Plymouth Hospitals NHS Trust

Derriford Hospital

Quality Report

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

Ratings

Overall rating for this hospital	**Requires improvement**
Urgent and emergency services	Requires improvement
Medical care	Requires improvement
Surgery	Requires improvement
Critical care	Good
Maternity and gynaecology	Good
Services for children and young people	Good
End of life care	Good
Outpatients and diagnostic imaging	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected Plymouth Hospitals NHS Trust as part of our programme of comprehensive inspections of all acute NHS trusts between 21 and 24 April 2015.

The trust has 12 registered locations:

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

During our inspection we inspected the following locations:

- Derriford Hospital
- Mount Gould Hospital

We did not inspect the following locations:

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

We rated the trust as requires improvement overall and as requires improvement for safety, responsiveness was rated as inadequate. We rated it as good for effective and well-led key questions. There were three services – maternity, end of life care, and services for children and young people – where caring was judged to be outstanding. All other services were rated as good for caring. At hospital level Derriford and Mount Gould Hospitals were rated as requires improvement for the well-led key question, and also requires improvement overall.

Our key findings were as follows:

- We saw and heard many examples where staff had demonstrated outstanding support for patients and their families. The patient bereavement survey undertaken between January 2015 and April 2015 covered eight different wards and all comments seen were very positive, confirming that relatives felt that the care provided was excellent. Patients said they felt able to influence decisions made about them, and relatives felt included in treatment decisions.
- In the maternity service we observed compassionate, dignified and person-centred care. Staff demonstrated a familiarity with how patients preferred to receive their care. Children in both acute and community services were

truly respected and valued as individuals and encouraged to self-care, and they were supported to achieve their full potential within the limitations of their clinical condition. One young person said, "I have a whole heath team around me who have worked with me and my family over many years. I have always felt involved in my care and the children's community nurse is excellent and I would like to nominate them for a trust WOW award."

- The trust had been experiencing a period of high activity since December 2014, with an increase in attendances at the emergency department. As a result the trust had operated at a position of red or black escalation for a number of weeks, leading to an enhanced focus on patient flow, discharge and liaison with other external organisations to ensure patients were seen, treated and discharged in a timely way. At times this proved challenging. We saw on our inspection that in the emergency department staff were sometimes stretched in being able to care for the numbers of additional patients, who at times were cared for in corridor areas.
- People were frequently unable to access services in a timely way for initial diagnosis and treatment. People experience unacceptable waits for some surgical services.
- At the peak of activity there were times when there had been more than 100 medical patients being cared for on surgical wards, peaking in January 2015 at 167. The increased demands on the trust's services and beds resulted in a high number of elective operations being cancelled. The trust was also not always meeting the national targets for rebooking patients within the 28-day timescale.
- There was a lack of robust system for booking patients for surgery. The system used was not streamlined and relied upon a number of individuals to populate the theatre lists with no one in overall charge of this process. We were told of plans to introduce new IT software to help this and re-introduce a scheduling team to take over the process.
- Concerns were identified with the management of medicines in a number of areas. This related to some practice not being in line with trust policy and a lack of suitable arrangements for storage of medicines.
- In diagnostic imaging there was a backlog of radiology reporting, with a total of 12,693 unreported diagnostic imaging scans in September 2014. An action plan was implemented consisting of: prioritisation of urgent scans; general practice chest X-rays taking ultimate priority; a waiting list initiative to prioritise patients at risk. This was managed by radiologists and radiographers volunteering to report on these scans as well as close monitoring of reporting capacity. As a result, unreported scans dropped to 4,750 in March 2015. However, since then and before the inspection this had increased to approximately 7,000.
- In April 2015 there was a total of 110,657 patients on a follow-up waiting list, with 36,724 (33%) of these patients in breach of their see-by date. A total of 1,961 patients had their outcomes missing and no see-by date (meaning that the hospital did not know when a follow-up appointment was required). Of the patients in breach of their see-by date, more than 26,000 (71%) did not have appointments.
- In October 2014 a validation exercise was started to identify and prioritise patients who may be at high risk of harm as a result of long waiting times. There were a total of 4,703 'time critical' patients identified at the time of the inspection. However, progress with the validation exercise varied between service lines, as not all of them had begun the validation exercise and there remained a risk to those patients who had yet to be identified as urgent or at risk of harm from a delay in their being seen or treated.
- The hospitals were predominantly seen to be clean and well maintained, although the maternity delivery suite required improvement in the fabric of the building as it was difficult to clean and not all hand wash basins met the required standard.
- Levels of staffing were raised as a concern in several areas. This had an impact on patients, particularly in diagnostics in addressing the diagnostic reporting backlog. In wards and departments bank and agency staff were frequently used. While this enabled some shifts to be adequately staffed, at times there were fewer staff on duty than was required. We heard of difficulties in recruitment and retention, and how the trust was working on a targeted approach to attract staff to the area.
- Access to the Children's and Adolescent Mental Health Services (CAMHS) at weekends was not always timely. There were internal issues around the security team – although they were present, they were not able to provide practical assistance because they had not been trained in dealing with young people. The practice educator had begun a programme of training for paediatric ward based staff in the use of restraint and conflict de-escalation.

Summary of findings

- Patients were at the centre of the critical care service and good results were achieved for patients who were critically ill with complex problems and multiple needs. The mortality rates within units showed that more people than would have been expected survived their illness due to the care provided.
- Care pathways complied with National Institute for Health and Care Excellence (NICE) guidelines and the Royal College standards. Outcomes demonstrated that the majority of services provided care, treatment and support that achieved good outcomes, promoted a good quality of life and were based on the best available evidence.
- There was good multidisciplinary working within the units and wards to make sure that patient care was coordinated, and staff in charge of patients' care were aware of their progress. We saw physiotherapists and occupational therapists assessing and working with patients on the wards, then liaising with and updating the nursing and medical staff.

We saw several areas of outstanding practice including:

- The care and support provided to patients at the end of their lives was outstanding. Patients and relatives told us that they felt included and involved in decisions about care and treatment, and that they had been treated as individuals, with their choices listened to and respected. Feedback from all patients and relatives was extremely complimentary about the care they had received and the staff who had delivered the care.
- The involvement with community services in patient care was integral. As a result discharges were seen to be managed quickly to meet patients' needs. We heard and saw instances of how the specialist palliative care team (SPCT) within the hospital worked with the local hospice and Hospice at Home team within the community to improve patient support.
- The tea with matron initiative helped patients to feedback their views about the service they received.
- The procurement team were working with the clinical staff in theatre to review the use of some equipment and to help reduce their capital spend.
- The use of the Enhanced Recovery After Surgery (ERAS) pathway, which has been converted into a mobile phone app provided evidence-based protocols to ensure patient recovery was maximised.
- The acute care team within critical care providing an outstanding service in terms of outreach and responding to deteriorating patients in the hospital. This was recognised by other staff, in particularly the surgical and medical wards. We were told the team were quick to respond, were highly experienced and knowledgeable, and staff could ask their advice and support on any matter. Staff said the acute care team had encouraged and enabled them to ask for advice or a review of any patient where, although the patient might not be triggering a risk level, the nurse or doctor had doubts or, as was described by one of the staff, "something that didn't feel quite right, or a gut instinct."
- The consultant intensivist clinical lead provided an outstanding example of compassion and support to a past patient who came to the unit during our inspection. This patient had effectively become "lost within the healthcare system" for a number of reasons linked to other events in their life. The patient was not judged for perceived or accepted failings in their life so far, but was offered compassion, advice, support, understanding and encouragement to move forward.
- There was outstanding care and support for those affected by a catastrophic brain injury. In the last five years all patients admitted into the emergency department, with just one exception, had been transferred to the critical care unit. Their family and friends could then spend time with them in the relative peace and quiet this unit afforded before their life-support was removed.
- Staff on the delivery suite, Argyll ward (maternity) and Norfolk ward (gynaecology) provided outstanding care to patients. The culture was focused and embedded on the provision of person-centred care and treatment to meet individual patient needs. Patient feedback was overwhelmingly positive, which was also reflected in monthly Friends and Family tests. Patients said that the reassurance and care given had increased their own confidence. Staff of all professions and grades demonstrated kindness, compassion, dignity and respect. Patients were fully involved with their care and treatment and were actively encouraged to ask questions. Specialist professional counselling was available from midwives and a clinical psychologist supported women with difficult or complex decisions, care or treatment.

Summary of findings

- The neonatal intensive care unit (NICU) clinical director was an advanced neonatal nurse practitioner (ANNP). NICU benefitted from a neonatal technician service, which staff found invaluable. The clinical educator for general paediatrics offered bespoke training and had performed a comprehensive training needs analysis to ensure staff were able to access training to meet their needs.
- The paediatric services benefitted from dedicated pain assessment services and dedicated pain nursing staff.
- We found staff to be very caring and supportive of the children, young people and their families that the paediatric services looked after – both in the acute and community settings. We heard many positive comments about staff going beyond the call of duty to provide care and support. Children were truly respected and valued as individuals and encouraged to self-care and were supported to achieve their full potential within the limitations of their clinical condition. Feedback from children who used the paediatric community services, parents and stakeholders was continually positive about the way staff treated people. Parents said staff went the extra mile and the care they received exceeded their expectations.

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

Importantly, the trust must ensure:

- All staff are aware of their role in incident reporting and there are systems and process in place to monitor not only individual incidents but trends and themes.
- Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be are deployed to provide adequate levels of nursing and medical staff to ensure the safety of patients at all times. This applies to the emergency department, children's services, outpatients and diagnostics, maternity services and medical services.
- Patients in the emergency department that are awaiting x-rays in the corridor and the reception area away from staff vision are suitably monitored.
- The safety and security of staff and patients in the CDU by providing a means of calling for assistance in an emergency.
- The reception and waiting area in the emergency department complies with the Disability Discrimination Act.
- Staff are administering medicines in line with the NMC standards for medicines management.
- The checking systems for ensuring medication is fit for use, is consistently followed by staff. Intravenous fluids should be stored securely so that they are not accessible by patients and visitors to wards and departments.
- Medicines and controlled drugs are kept in locked in cabinets in the obstetric theatre and anaesthetic rooms when not in use.
- Medications are managed appropriately in the outpatients departments and trust processes and policies are followed.
- Patients receive appropriate and ongoing risk assessments such as mental health risk assessments and complexity scoring, to determine the appropriate place for them to be cared for and monitored.
- All staff have sufficient knowledge of and implement the Mental Capacity Act so that patients' mental capacity is confirmed and to identify patients who lack capacity to make decisions, so that patients' best interests were being served.
- Patients are protected from risk through improvement of systems and performance in relation to the time patients spend in the emergency department.
- Treatment Escalation Plans (TEPS) are fully completed to ensure patients' choices and preferences and ceilings of care are identified.
- It improves the premises for patients who are using Interventional Radiology, to make sure there is a suitable environment for patients to recover post procedure.
- Patients' records are stored securely at all times to prevent unauthorised access to them.
- It improves the experience of patients by addressing the high numbers of elective operations that have been cancelled.

Summary of findings

- The critical care service improves the experience of patients by addressing the significantly high levels of discharge from the unit that are either delayed for more than four hours or happen at night.
- Systems for booking theatre slots are robust and coordinated across the trust so that theatre time is utilised to provide a timely and consistent service.
- Ensure there are systems in place so that the impact of system escalation does not delay patients who are cancelled at short notice and that they are re booked for their surgery within the 28 day requirement.
- It provides a suitable environment for patients awaiting x-ray that will provide privacy and the ability to call for assistance if required.
- The environment and equipment on the delivery suite is fit for purpose and is able to be effectively cleaned and decontaminated to prevent the risk of cross infection. The delivery suite did not comply with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.
- Care and treatment is provided in a safe way for patients by ensuring premises are safe to use for their intended purpose, that is cleaning materials and sharps materials are stored securely in areas that are not accessible to patients or visitors.
- There are sufficient resources to ensure the cleaning of blood and body fluid spillages does not pose a risk that clinical staff are unable to meet the clinical needs of patients in preference to cleaning
- The ratio of supervisor of midwives to midwives is at the recommended level of 1:15 (Midwifery Rules and Standards, rule 12, Nursing and Midwifery Council, 2014).
- Staff working in gynaecology are supported to have annual appraisals.
- Rooms used for recovery of children following procedures under general anaesthetic on the children's Outpatients Department meets laid down recommendations.
- The safety of adolescents with mental health issues when using any of the paediatric services at all times.
- All children using the acute or community paediatric services have a care plan in place that is updated at regular intervals or when changes occur to the child or young person.
- Systems and process are in place to manage the backlog of follow-up appointments and the backlog of imaging reporting, to mitigate the risks to patients of delayed diagnosis and treatment.
- Action plans are realistic and focused on the areas of concern in relation to the backlog of unreported scans in diagnostic imaging.

