in neurology was lower than the England average.

The average length of stay for non-elective patients in general medicine and geriatric medicine was higher than the England average. The average length of stay for non-elective patients in neurology was lower than the England average.

In June 2021, 579 medical service patients were treated in an admitted setting, with 83% of patients treated within 18 weeks. This compared to 81% treated within 18 weeks at acute trusts nationally.

In June 2021, 12 admitted patients were treated over 52 weeks. The majority of these patients were in cardiology (seven patients, 5% of all admitted patients treated in cardiology). Only 66% of cardiology patients (85 patients) and 69% of dermatology patients (49 patients) were treated in an admitted setting within 18 weeks.

To decrease the number of patients seen in the same day emergency care (SDEC) and to increase capacity, patients were being referred to the medical assessment unit directly from the emergency department. The aims were to provide early medical review to decide on the patient pathway of care i.e. to admit or treat; enable easy and quicker same day diagnostics; and provide action to follow up in the acute assessment unit for further review avoiding the need for overnight admission.

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.

The number of patients referred to the acute assessment unit by the emergency department had increased to 10 patients a day. The number of patients referred and any limiting factors such as capacity were recorded daily to shape future improvements to the service.

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. We were told of examples within the previous month where patients who were living with dementia had been moved late at night.

During the period from September 2020 to August 2021 there had been 742 overnight moves.

Managers made sure they had arrangements for medical staff to review any medical outlier patients. Capacity continued to outstrip demand for beds and the management of medical patients in non-medical beds continued to be a challenge. The overuse of non-established medical escalation beds had been raised as a risk to patient safety and experience on the risk register.

There was a standard operating procedure (SOP) for medical outlier patients to support safety at times of high demand. The processes ensured patients admitted to wards outside of the medical bed base received the same level of care as those within the medical bed base. The SOP included the route of access for speciality advice; a clear management plan on admission; responsibility for patient care whilst on the ward; movement to speciality wards.

Data from August 2020 to September 2021 showed there were 9,543 outlying patients during this period. During the inspection we saw there were 141 patients across the trust in an outlying bed. Patients were 'tracked' on the trust computer system to make it clear where an individual was in an outlying bed. We visited patients who were identified as being cared for on non-medical wards and saw they had all been reviewed promptly by medical staff.

Staff said every escalated bed was open and they felt escalation and the use of additional beds had become "the norm". They wanted procedures to be reviewed to ensure demand was managed safely. They were concerned outlying patients were increasing and were at high risk of being missed. Staff told us not all patients were reviewed in a timely manner and there was a lack of ownership of outliers, and a lack of specialty input. Responsibility to see patients often fell to junior doctor (foundation year two) level rather than consultants.

There were plans to cohort outlier patients on non-medical wards and support them with extra outlier medical teams. This would enable patients to receive the right medical care when not in the right speciality ward. As a further workstream staff were looking at improving plans for patients admitted overnight to try and enable them to be admitted to the right ward and so be seen quicker.

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.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The service clearly displayed information about how to raise a concern in patient areas. Information about making complaints was available in all the areas we visited. Leaflets were available in all departments and information could be accessed on the trust website with links about how to resolve concerns quickly and how to make a complaint.

Medical care (including older people's care)

Most patients, relatives and carers knew how to complain or raise concerns. Patients said they felt they could raise concerns with the clinical staff they met. Most patients told us if any issues arose, they would talk to the senior nurse available.

Staff understood the policy on complaints and knew how to handle them. There were policies and processes to appropriately investigate, monitor and evaluate patient's complaints.

Managers investigated complaints and identified themes. There was a focus on improving the quality and timeliness of complaint responses within the medicine care group. During complaint investigations staff were required to provide comments, and when indicated, written statements. The complaints and Patient Advice and Liaison Service (PALS) supported the trust in the delivery of the complaints investigation policy.

The service monitored complaints and identified themes. From September 2020 to August 2021 across the medicine care group there had been 241 complaints. The main themes included clinical review, continuing care, communications, delayed diagnosis and discharge arrangements.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff were aware of complaints and any learning that had resulted. All staff we spoke with were aware of the complaints system within the trust and the service provided. They were able to explain what they would do when concerns were raised by patients. They said they would always try to resolve any concerns as soon as they were raised, but should the patient remain unhappy, they would be directed to the manager or the trust complaints' process.

Managers shared feedback from complaints with staff and learning was used to improve the service. Every complaint was reviewed to identify the issues raised by the complainant to ensure learning and continuous improvement.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good.

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

Leadership capacity to undertake business as usual had been affected by both operational pressures related to flow and the COVID-19 third wave. There were arrangements to mitigate this as far as possible and to ensure that all safety related issues were monitored and acted on in a timely manner.

Command and control structures had been 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.

Medical care (including older people's care)

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.

The team were knowledgeable and passionate about the service and actively worked to improve delivery of care. Most staff said managers were approachable and they felt able to openly discuss issues and concerns with senior staff and their managers. They believed they would be listened to, and actions taken when necessary if anything needed to change or be addressed. However, others said not all managers were present and visible. They recognised managers were stretched with operational challenges but explained "it feels that you are only visited from leaders when something has gone bad or you have done something wrong."