In addition the trust should:

- Ensure adequate infection control processes are in place in the emergency department while alternate entry doors are in use.
- Ensure the safe storage of medical gases at all times.
- Review privacy arrangements for patients arriving in the emergency department, either through reception or via ambulance, awaiting investigations such as x rays and while in the 'corridor' area.
- Review the provision of translation services in the emergency department to ensure they can be provided in a timely manner.
- Review bereavement and viewing facilities within the department.
- Review the governance systems to improve the function, monitoring and learning from incidents, complaints and risks.
- Review nursing leadership within the CDU.
- Review the provision of a play specialist for the paediatric emergency department area.
- Ensure that the facilities for multi-faith prayer are large enough to enable Friday prayers for men and women and ensure the arrangements for ritual ablutions are appropriate.
- Ensure that patients' dignity and respect are considered in the arrangements for discreet use of lifts when transporting the deceased.
- Within critical care, review the nursing presence in case review and other relevant meetings. This is to ensure communication and learning from risk meetings is cascaded to the nursing team.

Summary of findings

- Prioritise pressure area care within critical care to reduce the incidence of pressure ulcers. The target levels for patient harm from falls or pressure ulcers being considered as 'acceptable' at levels above zero should also be reviewed and reflected on. Data on venous thromboembolism (VTE) or urinary tract infection (UTIs) should also be captured in dashboard reports and incident data.
- Ensure the emergency equipment trolleys within critical care are of a type to make them easily differentiated from other trolleys in use. They should be sealed to prevent tampering, or show when equipment had been used but the trolley not replenished and resealed.
- Review the level of physiotherapy provided to general and neurosurgical critical care patients, as it did not meet recommended levels of the Faculty of Intensive Care Medicine for therapeutic treatments.
- Review the level of pharmacy support provided to general and neurosurgical critical care patients, as it did not meet recommended levels of the Faculty of Intensive Care Medicine.
- Review the professional development of the nursing team within critical care and ensure over 50% have a post-registration award in critical care nursing, as recommended for safe care by the Faculty of Intensive Care Medicine. Appraisal rates should be improved to trust levels and continuous professional development should be funded and included in this review, to ensure staff skills and rates of retention are continually improving.
- Produce a clear local audit calendar within critical care to meet the recommendations of the Faculty of Intensive Care Medicine, to ensure it analyses care effectiveness and outcomes and can identify where this is sub-optimal or of particular success.
- Decisions around consent, mental capacity assessments and the use of any deprivation of liberty or restraint should be improved in the critical care medical notes.
- Review the provision of mental health support given to patients and their families who are or have been patients in the critical care unit.
- Ensure all patient records on the delivery suite are stored securely and have accessible monthly midwife to birth ratio figures in order to be able to confidently audit and monitor safe staffing levels.
- Ensure the process for learning from incidents is embedded in practice at ward level.
- Provide a staffed perinatal mental health service.
- Ensure the information collated for the regional maternity dashboard can be displayed in a way which provides context and clarity. For example; the midwife to birth ratio figures for the trust were not easy to identify or to track any changes. This meant it was difficult to assess the how governance and quality standards had been monitored.
- Ensure a visible birth pool cleaning schedule is available, to show that it is clean and ready to use at any time, and ensure there is a an audit trail that this has been completed .
- Ensure staff have adequate guidance and equipment available at all times to enable the controlled removal of body fluid spillages to prevent risk of cross infection.
- Provide a midwifery led unit to ensure the recommended choices of place of birth for low risk women. This should involve and communicate with all staff in the development, delivery and evaluation of their service visions and strategies.
- Have a baby abduction policy, and review the policy and procedure for discharge of patients from the maternity unit.
- Patients and the public should have access to the ward patient safety information.
- Ensure that the dissemination of information from investigations following incident reporting should be communicated more thoroughly to support learning across the trust.
- Ensure that service specific mortality and morbidity meeting minutes are recorded in sufficient detail to enable any trends or issues to be identified, in order to take action or learning from the minutes.
- Ensure staff consistently complete infection control training and that patients with communicable infections requiring isolation are cared for in isolation.
- Ensure that there is evidence that up-to-date servicing and maintenance of equipment has taken place.
- Ensure that patients' personal and confidential information on computers and electronic systems is kept securely.
- Ensure risk assessments and care documentation for individual patients are consistently and appropriately completed by staff.

Summary of findings

- Ensure that all staff are knowledgeable about the sepsis identification and management system in operation within the trust.
- Ensure that the system for advising staff of the medical cover for medical outliers is disseminated efficiently and to all staff.
- Ensure that the PALS department is able to respond promptly and efficiently to patients and visitors to the hospital.
- Ensure the milk kitchen is kept locked so it is not indiscriminately accessible to patients or visitors on Woodcock Ward.
- Review the caseloads of the diabetes service in the children's community nursing service in line with national guidance (RCN 2013).
- Review the standard operating procedures for Patient Group Directions used in Outpatients to ensure these comply with the legislation and best practice.
- Ensure that staff in outpatients have an adequate understanding of safeguarding to ensure that incidents are identified appropriately.
- Ensure that there is adequate and suitable seating available for patients waiting for an outpatient appointment and that these seating areas are not obstructed.
- Review the processes for the referral to diagnostic imaging scans, particularly in computed tomography to reduce the risks of patients receiving multiple scans.
- Ensure that staff understand their role in relation to the responsibility, management and oversight of the risk registers throughout all levels of the organisation related to outpatients and diagnostic imaging.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	The emergency and urgent care services at Derriford Hospital require improvement for the safe, responsive and well-led key questions. Both caring and effectiveness were found to be good. There was an inconsistent approach to incident reporting, with some incidents accepted as normal. The environment within CDU was not always safe for patients with mental health needs and mental health care was not provided in line with national guidance. Staff lacked training in the Mental Capacity Act. Staffing was not always sufficient and children did not always receive care from an appropriately trained nurse. Patients did not always receive timely care and treatment, or treatment that met their individual needs. The department consistently failed to meet the national standard requirement for 95% of patients to be discharged, admitted or transferred within four hours of arrival. Nursing leadership was variable and at times lacked effectiveness and visibility. Governance systems were not fully effective. The care provided was compassionate and kind, with good regard to patients' involvement and understanding. Care was evidence-based. However some patient outcomes were worse than the England average. There was a positive approach to education and training and good evidence of multidisciplinary working.
Medical care	Requires improvement 	Patients were positive about the care and treatment they received at Derriford Hospital. We saw that staff provided patients with a kind and caring service, respecting their dignity and privacy and showing empathy and understanding. Safety in the medical services was compromised and we rated this as requires improvement. We found that staffing levels of both nursing and medical staff were below the assessed levels, which presented a risk to patient care. Systems were not in place to ensure that staff were clear about the medical cover for patients who were admitted to the surgical wards when medical wards were full.

Summary of findings

Patients were not protected from the risks of hazardous substances as cleaning materials were stored in unsecured areas that patients and the public could access. These areas included wards where patients who were confused or living with dementia were receiving care and treatment.
Patients received good outcomes because they received effective care and treatment that was delivered in accordance with evidenced-based guidance, standards, best practice and legislation.
The trust participated in national audits and used the outcomes from audits to improve services.
Multi-disciplinary team working was seen throughout the medical wards and departments and within the wider community, leading to consistency of care to patients.
Patients received their care and treatment from competent staff who were provided with supervision, appraisals and training.
Services did not always meet people's needs. The cardiology referral to treatment times did not meet trust targets and people were waiting for longer than 18 weeks to access care and treatment.
Patients experienced delays in discharge and were unable to leave hospital when they were medically fit. A discharge team were in operation within the hospital, working towards improving the discharge process for patients with complex needs.
Patients who required medical care and treatment were not always provided with a bed on a medical ward and medical outliers were admitted to surgical wards. Staff were not always aware of which doctors were providing specialist medical care and treatment to the medical outlier patients.
Patients experienced transfers within the hospital wards often late at night and on more than one occasion during their stay.
Not all patients were aware of how to make a complaint should they need to do so. People provided us with information on the lack of response they had received from the Patient Advice and Liaison Service (PALS) when they had raised concerns or complaints.
The medical service were well-led. The quality of services was reviewed in board meetings and in other relevant meetings within the medical division.
Information regarding the vision and values of the

organisation was available in some areas of the hospital and senior staff were all clear of these. Not all junior staff were familiar with the aims. Staff told us there was a positive culture within the hospital and they were proud to work there.
The senior leadership team were visible on wards and departments, with staff showing an awareness of the senior team and making positive comments regarding their presence on the wards.
We saw evidence of innovative practice within the medical services. Staff were confident that they were able to make suggestions and were provided with support to implement innovative practice.

Surgery **Requires improvement**

While services were seen to be caring and compassionate across all areas, improvements were required to ensure that surgical services were safe and responsive. Staff were encouraged to report any incidents on the trust's system. However, junior doctors were not consistently doing this. Learning from incidents was shared at ward and unit meetings. Staff told us the trust had an open culture and they were not blamed when things went wrong.
Prior to our inspection, the trust had increased pressures on their services where they had a very high number of unplanned admissions. This had resulted in a high number of elective operations being cancelled. Their elective orthopaedic ward had been turned into a medical ward to cope with the pressure for their beds. This had also affected their referral to treatment times on some of their surgical specialties. Due to this pressure, the number of medical and surgical outliers had increased on the surgical wards. Some staff felt they did not always have the skills or knowledge to meet the needs of these patients.
The trust was not meeting its mandatory training targets. Staff told us they did not always have time to complete the training, or training was cancelled due to the increased pressures on the hospital services.
The environment in interventional radiology was not fit for purpose. Patients did not have a waiting area and they were recovered in a corridor post procedure. This meant their privacy and dignity was

compromised. The trust had plans to reduce the number of beds in some of their bays on their surgical wards because of the constraints with space.

We found that not all patient records were stored securely on Fal or Postbridge units. Fal had lockable cupboards but these were not always locked. We also found that not all patients care plans and risk assessments were up to date with their current care needs.

There was good multidisciplinary working within the wards to coordinate patients' care. Information was provided for patients about their operations, and patients were able to ask questions and were kept up to date on their progress. The trust had processes in place for obtaining the consent from the patient, and other arrangements were in place for patients who were not able to consent.

Patients we spoke with praised the staff on the wards and units we visited. We found some areas where patient privacy could be improved. We saw each ward had dedicated protected mealtimes and used a system to identify patients who required more assistance. We found this worked very well on the majority of wards.

Not all staff were aware of the trust's visions and values. Staff on the wards and units told us they felt supported and listened to by their management team, surgical care group management and executive board. Governance systems were in place for monitoring their services. Any serious risks were shared with the executive board.

Critical care

Good

We have judged the overall critical care services at Derriford Hospital as good. There were two distinct units. The general (Penrose) and neurosurgical (Pencarrow) units ran as one service called the Department of Critical Care (DCC) and there was a cardiac critical care unit in Torrington ward in another part of the hospital. The safety, effectiveness, caring and leadership of the service were good. However, the responsiveness, in terms of arrangements to discharge patients at the appropriate time, required improvement.

There was a good track record on safety with lessons learned and improvements made when things went wrong. This was supported by staff

Summary of findings

working in an open and honest culture and a desire to get things right. Staff responded appropriately to changes in risks to patients and produced and completed appropriate assessments and care plans that were followed. There was an Acute Care Team providing an outreach service to all wards 24 hours a day, every day of the year.

There was high-quality well maintained equipment and a safe environment. The units were clean and well organised and staff adhered to infection prevention and control policies and protocols.

Bed numbers had been reduced in the Penrose general unit and Torrington cardiac unit to ensure there were safe levels of nursing staff. But to achieve this, bank staff were employed in the Penrose unit to make up for the lack of substantive staff. Active recruitment was taking place to address this. Nursing staffing on the Pencarrow neurosurgical unit was closer to required levels. The consultant and doctor cover was mostly meeting the Intensive Care Core Standards. There was a strong commitment of experienced consultant intensivists, and rarely any locum cover used. The provision for pharmacy and physiotherapy services did not meet the recommendations of the Intensive Care Core Standards. The service provided was safe, but there was not enough staff to provide more than the minimum service.

The electronic patient records were comprehensive, well maintained, clear, and contemporaneous, although the speed of access to and reliability of the electronic system needed to be improved.

Medicines and consumable stocks were managed, stored and used safely. There was a shortfall in staff having completed their mandatory training due to a busy winter period.

Treatment and care was delivered in accordance with best practice and recognised national guidelines. There was a multidisciplinary approach to assessing and planning care and treatment for patients. Patients were at the centre of the service and the overarching priority for staff. Good results were achieved for patients who were critically ill with complex problems and multiple needs. The mortality rates within units showed more people than would have been expected survived their

Summary of findings

illness due to the care provided. There was, however, a limited presence from the nursing team in case review and other relevant meetings in the DCC.

The DCC did not meet the Core Standards for nursing education. Only 38.5% of the nursing staff had obtained a post-registration award in critical care when the Core Standards recommended at least 50% of the nursing staff achieved this. Appraisal rates also did not meet the trust's target levels. Local audit work was not routine or prioritised to ensure outcomes and effectiveness of care were well understood, could be improved, or celebrated as necessary. The medical notes were not capturing well enough the recording of decisions around patient consent, mental capacity and the use of any deprivation of liberty.

Feedback from people who had used the service, including patients and their families, had been very positive overall. Staff ensured patients experienced compassionate care, and care promoted dignity and human rights. It was not noticed by us as a frequent problem, but unnecessary noise within the DCC did at times disturb patients.

The DCC service responded well to patient needs. But there were bed pressures in the rest of the hospital that meant a significant number of patients, were delayed on discharge to other wards and too many were being discharged at night. There was a relatively high level (when compared nationally) of elective surgical operations cancelled due to unavailability of a critical care bed. Otherwise, the unit protected a bed for admission of a patient only in an emergency. With very few exceptions, all patients who had needed emergency admission onto the unit had been admitted.

The facilities in critical care were excellent for patients, visitors and staff, and met all of the modern critical care building standards. There were no barriers to people to forward complaints, and there were very few complaints made to the department. Those that had been made were fully investigated and responded to in a timely way with improvements and learning evident. There was,

however, no provision in the DCC for any support to patients with mental health needs or the anxiety they or their relatives and friends might be experiencing.
The leadership and culture in the service were used to drive and improve the delivery of high-quality person-centred care. All the senior staff were committed to their patients, their staff and their unit with a shared purpose. Elements of the governance of the unit such as quality and safety audit results were not consolidated, and brought into the departmental meetings in the DCC.
There had been some recent senior nurse appointments to the DCC who were being supported from the Service Line Cluster Manager, the Service Line Clinical Director, and the senior nurses.

Maternity and gynaecology

Good

Overall we have judged maternity and gynaecology services as good. The service required improvement for safety; effective, responsive and well-led were judged to be good; and caring was viewed as outstanding.
The maternity services needed to make safety improvements. The environment and some equipment was not conducive to the prevention and control of infections and related guidance. There were gaps in the cleaning contract schedule. These were alternatively completed by healthcare assistants; taking them away from assisting with clinical duties. Improvements were required for the safe discharge process of mothers and babies. Refurbishment was part of the trust's redevelopment plan but this did not have any agreed timescales.
The national recommended ratio of Supervisor of Midwives (SoM) to midwives is 1:15, and was not being achieved (Midwifery Rules and Standards, rule 12, Nursing and Midwifery Council, 2014). The ratio of SoM to midwives at Derriford hospital was 1:27.
There were established and thorough safeguarding systems in place and good mandatory and other training for maternity staff. Patients had risk assessments completed and reviewed regularly. Staff were knowledgeable about incidents and learning from these was demonstrated.

Summary of findings

Both services provided effective services. Staff followed most nationally recognised policies and procedures. However, there were no specialist perinatal mental health services. There was good communication between all grades of staff and different professionals. Team working was described as good which supported staff's ability to meet the individual needs of patients.

Patients and relatives were impressed with the care provided in both gynaecology and maternity services, reporting it exceeded expectations. Patients told us they had been fully involved in all aspects of their care. Staff provided person-centred care and support which was delivered with compassion, kindness, dignity and respect. Additional specialist counselling and support services were available for women to access as required.

The maternity and gynaecology services were responsive to individual needs. There were patient access and flow issues on Norfolk ward. This was due to medical patients being admitted to manage unprecedented demand in the hospital. This had impacted by breaches in the 18-week standard of referral to treatment times.

Complaints were reviewed and appropriate actions taken. Learning from complaints was shared in meetings and within staff newsletters.

The service was judged to be good for well-led, although ward staff were not familiar with the service's vision or strategy. There were comprehensive risk, quality and governance structures in place. However, improvements should be made to processes to investigate and learn from incidents, and ensure this learning is embedded in practice.

Staff described leadership and support from ward level and above as good; with senior managers visible and approachable. The staff we spoke with were proud of the care they provided. There was good evidence of a positive working culture and innovations and actions taken to make service improvements.

Summary of findings

Services for children and young people

Good

Paediatric services were provided across the Plymouth Hospitals NHS site. They provided effective and responsive planned and emergency care and support to children and young people and their families. People who used the services told us they felt safe.

We found without exception that staff at all levels were caring supportive and very keen to do the best job they could.

People who used the services told us they felt safe. There were some aspects of the system that did not assure us that children and young people were always safe in some areas of the paediatric services: staffing levels were often below recommended levels on the paediatric wards and neonatal unit, although recruitment was ongoing. The rooms used for recovering children following procedures under general anaesthetic on the Children's and Young Peoples Outpatient Department (CYPOD) did not allow for constant line of sight by a trained nurse. The paediatric wards were seeing an increase in admissions of young people with mental health issues. The lack of clarity about how the internal security team could help and access to Devon, Cornwall and Plymouth Children's and Adolescents Mental Health Services (CAMHS) teams at weekends meant that these young people remained vulnerable while in the hospital setting.

We found the paediatric services were well-led at a local level and the staff felt engaged with the trust-wide senior team. They said the Chief Executive Officer and the Director of Nursing visited their wards and departments. Staff felt able to raise issues with local and senior management and felt they were listened to and their concerns understood.

We found community paediatrics provided a caring and effective multidisciplinary and multiagency service for children and young people who required assessment, support and intervention to ensure their wellbeing and development.

Services were provided in a child friendly environment by a highly skilled and empathetic workforce across the Child Development Centre and the Children's Community Nursing Service. Services accessed at the Child Development Centre, or when clinically required included visit's to a child's home,

nursery, school or other locality setting. This enabled the development of holistic packages of care for each child and minimised the need for multiple appointments and duplication of history taking and documentation. There were concerns with regard to the small number of child assessments and care plans that had been completed in the Children's Community Nursing Team. Services were well-led and staff were aware of the wider vision of the trust and felt supported in their roles.

End of life care

Good 

End of life care was provided safely throughout the trust which protected patients from avoidable harm and abuse. The Specialist Palliative Care Team provided consistent, safe care and advice for patients, relatives and staff throughout the trust. The Specialist Palliative Care Team worked closely with the Acute Oncology Service to support safe patient pathways through the hospital.

The effectiveness of some aspects of end of life care required improvement. While some aspects were good, including multidisciplinary working, several areas required further improvement. These included the Treatment Escalation Plans (TEP) used to identify decisions around resuscitation and ceilings of care agreed with the patients which were not consistently completed to ensure patient choice was being identified. The ceilings of care were an indication of when a patient wanted treatment to stop or what treatment they did or did not want. The facilities for multi-faith prayer were not large enough to enable Friday prayers for men and women separately. The arrangements for ritual ablutions also required improvement. The arrangements for discreet use of lifts when transporting the deceased required improvement. Some patient outcomes were being developed to achieve effectiveness. Seven day working was not yet in placed but was planned to be.

The compassionate and sensitive end of life care provided to patients on wards by medical and nursing staff and by the Specialist Palliative Care Team was seen to be outstanding.

Patients and relatives told us they felt included and involved in decisions about care and treatment and that they had been treated as individuals with their

Summary of findings

choices listened to and respected. We saw that the responsiveness to patients' individual care needs was outstanding. The Specialist Palliative Care Team was responsive to requests to support patients with complex end of life symptoms and care needs. Close working relationships with the Acute Oncology Service improved the patient's pathway through the hospital.

The involvement with community services in patient care was integral and as a result discharges were seen to be managed quickly to meet patients' needs. Fast track discharges were seen to be managed in the patient's best interest, with a proactive approach taken to ensure the support and safety of vulnerable patients.

We found leadership of the end of life service to be good. Leadership of end of life services by the Specialist Palliative Care Team was clear to staff throughout the trust. The Specialist Palliative Care Team promoted a culture of sharing knowledge and developing the skills of others. The trust's vision for the end of life service was shared by all staff.

The culture was seen to be that end of life care is 'everybody's business' and all staff shared a priority to ensure the care provided was right for the patient. The trust recognised the need for ongoing development of the service to include further access to the SPCT.

Outpatients and diagnostic imaging

Inadequate

Plymouth Hospitals NHS Trust outpatient and diagnostic services were overall rated as inadequate

We rated safety as inadequate. We found the level of staffing did not match the establishment in many service lines, increasing the risk of harm to patients waiting for an outpatient appointment by delaying diagnosis and treatment. We found multiple incidents of harm to patients as a result of delayed appointments and diagnosis of scans. Examples of this included: patients having deteriorating sight, and patients having had delays in the diagnosis of cancer. We also found that the safe use of medicines was inconsistent, as responsibilities for dispensing medications and the responsibility of keys were not following trust policy. We also found that fridges in outpatients, used for the storage of medications, were not being monitored appropriately.

Summary of findings

We do not currently rate the effectiveness domain in Outpatients and Diagnostic Imaging. We found that staff followed competency frameworks based on standard operating procedures for all processes. We found that patient outcomes were monitored and benchmarked in the therapies department and that dose audits were regularly conducted in diagnostic imaging. Good multidisciplinary working was evident for one-stop clinics which were reflected by positive comments from patients. However, we found that staff understanding of the mental capacity act was limited.

Patients told us that they received compassionate care from staff and we observed that patients were being spoken to appropriately, kindly and politely. Patients told us they were included in the decision making process. However, we were told that due to delays in clinics the emotional support that patients expected was not always evident.

We rated responsiveness as inadequate. We found that due to the scale of the backlog in the follow up of patients, image reporting backlog and restrictions in the capacity of clinics, people were frequently and consistently not able to access services in a timely way for an initial assessment, diagnosis or treatment. People experienced unacceptable waits for some services. Large numbers of patients were in breach of their see-by date for follow up, many of which had not received appointments. We also found that the waiting areas in some service lines were not appropriate, as these areas were crowded and obstructed with equipment and some areas such as nuclear medicine did not have a waiting room at all.

We rated the leadership of the service as inadequate. Action plans did not match the urgency required to manage the risks to patients, and improvements to services were slow. In diagnostic imaging action plans to reduce the backlog were described as 'work in progress' and the urgency had not been identified. We also found that there was little understanding of risks to outpatients at a trust and service line level.

Derriford Hospital

Detailed findings

Services we looked at

Urgent & emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and Gynaecology; Services for children and young people;End of life care; Outpatients & Diagnostic Imaging

Detailed findings

Contents

Background to Derriford Hospital

Plymouth Hospitals NHS Trust is the largest hospital trust in the South West Peninsula. It is a teaching trust in partnership with the Peninsula College of Medicine and Dentistry. The trust is not a Foundation Trust.

The trust provides comprehensive secondary and tertiary 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 1.6 million people in the South West of England. The majority of these services are provided at the Derriford site.

The trust has 994 beds consisting of:

- 890 general and acute (of which 47 children's beds)
- 61 maternity
- 43 critical care (of which 4 paediatric beds).

There are 5,639.5 whole time equivalent staff employed at the trust, consisting of:

- 883 medical staff
- 1,563 nursing staff
- 3,193.5 other staff.

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

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

Our inspection team

Our inspection team was led by:

Chair: Nick Bishop, Senior Medical Advisor, Care Quality Commission

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

The team included CQC inspectors and a variety of specialists: Consultants from medicine, anaesthetics,

Detailed findings

surgery, emergency medicine, paediatrics, obstetrics, an intensive care consultant, a junior doctor, newly qualified nurse, a midwife and nurses from medicine, surgery, care of the elderly and critical care, a children's community nurse. The team also included three Experts by Experience, analysts and an inspection planner.

How we carried out this inspection

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

We held a listening event on 14 April 2015 in Plymouth, where people shared their views and experiences of care and treatment at Plymouth Hospitals NHS Trust. More than 35 people attended this event. People who were unable to attend the event shared their experiences by email, telephone and our website.

We carried out our announced inspection on 22, 23, 24 April 2015 and unannounced inspections at Derriford Hospital on April 30 and 1, 5 May 2015. We held focus groups and drop-in sessions with a range of staff in the hospital including nurses, junior doctors, consultants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, staff side representatives, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from across the trust. We observed how people were being cared for, talked with carers and family members and reviewed patients' records of their care and treatment.

Facts and data about Derriford Hospital

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

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

The trust's activity for Apr 2013 – Mar 2014 included 109,808 inpatient admissions, 585,503 outpatient contacts (total attendances, all sites Jan 14 – Dec 14), and 92,770 (Feb 14 – Jan 15) accident and emergency attendances. Bed occupancy was between 82.5% and 86.0% over the six quarters prior to our inspection.