The team of matrons operated an 'open door' policy, which staff were positive about. Staff were supported to develop their skills and competencies within their roles. We received consistently positive feedback from staff who had a high regard and respect for their matrons.

Managers encouraged learning and a culture of openness and transparency. They had an awareness that staff required different leadership styles and were flexible in their approach to the needs of their teams.

Most staff we met said they felt valued and part of the team and were proud to work in the team. They felt supported by the leadership team, heads of nursing, matrons and their colleagues.

Nursing staff told us matrons visited the wards at least once a day and covered shifts when required and provided support to staff, which was appreciated.

Leaders spoke positively about their staff and told us they recognised the incredible efforts they had made across the trust during the COVID-19 pandemic.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

All staff were aware of the trust values and told us those values were meaningful for them. These were putting people first; taking ownership; respecting others; being positive; and listening, learning and improving. Staff felt the trust upheld these values.

The trust vision was to provide outstanding integrated care. The improvement priorities included valuing staff; delivering safe, high quality services; providing services in a sustainable way; and working with partners across the community.

The service was working with system partners to develop the strategy. For example, with GP colleagues to optimise the use of primary care in areas such as the acute assessment unit (AAU) and the Acute GP Service and with the local community trust to integrate care pathways to improve patient flow and reduce hospital length of stay.

Medical care (including older people's care)

Culture

Staff felt respected, supported and valued. 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 where patients, their families and staff could raise concerns without fear.

The trust intranet detailed the resources staff, or their managers could access to support and promote well-being including access to psychological support, and activities to promote physical well-being. Managers actively monitored sickness to ensure staff were referred to the occupational health department in a timely manner, if required. There was a suite of policies to support flexible working arrangements for staff.

Managers encouraged learning and a culture of openness and transparency. Senior staff agreed that staff or teams would speak up to them when they needed to and would be heard. Most staff said they were encouraged to speak up and felt comfortable about raising any concerns. However, not all staff were aware they could raise concerns about patient care and safety, or any other anxieties they had with the Freedom to Speak Up Guardian. Some staff thought it was not worth speaking to the Freedom to Speak Up Guardian as they were not confident this would lead to change.

Staff told us about how the trust shared learning and take action when a never event, serious incident, or near miss occurred.

Some staff said they felt valued, confident and proud of the care they provided. They told us they were proud of being able to make a difference and felt supported by the leadership team and their colleagues. However, others felt pressured and struggled to feel heard.

Managers said they were proud of the staff they supervised. They said there was a high level of commitment to providing quality services. In addition, managers explained staff had volunteered to move to other areas at the height of COVID-19 and had shown great resilience and commitment to the wider trust during a time of crisis and had made a real difference.

However, staff described a gradual erosion of their good will in the way moves to other areas had been managed and communicated. Some staff had volunteered to move during each of the waves and did not want to do it again and wanted a more fair and equitable system for managing moves in the future.

Staff said they felt “like pawns on a chess board – that goes right across all bands and staff members.” Managers said they were working on how to minimise the impact of these moves on staff morale and mental and physical health.

Patients and their families were at the centre of the service. There was an emphasis on the importance of education and awareness for patients and their families. It was clear staff had the patients at the centre of their work. They were passionate about services for patients and were dedicated to their roles and approached their work with flexibility.

The team provided support to each other. It was clear their work was important to them and they felt passionate about their contribution to care and were committed to improving the health of local patients.

Staff were positive about working for the trust, although there had been times when they felt stretched and under pressure during the last year. Many staff had worked in the medicine care group for some time and were very proud of their length of service.

Most staff were aware of the whistleblowing policies and procedures and felt able to approach managers to raise any concerns or suggestions and most staff were confident they would be listened to and action taken.

There was an opportunity for staff to access support and debriefing when this was required. The trust also had a staff support/counselling service available to all staff.

Staff told us they were well supported by their immediate managers and matrons and were able to raise issues. However, they felt less supported by the senior management team. Staff were not convinced the senior management team understood the challenges they faced or respected their efforts.

Staff described the months during the COVID-19 pandemic as “exhausting and traumatic”. Excellent teamworking and support from colleagues were the main reasons they were able to cope and continue. Good working relationships with wider trust colleagues, especially in the emergency department had improved an awareness of the challenges faced in other services.

Staff were passionate about providing the best care for patients. They described how good care could be achieved through care planning and effective risk assessments and were aware of their responsibilities and roles.

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.

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

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.

An extensive set of policies was readily available on the intranet and was 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 performance review 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.

The medicines governance and medicines safety groups reviewed new medicines requests to ensure there was an evidence base for their use and they were appropriate for the condition that they have been requested for and that they were cost effective.

Medical care (including older people's care)

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.

Risk management processes had improved and were more effective. The trust had systems for identifying risks and plans to eliminate 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.

The trust used a board assurance framework to provide information about severe and very likely risks, these included risks related to Covid-19.

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 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.