For the period of Jan 2014 – Dec 2014 the Trust Revenue was: £422,621,000 against a full cost of £427,802,000. There was a deficit of £5,181,000 for the same period.

More than 48,000 people pass through the main entrance of Derriford in a week. The hospital has more than 900 beds and 1,000 public car parking spaces. Derriford Hospital is the second largest bus terminal in Plymouth, beaten to first place only by Plymouth central bus station.

The trust has an integrated Ministry of Defence Hospital Unit which has a tri-service staff of approximately 240 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.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

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

Urgent and emergency services

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

Information about the service

Urgent and emergency care and treatment is provided at Plymouth Hospitals NHS Trust on the Derriford Hospital site. There is an emergency department (ED), sometimes known as the Accident and Emergency Department, which operates 24 hours a day, seven days a week. During 2013-14, the adult emergency department saw 68,304 patients, with the paediatric emergency department seeing and treating 18,890.

The ED is designated as a major trauma centre for adults, providing care for the most severely injured trauma patients from across the south west. The hospital has approximately 1,100 trauma calls per year, of which 200 are 'hospital trauma calls'. It is a major trauma unit for children, meaning it receives and stabilises children prior to transfer to the children's major trauma centre in Bristol. The department is served by a helipad.

The emergency department has a reception area, accessible separately to the ambulance arrivals area. It has a glass-fronted reception desk and a seated waiting area with access to food and drink vending machines.

The minors' area has its own small seated waiting area where patients await treatment following initial triage. The area consists of two triage cubicles and seven treatment cubicles, two of which are used at various times for rapid assessment and treatment.

Within the majors' area there are 17 cubicles. In addition, there are four resuscitation bays (resus area), with one being designated for paediatric resuscitation if required. The resus area also has its own x-ray facility on an overhead track. This is a central area in majors used as a 'corridor' which was used when there were no cubicles available.

The emergency department has a small paediatric area, including a paediatric waiting room and three treatment rooms and is open between 10am and 10pm.

There is a 10 bedded clinical decision unit within the ED, comprising of one four bedded bay and one six bedded bay, with a waiting area/ lounge.

We visited the department over two and a half weekdays during the announced part of the inspection, and conducted further unannounced visits on two further occasions. We spoke with 57 patients and /or relatives. We spoke with 43 staff, including nurses, doctors, managers, therapists, support staff, military staff, ambulance staff and the police. We observed care and treatment and looked at 20 sets of care records. We observed handovers and attended meetings. We received information from our listening event and from people who contacted us to tell us about their experiences. Prior to and following our inspection, we reviewed performance information about the trust and information provided by the trust.

Urgent and emergency services

Summary of findings

The emergency and urgent care services at Derriford Hospital were judged as requiring improvement for safety and well led, responsive was judged to be inadequate. Both caring and effectiveness were found to be good. There was an inconsistent approach to incident reporting, with some incidents accepted as normal. The environment within CDU was not always safe for patients with mental health needs and mental health care was not provided in line with national guidance. Staff lacked training in the Mental Capacity Act. Staffing was not always sufficient and children did not always receive care from an appropriately trained nurse. Multidisciplinary trauma review meetings encouraged staff to question, challenge and identify learning which was then shared amongst all staff in the department. There was good regard to infection prevention and control. Staff had a good understanding of what constituted a safeguarding concern and were alert to potential issues with all who attended the department.

Patients did not always receive timely care and treatment, or treatment that met their individual needs. The trust consistently failed to meet the national standard requirement for 95% of patients to be discharged, admitted or transferred within four hours of arrival. Nursing leadership was variable and at times lacked effectiveness and visibility. Governance systems were not fully embedded or effective.

The care provided was compassionate and kind, with good regard to patients' involvement and understanding. Care was evidence-based. However some patient outcomes were worse than the England average. There was a positive approach to education and training and good evidence of multidisciplinary working.

The Trust was on 'Black Alert' escalation for 3 months, which caused us concern about the effectiveness of the leadership to overcome the issues during this time and that services were not being responsive to deal with the issues the Trust was experiencing.

Although there were some good examples of leadership in the department, there were areas that needed improving.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

We judged the service to require improvement for safety. Incidents were reported but there was an inconsistent approach with some incidents that occurred more often being accepted as 'normal and not being reported. The environment within CDU was not always safe for patients with mental health needs. This put patients and staff at risk.

Patients who were unwell were not always adequately monitored. At times the department struggled to cope with the number of patients and often experienced overcrowding. During these times, nursing staff were stretched to provide care for more patients than the recommended number.

There were insufficient band seven (senior) nurses to enable the required level of experience and support per shift, and there was no rostered consultant medical presence in the department from midnight until 8am. Children did not always receive care from an appropriately trained nurse.

Multidisciplinary trauma review meetings where held at which staff were encouraged to question, challenge and identify learning which was then shared amongst all staff in the department. The department was visibly clean and staff adhered to infection prevention policies and procedures. Staff had a good understanding of what constituted a safeguarding concern and were alert to potential issues with all who attended the department.

Incidents

- Staff reported incidents via an electronic incident reporting system. This was easily available for all staff to use.
- Staff told us they knew about the incident reporting system, but often did not report incidents or 'near-misses' because there was a general acceptance that some of these occurrences were 'normal' within the department. For example staff described incidents occurring in the CDU which they had not reported through the incident reporting process while these were known to have occurred by senior staff, the lack of an incident report had not been challenged. This lack of challenge meant the belief that some occurrences were 'normal' was reinforced and opportunities to learn and prevent reoccurrence missed. Senior staff spoke of a staff members "right to report an incident", rather than their duty in line with the organisational policy on incident reporting.
- Staff within the department said they saw little change as a result of incidents they reported, and spoke of seldom receiving comprehensive and useful feedback. However incidents were used to inform content of safety days, blogs and teaching sessions. Staff were not always aware that incidents reported had affected change or informed learning and education.
- Senior staff were aware of the systems in place and reviewed all mortality data on a monthly basis using the College of Emergency Medicine 'safer care' tool kit. This data was collated on an organisational basis and linked to incident reports to aim to identify themes. Learning fed into the monthly Governance Education Meetings, quarterly Safety Team meetings and Safety days which were held twice a year to review incidents and discuss learning.
- There was a weekly trauma review meeting where staff reviewed three trauma cases in detail. We attended one of these meetings, which were multidisciplinary and saw staff question, challenge and identify learning which then had a plan identified to share amongst all staff.
- The term 'Duty of Candour' was not recognised by the majority of staff we spoke with; however, all staff stated there was an open and honest culture with patients and their relatives when things went wrong. Duty of candour was recorded on the trust electronic incident reporting system.

Cleanliness, infection control and hygiene

- There were systems and process in place to reduce the risk of cross infection in the department. We observed staff adhering to the trust requirement to be 'bare below the elbows.' Staff were seen washing their hands and there was good use of and access to antibacterial hand disinfectant. Staff were seen wearing personal protective equipment as appropriate.
- The main entrance into reception had antibacterial hand disinfectant available for attendees to use.

However this entrance was out of order for most of the time during the inspection and there were no facilities for hand decontamination on arrival for patients or staff attending through the temporary entrance.

- All areas appeared to be visibly clean and appropriate equipment was available for cleaning of areas after blood and body fluid spillages.
- Staff were seen cleaning equipment after use and 'I am clean' stickers were applied to indicate an item was ready to be re used.
- The department participated in trust-wide hand hygiene audits. Data for October, November and December 2014 showed ED and CDU both had 100% compliance with the hand washing audit questions.
- The departmental dashboard for 2014-15 reported no cases of Methicillin-Resistant Staphylococcus Aureus or Clostridium difficile infections in the department
- There was a completed record in the cleaners' cupboard identifying when curtains had been changed on the cubicles, along with the reason they were changed.
- The department had limited isolation facilities for patients admitted with potential infections, as the two side rooms did not have ensuite facilities and were located within the department on the thoroughfare to imaging and CDU where control of staff entering and leaving the rooms was limited.

Environment and equipment

- We reviewed a number of pieces of equipment and saw maintenance checks were all within date.
- CT scans were available 24 hours per day, seven days a week. However, the information technology system used in ED did not interface with the one used in radiology. As a result clinical staff were required to walk to the radiology unit to submit a request form, taking them out of the department for a short period of time. Though adjacent to the department, the CT scan room was some distance from the 'resus' area. However, when patients left resus for a CT scan, staff were seen escorting them accompanied by full resuscitation and emergency equipment.
- Chairs were available outside the imaging facilities; however there was no designated area for patients on trolleys. Because of this patients were left waiting for procedures or to return to the ED on trolleys in the open corridor with little privacy.
- Resuscitation equipment was readily available within the majors area and was seen to be clean, stocked and organised. Items with expiry dates were within date.
- The sluice room was clean, tidy and of a good size. However, we noted the door was left open at all times and saw an unlocked cupboard containing disinfectant cleaning tablets. The packaging stated these were both 'Harmful' and 'Dangerous for the environment'. This meant there was a risk that patients and visitors to the department could access them.
- Nurse call bells were available in all cubicles, and at every bed in CDU. These were seen to be in working order; however, they were not always made accessible to patients. For example, we observed one frail patient who was in a majors' cubicle. Their call bell was attached to the wall, out of reach.
- The CDU was remote from the main emergency department areas. Access was via a buzzer system (or swipe card for members of staff). There was no immediate means of calling for assistance, except in the case of a cardiac arrest. Staff described incidents of violence and aggression against them from patients. One member of staff described an incident where a staff member was locked in a store cupboard by a patient with mental health needs. Staff had not received training in de-escalation or breakaway techniques to support them to manage such situations. We raised our concerns with managers at the time of the inspection. During the unannounced inspection we found the staff had been issued with personal alarms which linked into the security system. When activated these alerted both audibly and visually in the majors and minors areas.
- Patients with mental health concerns were assessed by the Psychiatric Liaison Nurse in an office space in the CDU. This environment was not safe for patients or staff, with furniture and equipment not being fixed. The office was cluttered and contained a fridge and staff personal belongings. It contained no means of summoning help in an emergency. We were told that there was a plan to redevelop this office into a dedicated and suitable space for mental health patients; however, there was no timescale for the commencement of this work.
- Patients awaiting mental health assessment, and others awaiting some results were transferred to wait in the lounge area of the CDU. This area was furnished with chairs and a television But no other facilities to allow patients to recline or rest while waiting.

- While we were undertaking our inspection, the main reception doors were out of action. Staff described reoccurring problems with the doors over a period of six years. Staff informed us they had been condemned the previous year but put back into service rather than being replaced. While the doors were not working, walk in access was diverted to a door by the side of the ambulance entrance. This lead straight into the rear of the 'minors' cubicles, which had only a curtain to provide any privacy or to stop cold air for any patient being treated. There was no antibacterial hand disinfectant available at this entrance. Once in through these doors, which were unmonitored and not visible from either minors or the reception area, members of the public were required to walk past the paediatric ED waiting and treatment area in order to access reception. Whilst repairs were undertaken during the inspection, they once again broke and were therefore out of action when we returned to undertake our unannounced inspections a week later. We raised security concerns with senior managers at the time and were told new doors had been ordered but would not be delivered until early June. We were told that until that time a repair company had been placed on 24/7 call-out to ensure the doors remained functional. However, they remained out of action at the time we concluded the unannounced inspection.
- All areas of the department were cramped. In addition, overcrowding in the department meant at times patients were cared for on trolleys in a central area of majors known as the 'corridor.' This area had no curtains or call bells, although staff had access to portable oxygen and suction.
- Not all patients waiting in the main waiting area could be seen from the reception desk. The area had been redesigned during the construction of the paediatric waiting area and although reception staff had requested better waiting area visibility, this had not been included when built. There was a small mirror positioned to give some visibility but there remained several 'blind spots.' When asked of patients safety within the reception area, one staff member told us "we have to rely on other patients coming to tell you someone's collapsed or fallen."
- We were told bariatric equipment was available to the ED from other areas of the hospital because there was no space within the department itself to store such equipment. During our inspection we did not witness any need to access this equipment by the department.

Medicines

- Medicines were appropriately stored in locked cupboards or fridges. Fridge temperatures were regularly checked and were correct the time of our visit.
- Controlled drugs (medicines which require extra checks and special storage arrangements because of their potential for misuse) were stored appropriately and suitable records were kept.
- However we observed one patient in receipt of a propofol infusion (a drug used for sedation). The syringe not labelled with the strength of the infusion or a signature to indicate who had prepared the infusion. This meant there could be confusion over the dose given to the patient. We brought this to the nurses attention at that time and were told this was normal practice for the department. Whilst this appeared an isolated incident, this posed a risk that staff were not aware of the strength of the dose of medication the patient had received.
- Patients who attended with their own medication had this placed in a green property bag, which was left with them. If they were then admitted to the hospital, the property bag travelled with the patient. However, there was no record made that a patient had brought in their own medication this posed a risk that medication could go missing and not be discovered or accounted for. The store cupboard for the Oxygen and Entonox cylinders was found to be unlocked with several full cylinders being left insecure. The store cupboard was located in a corridor that patients and the public can easily access. We notified this to the nurse in charge who immediately took action to secure the cupboard.
- Seven patient records were reviewed and each was observed to have allergy information recorded clearly.

Records

- In total we reviewed twenty sets of patient records during the inspection. Records were stored in open trolleys behind the majors and minors desks. However as trolleys were not locked, there was a risk of a breach in patient confidentiality.

- Previous medical records were not available for staff to access in ED as they were stored in a facility away from the hospital. Records were paper based with ED notes generated on admission. Information obtained by the ambulance service was printed from the electronic ambulance system; where this was not available, the ambulance paperwork was photocopied and a carbonated copy of the patient clinical record obtained. This process allowed the medical staff to have access to all information while the ambulance service were able to maintain their own records.
- We saw that pressure areas were assessed on all patients when they arrived in the department. This was recorded on a body map on the ED paperwork. Other risk assessments were completed, for example tissue viability and venous thromboembolism risks, though not in all cases. We observed the care records of one patient who had been on CDU for four days. A VTE risk assessment had not been undertaken for 72 hours. Records had not been maintained to indicate whether they had their bowels opened for four days. This was relevant to the persons condition and may have meant important information was not available to medical staff.

Safeguarding

- Staff had a good understanding of what may constitute a safeguarding concern and were alert to potential issues. We observed staff discuss the completion of safeguarding referrals to social services where concerns were raised for both vulnerable adults and children. For example we saw staff refer one adult patient as they had 'hoarded' prescribed medicines and then taken an overdose. Staff told us the process for safeguarding referral was uncomplicated, both within and out of hours.
- There were processes in place to ensure all children attending the department under the age of one were seen by a senior doctor before discharge.
- During our first unannounced inspection we saw the paediatric area unattended by staff for a period of about 20 minutes. During this time there were five children in the area, with their parents. The door to the area was left open, and as a result of the reception doors being out of order people entering the department had to pass this insecure area. We raised safeguarding concerns with senior medical and nursing staff before leaving and were given assurance that immediate action would be taken.
- When we returned for our second unannounced inspection, we found that the paediatric area door was being kept closed and repairs were being carried out to the reception doors to further reduce the risk.
- 80% of staff had attended child protection training, level 2, and 75% child protection training, level 3.
- There were safeguarding prompts for staff providing care for children in the department, particularly in relation to non-accidental injury.

Mandatory training

- Staff completed most mandatory training using e-learning.
- Data provided by the trust showed that overall 85.6% of staff were up to date with their mandatory training within the ED against the trust target of 95%.
- Breakdown for training components was as follows:
  - Basic life support – 85.3%
  - Manual handling – 91.4%
  - Intermediate Life Support (Registered nurses only) – 100%
  - Basic Life Support – 100% nurses with the exception of 4 who were off on long term sick
  - Advanced Life Support – 100% band 6 nurses and some band 5 nursing staff
  - Paediatric Intermediate Life Support (Registered nurses only) – 100%
  - Advanced Paediatric Life Support (Band 6 only) – 73%
- Access to Advanced Paediatric Life Support training was difficult as external places were not always available. As a result, the trust resuscitation department had developed an unaccredited in house training course, designed to fall between Paediatric Intermediate Life Support and Advanced Paediatric Life Support.
- Staff told us access to training was good as often the military staff in the department were used to allow release of staff to attend mandatory training.
- The trust employed one band seven nurse whose role was lead for training and resuscitation, and a band six clinical educator. We reviewed the data they held

regarding staff training and saw dates had been booked for a number of staff to attend training throughout the year. They described the process for monitoring non attendees and of escalation to managers.

Assessing and responding to patient risk

- Guidance issued by the College of Emergency Medicine (Triage Position Statement dated April 2011) states that a rapid assessment should be made to identify or rule out life/limb threatening conditions to ensure patient safety. This should be a face-to-face encounter within 15 minutes of arrival or registration with assessment carried out by a trained clinician to ensure patients are streamed or directed to the appropriate part of the department. Known as triage, this also ensures serious or life threatening conditions are identified or excluded and appropriate care pathways are selected. The trust used a recognised triage system (Manchester) in ED for the initial assessment of all patients and had a Manchester Triage champion. New starters to the department did not undertake this role until they had been working in the department for one year to ensure they had the skills and knowledge necessary. Time from registration to triage was monitored and reported on the department dashboard. The department had not met this standard since July 2014, with average waiting times ranging from 16 – 24 minutes.
- Patients arriving by ambulance were met by a trained nurse and triaged on arrival at the department and directed to resus, majors or minors as applicable.
- Rapid Assessment and Treatment of patients occurred when there were sufficient staff on duty. The principle idea behind this is to provide a team of senior clinicians to assess and implement a prompt care plan for patients with minor injuries. The intention is to make early senior decisions about patient care thus improving the quality of care and reducing the length of time in the ED. However, this was not routinely provided. Two cubicles in minors were identified to specifically provide this function when it occurred.
- The department did not always monitor or respond to patient risks. For example, patients were seen waiting for x –rays unattended on trolleys in the corridor. We observed one patient with a cardiac monitor who was not accompanied. The monitor was therefore not being observed. We also saw one patient in receipt of oxygen left unattended. These two patients did not have access to call bells. This meant neither had any means of summoning help from staff in an emergency nor was any member of staff monitoring their condition for any deterioration. While in the corridor outside of x-ray patients remained the responsibility of the nurse previously assigned to them, however these patients were no longer in their line of sight.
- Patients who had expressed suicidal tendencies, for example by taking an overdose, were often transferred to the CDU lounge to await results or assessment by the mental health team. This lounge area was not easily visible to staff working in the CDU and therefore patients could be left unsupervised for long periods of time. Staff told us high suicide risk patients were cared for within the main ED with only those felt to be of lower risk transferred to the CDU. However there was no formal risk assessment process to support this which meant inappropriate patients who needed closer observation could be transferred to the CDU
- During the unannounced inspection, staff described an incident where a member of nursing staff had been assaulted by a patient with mental health needs in the time since our inspection the previous week. Staff described a number of occasions when patients with mental health needs had absconded from the department and spoke of two incidents where patients had attempted to harm themselves while awaiting review.
- We observed the lounge in the CDU had a number of items which could be used by a patient to further harm themselves such as leads and tubing that could be used as a ligature. We also observed a fixture on the wall above chairs that could be used to attempt suicide. We raised our concerns with the trust who immediately stopped placing patients with mental health needs into the area to wait for review and removed equipment with trailing leads and cables. However the area remained unsupervised, and patients with mental health needs who were transferred to CDU were able to access the area as they wished. We raised our concerns with senior nursing and medical staff. We were told patients going into the area with mental health needs would be supervised.
- During our unannounced inspections, we revisited the CDU lounge and found that the potential ligature point and ligatures had been removed. Staff told us that patients with mental health needs were no longer being placed in the CDU lounge, and were only placed into CDU if there was a bed available. However, the lounge

was still accessible to patients and it was not possible for the area to be observed from the nurses' station. We spoke to the security manager who advised us that a monitor for the newly installed CCTV cameras was planned to be installed at the nurses' station to allow monitoring of the lounge.

- The trust used a five point screening tool to score patient complexity. A score of three or above indicated a patient with complex care needs. Only patients with a score of two and below met the admission criterion for CDU. However we observed three patients with a score of four or five during the CDU ward round. Records did not indicate additional risks assessments had been undertaken to assess the suitability or a rationale considered before they were moved to CDU. This meant patients with complex care needs were placed in the CDU despite the departments admissions criterion.
- Children had their pain assessed on admission. A paediatric drug dosage calculator was then used which had been benchmarked to the local populations size and measurements which allowed accurate calculation of drug dosage.
- While all registered nurses had received Paediatric Intermediate Life Support training, only 73% were trained in Advanced Paediatric Life Support. This meant there was a risk that there would not be a member of nursing staff on duty trained to deliver Advanced Paediatric Life Support.
- There were processes in place to alert junior staff of the need for senior medical sign off before discharge. On arrival to the department a 'senior sign-off required' sticker was placed on the notes of, for example, children under one year of age, any child attending three or more times in one year, patients returning with the same condition within 4 weeks, those with abdominal pain over the age of 55 and any patient presenting with chest pain.
- We saw several patients brought to the department by ambulance following a 'pre-alert' telephone call for such cases as major trauma or when the air ambulance was used. This system worked well, and teams were formed in readiness for their arrival, with each team member easily identifiable, allowing immediate assessment and treatment to take place.
- Staff told us patients awaiting beds who were confused or had dementia and were at risk of falling were often brought on their trolley out of the cubical and cared for in the corridor area. Staff told us this meant there was greater visibility of the patient to prevent falls.
- The department had wanted to introduce the National Early Warning score to record and monitor observations and identify the deteriorating patient. However this had yet to be launched. Instead observations were recorded on a local early warning format.
- During the unannounced inspection we were told that a new direct to CT stroke pathway had started. This had been developed with the ambulance service so that patients fitting certain criteria brought in by ambulance could be taken straight to CT after a quick handover. This meant a CT scan could be performed quicker giving speedier access to the correct treatment (such as thrombolysis).
- The transfer of acutely ill patients to intensive care was well managed. We observed staff complete an intubation safety checklist prior to transfer to plan for adverse events and ensure all equipment was present.

Nursing staffing

- There were no current nursing vacancies in the department. Normal staffing was fourteen registered nurses during the day shift (12 hour shift) supported by four healthcare assistants, and ten registered nurses supported by three healthcare assistants at night (12 hour shift). During the inspection we noted these numbers were not always met However staff felt this was not a concern due to the large number of military personal in the department in addition to the rostered numbers. However, as these were subject to removal at short notice, senior staff told us that nursing staffing levels were one of the five biggest risks to the department.
- Military staff had carried out a review of staffing in the ED using the Baseline Emergency Staffing Tool (BEST). However, this had reportedly been onerous and was described as not yet having an impact on staffing. The department's strategy document, supplied to us by the trust, states: "There aren't enough doctors, nurses and support staff to deal with current demand." Information provided by the trust showed the production of business cases and workforce reviews to support requests for additional staffing, however at the time of the inspection these had not been agreed.

- The National Institute for Health and Care Excellence (NICE) guidelines, though unpublished recommend a band 7 nurse on duty on every shift. The department employed four whole time equivalent band 7 nursing staff who each worked one clinical shift per week. Whilst the NICE guidelines were unpublished and therefore not nationally agreed recommendations, the department supported the principles, however they rarely had a band 7 nurse providing clinical leadership to the nursing team.
- We reviewed staffing rotas on CDU which showed at times there were insufficient staff to provide the required staffing of two registered nurses and one healthcare assistant per shift. We reviewed rosters for two consecutive weeks at the end of March 2015 and saw that on 16 occasions (out of 28) staffing fell below the optimum level. We reviewed the bank and agency usage for those two weeks and saw that these vacant shifts were not always filled. On two occasions during our inspection the unit was seen to be below the planned level, with only one registered nurse and one healthcare assistant on duty instead of the required number of two registered nurses and one health care assistant. In addition, staff told us even when they were staffed at the optimum level they were often moved from CDU to work in other areas of the trust. We saw an email sent to the clinical site team and matrons raising concerns that staff movement from CDU left the patients and staff in CDU at risk. However staff told us the practice still continued.
- Planned and actual staffing levels were displayed on the wall in both the majors' area of the department and also the entrance to CDU, though these were not kept up to date on every occasion we visited. We saw a shortfall in planned and actual staffing in the main ED, for example on one occasion the board said there should be 14 registered nurses on duty but the actual numbers on were 11. This meant patients were at risk if there were insufficient nurses to provide care for them.
- Military staff were a part of the workforce on the ED and held a range of junior and senior nursing positions. There were four dedicated 'lines' within the duty rotas for nurses, which were assigned to the military and always staffed. At the time of the inspection there were in excess of these numbers present. However we were informed they could be called to meet military requirements at any time and with as little as 72 hours' notice.
- There was no protocol with regard to the staffing of the 'corridor' area which was used when the number of patients exceeded the number of cubicles available. Care was provided by nursing staff who were also caring for patients in the majors bay. This meant that at times nursing staff were required to care for patients in excess of the recommended number as per NICE guidance of two registered nurses to one patient in cases of major trauma or cardiac arrest and one registered nurse to four cubicles in either 'majors' or 'minors'.
- During the announced and unannounced inspections we observed up to five patients being cared for in the 'corridor' as all cubicles in majors were full.
- There was not a dedicated paediatric trained workforce in ED. The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012) states there should be registered children's nurses in ED at all times. If not, trusts should be working towards this. All other staff should, as a minimum, be trained in paediatric life support. The department currently employed four registered children's nurses. This meant at times there was not a paediatric trained nurse on duty. There were no plans to address this shortfall.
- During our unannounced inspection, we found that the paediatric area was being staffed by an 'adult' nurse. This staff member was then called to assist in resus, leaving the paediatric area unstaffed. We were told that nurses in minors would be monitoring the paediatric patients, but again these were not specifically paediatric trained nurses.
- We observed the nursing handover at the beginning of the day shift. This was led by the off-going nurse-in-charge and attended by the oncoming nursing staff. The night shift nursing staff remained in the department to ensure patients were safe.
- The trust used bank and agency staffing to fill shortfalls in the workforce. During January – March 2015, 8.4% of the total pay budget was spent on temporary staffing.