Staff felt able to raise issues around risk to their managers. Ward staff told us they were aware of specific risks that had been escalated.

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.

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

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.

During the inspection we saw records were kept securely. Paper records were stored in lockable trolleys or in rooms with restricted access.

Staff told us patient information was clear and records were easy to use.

Medical care (including older people's care)

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.

In line with guidance from NHS England / Improvement, the Friends and Family Test was suspended during the COVID-19 pandemic and formal submission restarted in December 2020. Data from December 2020 to May 2021 showed 95% of patients would be likely to recommend the service.

Staff and managers took action to improve the experience of patients. For example: analysis of the Friends and Family Test had highlighted a correlation between the frequency of comments and hospital occupancy. For example, more negative comments were made about staffing and responsiveness in March 2021 than for the four months covering April to July 2020 when the hospital was de-escalated in the first part of the pandemic.

In addition to the test there were plans to undertake other stakeholder surveys and networks, and patient group feedback in endoscopy, renal and hepatology.

Through the patient council, user group and patient support and focus groups, the trust had engaged with patients and patient representatives when considering change and improvements in the trust

Work had been completed prior to COVID-19 with Devon Healthwatch to identify options for joint working to improve links with hard to reach and ethnically diverse communities to promote equality.

There were effective systems to engage with staff. Most staff told us they felt engaged, informed and up to date with what was happening within the wider trust. Information was shared through different forums. These included the staff survey, regular team meetings and verbally. Five staff networks had been introduced to discuss issues and opportunities for change with members of staff.

The trust took part in the 2020 NHS staff survey. The response rate was 42%. In the question asked of staff whether they felt there were enough staff for them to do their job properly, results showed an increase from 22% to 23% for unregistered staff and for registered staff, the results reached the highest point for at least 5 years from 20% to 26%.

The most positive message from this year's survey was that despite the pressure staff had been under, 66% of respondents would recommend the trust as a place to work. This was an improvement of 4% since 2019 and continued a positive upward trend since 2016.

All staff felt able to raise concerns to their immediate clinical managers for example, ward managers and matrons but some staff had concerns about whether this would be acted upon by the senior management team. They also raised concerns about how messages were being delivered about emergency re-deployment between wards. They recognised their professional obligation to keep patients safe but expressed concerns about the way moves were managed as this was not done in a way that recognised the value of specialised roles. Staff felt their value disappeared as they were moved into other services.

There were regular meetings to discuss, share information and provide feedback to staff. Minutes were taken of each meeting and emailed to staff and paper copies were available to ensure those that could not attend had access to the information.

Staff had access to health and wellbeing packages. There were informal reflective debrief sessions and counselling services were available through the occupational health service. Well-being days were provided in addition to annual leave. Chocolates were delivered by the executive team.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

There was an emphasis for continuous, evidence-based improvement for improved health and better care. Staff told us they were always keen to learn and develop the service.

Innovation and improvement were encouraged with a positive approach to achieving best practice. There was a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care to ensure the delivery of high-quality care for patients. Staff and managers felt there was scope and a willingness amongst the team to develop services through training and research and by learning from when things went well and when they went wrong.

The pandemic and the overwhelming number of patients admitted had impacted on the pace of change and implementation of improvements. However, the trust took opportunities during wave one and wave two of the pandemic to continue with improvement. For example, the virtual improvement week in imaging which impacted on patient care and staff hopefulness.

We were also told of the following examples of learning and innovation:

- There was a medicine improvement wall with topics including: length of stay reviews; multidisciplinary processes; and a quality improvement approach to flow throughout the hospital. This had been running since September 2020 and outcomes were analysed to drive forward improvements.
- Participation in the improving quality in liver services (IQUILS) to share best practice with plans to be the first unit to achieve level 2 in the IQUILS to share their best practice across the region. A dedicated liver unit patient management system was required to integrate with other hospital systems to ensure service improvement initiatives were fully aligned with the service needs This was hindered by the capacity and availability of the IT team who had many competing priorities.
- There were plans to introduce an electronic observations package to identify and track a patient with suspected sepsis more quickly. The trust had invested in a trust wide digital safety observations system throughout the organisation. This would provide digital capture of all National Early Warning Score (NEWS) scores, support sepsis and deteriorating patient management with automatic escalations, provide alerts for acute kidney injury (AKI), fluid management support and work-flow management.
- The heart failure specialist nursing team were running a pilot through the acute admissions unit for the early management, signposting and admission avoidance of heart failure, chest pain or atrial fibrillation. The team had made progressive improvements since a whole system improvement event held in 2018.
- There was a clinical trials team who managed the pharmacy related aspects of investigational medicinal products. The trust's research and development department allowed innovative therapies to be trialled in Plymouth and the trials team ensured that medicines were provided in accordance with good clinical practice. One of the most recent trials involved the first preparation of a gene therapy product.

Medical care (including older people's care)

- There were 346 research studies across the care group. Specialties participating included: cardiology, haematology, hepatology, neurology, oncology and thoracic with 442 patients recruited to participate from April to September 2021.