Medical staffing

- Consultant cover was provided on site from 08.00 – 24.00hrs. After that time, consultant cover was provided on call from home. Consultants reported often staying beyond that time, but felt this was now manageable following a change in rota patterns. These now meant they did not work the following day and received payment for hours worked after midnight, however this

was not felt to be a sustainable staffing model. There were 14 whole time equivalent (WTE) consultants in post (18 people in total). Senior medical staff told us in order to provide consultant cover on site, 24 hours per day, seven days per week, an additional 10 WTE consultants were required. At present, weekend trauma shift cover was voluntary. The trust told us they have dispensation from providing physical 24/7 consultant cover for the major trauma centre status because they had limited numbers of trauma patients overnight. It was unclear who had made this decision. NHS England's major trauma standards state there should be 24/7 consultant cover on site to lead the trauma team; it does not state they have to be within in the emergency department. Additionally, specialist consultants must be available on site within 30 minutes when required (for example neurosurgery, vascular surgery, anaesthetics). We saw evidence of concerns raised at trust level and the production of business cases to support additional staffing. These had not been agreed at the time of the inspection.

- There were currently four military consultants working within the department, though none worked in a whole time capacity. Job planning made allowance for them to be absent on the rota for 20 weeks each year. All other consultants had annualised hours job plans. This meant they had greater flexibility to cover absent military personnel.
- Though military personnel were not full time in the department, they took a full time share of weekend working which staff felt improved working relationships.
- Middle and junior grade cover was provided on site 24 hours per day/ seven days a week.
- Junior medical staff told us they felt well supported. They told us there was always someone they could access for advice and if they were concerned with the advice given by a middle grade doctor, they would be happy to take their concerns to the consultant.
- The department currently employed three Advanced Nurse Practitioners who worked in a supernumerary capacity. It was anticipated they would in turn become part of the medical staffing rota which senior managers told us was under established by approximately thirteen medical staff.
- We observed the medical handover at the beginning of the day shift. This was jointly led by the off-going and oncoming senior doctors and was attended by the oncoming medical staff. The night shift medical staff remained in the department to ensure patients were safe.

Major incident awareness and training

- Staff told us they had limited major incident training. The military staff we spoke with told us they received major incident training as part of their military training, but had only received basic awareness training during their induction to the department. Other staff within the department told us they could not recall receiving any major incident training outside of their initial induction. In documentation provided to us by the trust, we saw that major incident specific triage training was included with the Manchester Triage System training.
- The department had enacted the major incident plan to full effect in May 2014 and had been fully prepared for patients presenting with Ebola symptoms.
- The department had a decontamination facility that could be erected outside the department. We saw boxes containing personal protective equipment for use during a HAZMAT (hazardous materials) related incident were clearly marked with their contents and contents expiry dates. We saw a number of these boxes had exceeded their expiry date by several months, yet were being stored amongst boxes that were still within date. This meant there was a potential risk to the users of this equipment.
- The main administration corridor housed a major incident board. This held tabards and action cards for staff to follow in the event of a major incident occurring.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

Care was provided that was evidence-based. There was a positive approach to education and training and there was evidence of good multidisciplinary working. However some patient outcomes were found to be worse than the England average. Mental health care was not provided in line with national guidance and staff lacked training in the Mental Capacity Act

Urgent and emergency services

Evidence-based care and treatment

- Policies and guidelines were readily available on the trust intranet. These were seen to be up to date. In addition evidenced based guidance was available on a locally developed and maintained system within the department. Care pathways complied with National Institute for Health and care Excellence (NICE) guidelines and the College of Emergency Medicine's Clinical Standards for Emergency Departments.
- We attended a meeting where improvement to the stroke pathway was discussed and changes were communicated to staff. These changes were designed to improve the speed of patient access to CT scans when they arrived within the department with a suspected stroke, in accordance with set criteria (for example, when the stroke was believed to have happened) This was designed to be accessible to ambulances arriving, therefore able to improve access times to CT.
- The department generally scored better than the England average in the College of Emergency Medicine's Consultant sign off clinical audit 2013. The number of patients seen by or discussed with a consultant was higher than the England average; however, the department scored worse than the England average for having notes reviewed by a consultant after discharge.
- One senior consultant in the emergency department had played a significant role in the creation of the toolkit for Mental Health in Emergency Departments (2013). However staff told us they had recently scored poorly in the College of Emergency Medicine Mental Health audit, though at the time of the inspection, formal results had not been published.
- Other than participation in national audits staff participated in some locally driven audits. We were shown audits for record keeping (May 2011), Propofol sedation (retrospectively, covering October to December 2013) and falls in the elderly (an undated presentation) but these had not been repeated.
- Patients presenting at ED in certain high risk categories were required to be reviewed by an emergency medicine consultant before discharge. This was monitored and reported on the dashboard. Results for April – December 2014 showed this had occurred between 94.8 -98.3% of the time against a trust target of 95%.

Pain relief

- Staff were seen administering pain relief to patients. However we reviewed ten records in the majors area and saw three patients had been triaged with a description of presenting with pain but had no pain scores completed on their observation chart, though assessments had all been undertaken on triage.
- In the CQC 2014 A&E patient survey the department scored about the same as other trusts for (overall) provision of pain relief.

Nutrition and hydration

- We were told by staff there were three meal rounds in the department every day, including the majors' area. One staff member told us that if they knew their patient was going to be in the department for a long period, they would offer food and drink, and collect this themselves From the CDU. During our inspection we saw sandwiches and drinks being given to some patients. However, staff told us they could not always guarantee that this would be possible if they were busy. There were no structured hot drinks rounds and the trust did not employ a housekeeper to undertake this task. Records reviewed showed food and drink had not been offered to all appropriate patients in the department in excess of two hours.
- In the CQC 2014 A&E patient survey the department scored about the same as other trusts for provision of suitable food and drink while in the department.

Patient outcomes

- The department participated in Royal College of Emergency Medicine Severe Sepsis and Septic shock audit 2013-14. Results showed they scored worse than the England average in 7 key questions covering observations and treatment particularly within the first hour of admission. The department had a lead consultant for sepsis and had since developed a proforma following the Sepsis 6 pathway to commence on any patient attending where sepsis was suspected. The proforma had only recently been implemented and an audit on its use and outcomes had yet to be conducted.
- The number of unplanned re-attendances to the department was better than the England average (6.4% compared to the England average of 7.5% in September 2014)

- In relation to trauma specific outcomes, the department was ranked 5 out of 24 Major Trauma centres for the year 13/14.
- Trauma Audit and research Network (TARN) also report the department as scoring well for unexpected survival in the 0-80% chance of survival band of patients attending following major trauma. This describes unexpected survivors with more serious injury and is felt to generally indicate good initial resuscitation and the treatment of head injuries.

Competent staff

- New members of staff undertook three to five weeks in a supernumerary capacity to allow them to obtain skills and familiarise themselves with the department. Rotational posts were created to allow newly qualified nurses the ability to obtain wider nursing skills.
- As well as mandatory training, staff undertook additional training which was delivered in a variety of ways – through simulation, e-learning and face to face delivery. Staff regularly covered topics in the form of a 'turbo teach' which was designed to update staff on a chosen topic. During our unannounced inspection, we saw some internal filming taking place following the route of a paediatric trauma patient. This was planned to be used for a number of purposes, including a training video.
- The department employed one clinical educator whose role was to support the education and development of nursing staff. This included spending time with new members of staff, or working alongside others where a need had been identified. We observed staff being informed of changes with equipment during briefings immediately following handover.
- Medical staff described their induction into the department as good, stating it focused very strongly on their learning needs.
- Nursing staff also told us that their induction into the department was effective, relevant and focused on their needs.
- Quarterly education meetings were held for all members of staff to attend. In addition, monthly divisional teaching occurred. During this time, in order to allow as many to attend as possible, military personnel staffed the department in the morning to release all of the trust staff. The session was then repeated in the afternoon for all military staff to attend. Recent topics included Major incident awareness, major trauma and plastering.
- Some nursing staff told us that they had not been able to complete their yearly appraisals due to the trust being on 'black alert'; however, they all believed that appraisals were useful to their development when they did take place.
- Medical staff told us that their appraisals were mostly up to date; these were facilitated within their protected learning time.

Multidisciplinary working

- There were strong links with military personnel. Staff felt they brought expertise, skills and drive to the department. However there was a risk of deployment at short notice.
- Staff described good working relationships with other departments and all specialities. We saw staff from ITU, MAU and oncology attend to review patients and observed handovers between these groups. There were good working relationships with the ambulance service and police. At times of greatest pressure, paramedics attended to support the care of patients waiting to be seen. We heard a trauma call come through on the emergency phone. On arrival of the patient a trauma team ready and waiting. There was a clear handover between the ambulance and hospital staff, and the ambulance staff assisted for a short period before handing over definitively.
- The department provided advice to the acute GP service provided by another organisation. In addition, staff were able to refer patients where admission was not required. There was good occupational therapy and physiotherapy input for patients on CDU with multidisciplinary care planning occurring.
- We attended a weekly trauma multidisciplinary team meeting, in which there was a review of three trauma cases from the previous week. All staff were encouraged to participate in the review of the cases and feedback was discussed.
- We were told that the department had quick and easy access to the Psychiatric Liaison Team within the hospital should they have any patients with mental health needs arrive. However this was not so easy to access out of 9-5 hours. There were good links with the

psychiatric liaison team and the local drug and alcohol support groups within the city. All appropriate patients were given information on the service before leaving the trust.

Seven-day services

- The ED and CDU were operational seven days per week with senior medical staff presence. Physiotherapist and occupational therapist support was provided to patients seven days a week on CDU.
- Access to CT, x-ray and diagnostics was provided 24/7
- Mental health liaison was available seven days a week from 9am – 9pm and via an on call Psychiatric junior doctor at night, with the exception of child mental health. This service was provided by another organisation, but was such that any child admitted from Friday afternoon was not seen until Monday.

Access to information

- The department had sufficient computer terminals allowing staff to access the trust's Intranet system. This held a wide array of standard operating procedures, guidelines and other information.
- There were two computer terminals displaying ambulance arrivals information. We saw this being used by staff to plan patient flow.
- We saw handover forms completed for patients being admitted to other areas of the hospital included in their overall notes pack. These travelled with the patient when they were admitted.
- The department's computer record system was limited in its capabilities. It did not integrate with the imaging department, for example, meaning staff had to walk between those departments to share information.
- Access to old medical records was difficult because these were paper-based and archived off-site.
- A discharge summary was sent to general practitioners when the patients were discharged from the department.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed patients being asked for verbal consent prior to examinations or tests being performed.
- We were told by nursing staff that unless they had started recently and undertaken the induction process, there had not been any Mental Capacity Act training. Nursing staff said they were unable to conduct a mental capacity assessment and if they had concern about a patient's mental capacity, they would escalate their concern to a doctor or the Psychiatric Liaison Nurse.
- The care records used in the Emergency Department did not have a specific area to record capacity assessments; instead, we were told that any capacity assessments would be recorded in the notes section. We saw no evidence that this was conducted during any patient stays in the ED. This meant it was unclear if capacity to make decisions had been considered for any of the patients whose notes we reviewed, including patients who were elderly, had consumed large doses of alcohol or who had taken an overdose.

Are urgent and emergency services caring?

Good

Services were found to be caring. All patients we spoke with were positive about the care they had received. Care was delivered that was kind and compassionate. There was good understanding and involvement of patients and emotional support was given to patients, relatives and staff alike. However, patients privacy and dignity was not always respected while in the department.

Compassionate care

- Patients' privacy and dignity was not always respected. When ambulances arrived, ambulance crews waited with their patients in a queue outside the resuscitation area. There was nowhere private for the handover between the ambulance and hospital staff to take place, and ambulance crews expressed concern about the lack of privacy and confidentiality because there were often staff, patients and relatives walking past as confidential information was handed over and observations were taken on the patient.
- We observed patients on trolleys unattended in the corridor awaiting an x-ray. We saw one patient with his chest exposed and no means of covering himself up. We observed patients in the corridor area being assessed openly with no privacy. Another patient was seen waiting in the CDU lounge with a vomit bowl containing vomit. Staff had not removed the bowl or given privacy

to the patient. A further patient in the resuscitation area was naked below the waist but was seen to be left uncovered while his upper body was being cleaned for a procedure.

- At the time of the inspection we observed one recently deceased patient in the resuscitation area. Staff provided mobile screens around the deceased person however these provided limited privacy. As a result the deceased person was visible to other patients, staff and relatives who were in the resuscitation area at the time. We raised this as a concern at the time of the inspection.
- We were told by staff they were concerned about the lack of privacy and confidentiality afforded to patients when they arrive in the department's reception area. The reception desk offered little privacy from others in the area. While there was a 'privacy line' behind which queuing patients and relatives were requested to stand, the reception desk was designed such that two people could be stood side-by-side talking to separate receptionists.
- In CQC's 2014 A&E patient survey, the trust scored 'about the same' as other trusts for caring related questions. For example, 8.8 out of 10 patients said they were treated with dignity and respect whist in the ED, and 6.8 out of 10 patients felt reassured by staff if they were distressed while there.
- The department recorded patient feedback on the friends and family test. In line with other trusts, response rates were low. However, from responses received, the trust scored higher (better) than the England average when patients were asked if they would recommend the department to their friends and family. The department had a plan to collect 50 responses daily, and were using a tablet device in some areas to try and capture responses before patients left the department. Data received dated February 2015 reported a response rate of 23.9% (1005 of 4213) of which 94.2% would recommend the department (947 of 1005).
- At the time of the inspection a research study was underway obtaining patient views on communication within the department. Staff expressed concern that while this would provide excellent feedback and data, it may affect the response rates for the friends and family test while the study was underway as patients would not want to complete two 'surveys'
- We observed staff delivering care with kindness and compassion. Staff were heard talking kindly to patients and relatives, interacting well and offering reassurance and explanations. We saw one consultant assist a distressed relative in locating a family member, even though that patient had not come to the Emergency Department. They took the time to take the relative to reception, and allowed them to use the telephone at the nurse's station. They then guided them to the correct area within the hospital. We also saw a registered nurse in the CDU take time to talk to two patients who were having a conversation, and assist them by moving the curtain out of their way to make their conversation easier.
- Patients told us that staff were caring, although were extremely busy so didn't have as much time to spend with them as they would have liked.

Understanding and involvement of patients and those close to them

- Patients and those close to them were involved as partners in their care. In CQC's 2014 A&E patient survey the trust scored 'about the same' as other trusts for patients understanding and involvement. For example, an average score of 7.7 out of 10 was achieved for patients being involved as much as they wanted to be in decisions about their care and treatment. A score of 8.5 out of 10 was achieved for patients who felt the doctor or nurse explained why tests were required in a way they could understand.
- We observed a telephone conversation with a distressed relative who was unable to attend the department. Staff were heard to talk to the relative in a kind a reassuring manner, providing all information, reiterating points and ensuring the relative understood. In addition they were heard providing contact numbers for the relative to call back with any questions.

Emotional support

- The CQC 2014 A&E patient survey reported a score of 6.5 out of 10 for patients who said the doctor or nurse discussed any anxieties or fears they had about their condition or treatment.
- There was no specific bereavement support for relatives or staff within the department.
- Schwartz Center Rounds® occurred trust-wide. These were one-hour sessions for staff from all disciplines to discuss difficult emotional and social issues arising from patient care. In addition, the department conducted 'Hot' debrief sessions immediately after a traumatic or

particularly upsetting event for all staff involved. This was followed up a week later in the form of a 'cold' debrief. Staff told us they had positive experiences of the Schwartz Center Rounds®, and that they were both well attended and well supported.

- Staff could be referred to occupational health for emotional support. In addition, staff could self-refer without the need for manager approval and referral.

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

Inadequate

Emergency and urgent services were judged as being inadequate for responsive.

The trust had failed to meet the 95% target for patients being admitted, discharged or transferred within four hours of arrival in A&E for all months in 2014-15 apart from in May 2015. Throughout the winter of 2014-15 there had been peaks of activity with high attendances at the emergency department coupled with high numbers of patients requiring admission to the hospital. The Trust worked with partners across the wider health and social care system in Devon and Cornwall to address issues with all types of service provision and maintain patient flow through the system. As a result the trust implemented a status of 'black alert' between 5 January-29 March 2015 due to the internal pressures and inability to maintain flow of patients through the hospital. This level of escalation, maintained for such a length of time, raised serious questions about the ability of the trust to respond to the demands that it was facing. This was especially concerning in a trust designated as a major trauma centre.

Patients did not always receive timely care and treatment or treatment that met their individual needs. This included patients who were moved from the resuscitation area to make way for others. Patients did not have access to call bells at all times, and were left unattended while waiting for x-rays. The department consistently failed to meet the national standard requirement for 95% of patients are discharged, admitted or transferred within four hours of arrival. The reception desk was not suitable for wheelchair users.

Care plans were devised and shared with GPs and other partner agencies for patients who were identified as being frequent attendees as a way of avoiding admission, or ensuring a consistent approach once they had presented in the department. Fewer patients left the department before being seen than the England average.

Service planning and delivery to meet the needs of local people

- The ED was accessible to patients with parking available relatively close to the department. There was a drop off zone adjacent to the ambulance bay; however, neither of these were covered meaning patients arriving in the hospital were exposed to all weathers while exiting the vehicles.
- The ED provided a service across a wide geographical area and to ensure quick and timely transfer of sick patients there was a helipad sited directly opposite the ED with relatively easy access to the ambulance entrance. However, the transfer from the helipad to the hospital entrance was across a road and on a slight hill which at times made transfer to the department difficult we observed one transfer where the transfer trolley began rolling sideways down the hill, requiring an additional staff member to quickly take hold of the trolley and assist with moving the patient. The trust was in the process of constructing a new helipad which would be able to receive heavier military aircraft which at present were required to land off site, with transfer then occurring by ambulance.
- The department had developed a system for the management of frequent attenders. Patterns of frequent attendance were identified, care plans developed and approved by a named consultant and these were shared with the GP and other local partners. The care plans contained management plans and enabled other providers in the community to prevent the need for attendance. These also contained plans of care once the patient had presented in the ED. Each care plan had a dedicated owner who was responsible for updating and archiving old plans to ensure only a current, up to date plan was in use. These were stored on a central repository accessible to senior nursing and medical staff.
- There was a dedicated lead consultant for mental health who contributed to the establishment of the Derriford Liaison team. This was a multidisciplinary team with staff from several organisations which was based at the

trust and available seven days a week. The consultant lead had been integral to the development of plans to develop the office on CDU into a mental health assessment room, for which trust approval had just been granted. This would mean a more suitable environment for the conduct of mental health act assessments.

- The department had no viewing facilities for recently bereaved relatives. Whilst staff were sensitive to the needs of relatives the lack of a dedicated area meant viewing and time spent with the deceased either occurred in a single room if available, a screened cubicle or on occasion due to high demand on cubicle space, the mortuary. This was recognised by staff as an area for improvement and was on the department risk register.
- Young people attending the department with mental health needs were referred to the Child and Adolescent Mental Health Services (CAMHS) team, part of the neighbouring mental health trust. This was a five day service. At weekends, young people under the age of 16 were admitted to the paediatric ward. Those aged 16-18 were admitted to the CDU to await assessment.
- The reception desk was not suitable for wheelchair users. People in wheelchairs could not see over the countertop, and reception staff told us they would have to stand, lean over the desk towards the window and look down at the person in order to talk to them.

Meeting people's individual needs

- Individual needs were not always met. We observed one patient arrive suffering with chest pain. As the department was busy with no free cubicles, they were cared for in the 'corridor' area. The patient was placed in a cubicle so that staff could perform an electrocardiogram (ECG). However this was only possible as the patient that had been in the cubicle went for an X-ray. Following the ECG the patient returned to the 'corridor' area in order to allow the original patient back into their cubicle on return from x-ray.
- We observed another incident of a patient requiring admission into the resuscitation area waiting in the corridor area while another patient was moved out to make space for them. This occurred quickly and both patients were accompanied at all times by nursing staff.
- A third patient was observed in a cubicle in majors without access to a nurse call bell. We observed the patient was not checked for a 20 minute period and when we spoke to the patient they told us they were desperate to use the toilet. We alerted a nurse immediately who then assisted the patient to the toilet.
- We were told by staff that telephone translation services were available should they be required. During the unannounced inspection we observed staff treat one patient for whom English was not their first language. In addition the patient was deaf and communicated with sign language. Night staff were able to 'sign' and communicate with the patient on admission. However once they went off duty there was no one in the department to perform that role. Staff told us they had called the translation service but had been told it would up to two weeks before a translator could be sourced. This meant the patient had little interaction with staff due to the lack of translator during the time we were present. The patients immediate medical needs had been addressed while the member of night staff had been on duty. The patient remained in the department awaiting review by the mental health team. It was unclear if they would have signing and interpretation skills.
- Patients with learning disabilities were 'flagged' on the computer system so that everyone involved in that patient's care were well informed. This flag would also alert the learning disability nurse who would attend the department to offer further support and assistance if required (for example, if the patient did not have anyone with them, the learning disability nurse would stay with the patient).
- Staff told us they were aware of the learning and disability 'passport', and that they would refer to it if it was present. The 'passport' contains patient-specific information, ranging from allergies and medical conditions to the name the patient preferred to be known by and what they liked to eat. This meant they could be cared for in the way that met their individual needs.
- The paediatric area did not employ a play specialist. This did not meet the Royal College of Paediatric and Child Health recommendations (2012). While there were some toys available and a television was on, these were designed for younger aged children. Though the department had free Wi-Fi available, this was not advertised to young people attending.

Access and flow

Urgent and emergency services

- The trust was consistently failing to meet the standard requirement that 95% of patients were discharged, admitted or transferred within four hours of arrival at A&E. The department dashboard for 2014-15 reported they had only met this target once (in May 2014). Figures provided by the trust showed the average performance since 4th January 2015 was 85%, with weekly percentages ranging from a high of 90.5% to a low of 78.4% of all attendees). The maximum wait time for admitted and non-admitted patients was reported on the department dashboard. The longest any one patient remained in the department was reported as 14 hours and 9 minutes for an admitted patient and 25 hours and 32 minutes form a non-admitted patient. The Trust was on 'black alert' between 5th January-29th March 2015. This level of escalation should not be sustained for long periods of time and gave us concern that services were not being responsive to deal with the issues the Trust was experiencing.
- The department employed a flow coordinator to monitor patient flow through the department. The flow coordinators role was to monitor the movement of patients throughout the department and identify patients who had been in the department for approaching four hours. Staff were then encouraged to consider a move to another place in the hospital if the patients clinical condition allowed, such as CDU and the Medical Assessment Unit. Staff held a daily review of all breaches to determine the reason for the breach if not for clinical need.
- The Royal College of Emergency Medicine state that crowding is associated with increased mortality. Crowding is also important because it reduces the quality of care that patients receive. The department was deemed to be overcrowded when there were more than 21 patients in majors and the resuscitation area combined. This was on the department's risk register as a 'serious risk'; however, the risk register did not have the date this was entered, showed no ownership and had no details of actions to address it. However the issue of overcrowding had been raised widely throughout the trust and at executive level.
- There was a trust-wide escalation policy, revised for winter 2013/14 which was currently under review. This set out a range of triggers and actions to be taken to mitigate risks associated with capacity and overcrowding. This was rated from level 1 (green status), to level 4, (black status). We asked the trust to provide us with details of how often the department was in red or black escalation but were told these figures were not collected or reported on. We were told the trust overall had been on black alert between 5th January 2015- 29th March 2015.
- At times of peak activity and high numbers of patients attending the department impacting on flow through the hospital the trust declared an escalation situation of 'black alert'. During the black alert there were daily conference calls in the morning between the hospital, community services and ambulance service to discuss pressures and plans for the day ahead. At the time of our inspection the trust had de-escalated to 'red alert', and conference calls were taking place weekly on a Monday. However, additional calls were scheduled should the need arise. The calls focused on the number of patients being discharged and how many beds were available in community hospitals and how many patients were waiting for packages of care before they could be discharged home.
- The percentage of patients who attended but did not wait to be seen was also monitored. This averaged 1.6% from 4th January 2015 to 30th April 2015, lower (better) than the England average of approximately 2.5%.
- The number of unplanned re-attendances was higher (worse) than the trust target of 5%, averaging 5.6% per month though this was better than the England average of 7.6%
- The department aimed to have no ambulance handover delays. Patients were met in the entrance to the department outside of the resuscitation area where staff took a hand over from ambulance staff. After the handover patients were assigned to the correct area. When the department was busy and there were no available cubicles, patients were transferred onto a hospital trolley and cared for by nursing staff in the central 'corridor' area. Timing of patient handovers from ambulance crews was reported on the department dashboard. This showed ambulance handovers within 30 minutes of arrival occurred on average 98.4% of the time, and 99.9% of all handovers had occurred within 60 minutes During the time period 01/04/2014 – 31/12/2014.
- In order to prevent ambulance crews remaining on site, and patients staying in ambulances awaiting handover to the department, the trust had arranged with the ambulance service for a paramedic to attend to care for

patients in the 'corridor' area which was used to place patients when there were no cubicles free. This was part of the trust escalation plan which included the action for staff to make a call to the Bronze controller in the ambulance service to request they provide a staff member in order to release ambulances from waiting. Staff reported this arrangement worked well.

- Medical patients who were stable were referred to the Medical Assessment Unit coordinator who then arranged admission into the MAU. Staff described this as a quicker process than referring through to the medical registrar.
- The corridor area was used on a daily basis to care for patients, which indicated overcrowding of the department. We saw this in use during the inspection, and staff told us this area was used frequently to care for patients. Overcrowding in the ED presented a risk to patient safety, patient experience and performance against key waiting time targets and was recognised as a trust-wide problem to be addressed.
- Department dashboard dated until the end of December 2014 reported the single longest time to assessment as being 348 minutes which occurred in June 2014. Each month, the longest time to assessment was reported on the dashboard as being between 175 -348 minutes. The mean wait to treatment time was reported as ranging from 47-64 minutes. There was a trust escalation policy which set out steps to be followed to ensure patient flow through the hospital was managed.

Learning from complaints and concerns

- Staff told us the department received the highest number of complaints within the trust. They felt this was due to longer than expected waiting times and also that many complainants journeys commenced in ED. In order to improve responses, the department had arranged with complaints team and trust management to send complaint responses to the complainant directly from the clinician, accompanied by a letter from the trust where appropriate. Staff told us they felt this was more appropriate than being altered into a formal trust written response. They felt this indicated a genuine review of the patient complaint and response to their concerns and included the clinicians apology. The number of complaints were monitored on the department dashboard on a monthly basis and averaged 7 per month.
- There was no formal process to disseminate learning from complaints within the department, or to share learning more widely with other hospital departments. Staff we spoke with were unable to describe any learning that had arisen.
- There was a single poster advertising the Patient Advise and Liaison Service (PALS) located next to the reception. No other literature existed within the department to advise people how they could raise concerns or make a complaint. Staff advised us that should a patient or relative raise a concern with them, they would obtain a PALS or complaint leaflet from behind the reception desk for them to fill in and either post back or hand to a staff member for sending to the PALS department.

Are urgent and emergency services well-led?

Requires improvement 

The emergency and urgent services require improvement for being well-led.

The Trust was on 'Black Alert' escalation for 3 three months. This raised questions about the effectiveness of the actions taken, within the department and across the trust to respond to the demands for services. It was recognised that the challenges with the flow of patients into, through and out of hospital was a whole trust issue and could not be resolved by the Emergency Department alone.

Although there were some good examples of leadership in the department, there were areas that needed improving.

Nursing leadership within ED was variable and at times lacked effectiveness and visibility. Governance systems were not fully embedded or effective with under reporting of incidents not being identified. The risk register did not indicate ownership or actions to risks and there was no evidence of progress made in the management of the risks. Staff were not always engaged in decision making.

There was a clear vision and a plan for emergency care in the future with strong, visible medical leadership. There were close links with both the military and The British Antarctic Medical Survey Unit (BASMU), providing staff with a broad depth of knowledge and experience.

Urgent and emergency services

Vision and strategy for this service

- The department had a strategy which outlined their plans and vision for the period 2014/15 to 2018/19 and was documented in a plan. The vision to 'optimise the front end' included the development of a single point of access for urgent and emergency care. This would streamline the emergency admission pathway for patients. Emergency patients would be admitted through a common access point and assessment and immediate treatment would occur in a single emergency zone.
- Staff told us they were aware of the department's strategy, describing the vision to have an 'emergency village' with all relevant services available together at the hospital 'front door'.

Governance, risk management and quality measurement

- There were governance systems in place though these were relatively new and therefore not fully embedded or effective. Incidents were reported although while managers monitored risks to patient safety through the incident reporting system, the process was focused on individual incident management rather than themes and trends. The number and type of incident category and any trends were not reported or compared across areas within the department This meant the incidents described to us by staff but were unreported had not been identified. Systems were in place to provide some correlation between incident, risk and quality outcomes for patients, however these were not fully effective. Individual incidents, once reported, were discussed daily with the senior teams to ensure any immediate actions needed could be taken but there was no general oversight. Learning was not fed back to staff in a structured way which meant there was no structured process to ensure learning occurred to reduce the risk of incident recurring.
- Staff had been involved in training 'away days' during which complaints and incidents were reviewed and identified learning shared. Staff felt this was very useful and enabled them to better understand the impact of quality measures.
- The Emergency Department had a risk register. This contained six risks which were deemed a serious risk with executive team action required. These risks were overcrowding in the department, ineffective isolation processes, inadequate resuscitation facilities, access to old medical notes, medical and 'other' staffing and a lack of isolation facilities. However, there were no dates recorded (for example, when the risk was identified and entered onto the register), no lead member of staff identified to take ownership and no action plans identified for each risk. We were told that the risk register was regularly reviewed by the ED management team, and escalated to the board where strategic oversight or actions were required, though this did not occur in a formal, minuted meeting. There was no evidence on the risk register of progress being made. However, we found the risk register was aligned with the concerns voiced to us by staff and managers.
- There was some internal quality auditing being undertaken, and evidence of planned improvements in response to audits. For example, an audit on Record Keeping clearly identified 5 areas for improvement and the steps required to achieve this. However this was undated and had no time frames against the actions needed. The action plan also failed to identify ownership of the actions. The department did not have a formal meeting where progress against the actions was monitored.

Leadership of service

- Staff reported a very strong medical leadership within the department, with good connection to and support from the board. Staff felt this had improved the trust's approach to breeches in targets where the issue was now viewed as a whole hospital problem, and not purely one for ED to manage alone. Staff described very good relationships with the executive.
- The leadership of the nursing staff was not as effective or visible to staff. The matron had good visibility within the department and was described as approachable and supportive. Due to the number of posts and managerial workload demands, senior nursing staff at band seven were not consistently seen working within the department while we were on inspection. Staff told us the band sevens undertook one clinical shift per week but were often busy undertaking management duties which made up the bulk of their workload rather than providing leadership to the shift staff. The band seven nurse with lead responsibility for the CDU was not present on the CDU rota, and when questioned

confirmed they did not work clinically in that area. Staff told us they did not attend staff meetings or provide clinical leadership which was devolved to the band six nurse.
- At times during the announced and unannounced parts of our inspection we raised concerns with the senior staff in the department. We found that the concerns were quickly acted upon with evidence of change on some occasions within less than 24 hours

Culture within the service

- Staff described a great sense of teamwork and mutual respect. They reported a sense of pride and commitment within the department, and told us they felt a caring and supportive culture at all levels. For example, we observed an additional senior medical staff member undertake a more junior role within the trauma team in order to support its function effectively.
- The department had close links with both the military and The British Antarctic Medical Survey Unit (BASMU). Staff worked with military staff and reported this in a positive light, feeling they benefited from their expertise. In addition, the military personal were described as bringing a 'calmness' to the department.

Public and staff engagement

- Staff did not feel that they were always engaged with when changes were made. For example, following our announced inspection we raised an immediate safeguarding concern within the CDU Lounge. Staff told us that changes were put in place and they were told that further changes would be made, but they were not involved in any discussion. They expressed concerns about the decisions that had been made, and had alternative solutions they felt would be more effective. It was, however recognised that changes were required immediately as a result of patient safety concerns.
- A research project was underway to review how patients and members of the public were communicated with. It was intended that the results of this would be used to shape future communication methods within the department.

Innovation, improvement and sustainability

- Staff from the ED supported the provision of 365 day/24 hour medical emergency back up to the British Antarctic Survey, with senior medical staff attending the Antarctic to support repatriation of those sick or injured. Senior staff told us this provided additional variety and was an additional role when attracting new recruits to work in the department.

Medical care (including older people's care)

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

Information about the service

Medical services provided at Derriford Hospital included the provision of 316 beds located within two medical assessment units, acute medical care, cardiology, clinical haematology, clinical oncology, neurology, gastroenterology, medical health care of the elderly, respiratory medicine and nephrology treatment and care wards.

We visited the following areas during our inspection; Short stay Unit, Planned Investigation Unit (PIU), The Medical Admissions Unit including Thrushell, Tavy and ambulatory care, Endoscopy and the Cardiac Catheter laboratory. We also spent time on the following wards: The Conservatory, Hembury, Shipley, Bickleigh, Mayflower, Meldon, Burrator, Monkswell, Brent, Hexworthy, Honeyford, Bracken, Hartor, Stannon, all of which provided medical care and treatment. We also visited Crownhill and Clearbrook wards to speak with staff regarding medical patients who were admitted to these surgical wards as medical outliers.

We spoke with 61 patients and 68 members of staff including consultants, doctors, senior and junior nurses, managers, administrators, porters, housekeeping staff, occupational and physiotherapists.

We reviewed 35 sets of patient records.

Prior to the inspection we reviewed information and data about medical services provided to us by the trust.

Summary of findings

Patients were positive about the care and treatment they received at Derriford Hospital. We saw that staff provided patients with a kind and caring service, respecting their dignity and privacy and showing empathy and understanding.

Safety in the medical care group was rated as requires improvement. We found that staffing levels of both nursing and medical staff were below the assessed levels, which presented a risk to patient care. Systems were not in place to ensure that staff were clear about the medical cover for patients who were admitted to the surgical wards when medical wards were full.

Patients were not protected from the risks of hazardous substances as cleaning materials were stored in unsecured areas that patients and the public could access. These areas included wards where patients who were confused or living with dementia were receiving care and treatment.

Patients received good outcomes because they received effective care and treatment that was delivered in accordance with evidenced-based guidance, standards, best practice and legislation. The trust participated in national audits and used the outcomes from audits to improve services.

Multi-disciplinary team working was seen throughout the medical wards and departments and within the wider community, leading to consistency of care to patients.

Medical care (including older people's care)

Patients received their care and treatment from competent staff who were provided with supervision, appraisals and training.

Services did not always meet people's needs. The cardiology referral to treatment times did not meet trust targets and people were waiting for longer than 18 weeks to access care and treatment. Patients experienced delays in discharge and were unable to leave hospital when they were medically fit. A discharge team were in operation within the hospital, working towards improving the discharge process for patients with complex needs.

Patients who required medical care and treatment were not always provided with a bed on a medical ward and medical outliers were admitted to surgical wards. Staff were not always aware of which doctors were providing specialist medical care and treatment to the medical outlier patients. Patients experienced transfers within the hospital wards often late at night and on more than one occasion during their stay.

Not all patients were aware of how to make a complaint should they need to do so. People provided us with information on the lack of response they had received from the Patient Advice and Liaison Service (PALS) when they had raised concerns or complaints.

The medical service were well-led. The quality of services was reviewed in board meetings and in other relevant meetings within the medical division. Information regarding the vision and values of the organisation was available in some areas of the hospital and senior staff were all clear of these. Not all junior staff were familiar with the aims. Staff told us there was a positive culture within the hospital and they were proud to work there.

The senior leadership team were visible on wards and departments, with staff showing an awareness of the senior team and making positive comments regarding their presence on the wards.

We saw evidence of innovative practice within the medical services. Staff were confident that they were able to make suggestions and were provided with support to implement innovative practice.

Are medical care services safe?

Requires improvement

Safety in the medical services was rated as requires improvement. We found staffing levels of both nursing and medical staff were below the assessed levels which presented a risk to patient care. There were periods of understaffing or inappropriate skill mix which were not fully addressed as additional staff were not always available to increase the staff team.

Clear systems were not in place to ensure that staff were clear the medical cover for patients who were admitted to surgical wards when medical wards were full.

Incidents

- Information obtained from the NHS Patient Safety website, relating to the period between October 2013 and March 2014 showed that out of 38 large acute trusts, the rate of incidents the hospital reported was the eighth highest. This showed the trust had a positive attitude to reporting incidents. The proportions of severe harm and death incidents were higher than the comparative data for all large acute trusts.
- The hospital reported that between February 2014 and January 2015 there were 33 serious incidents which required investigation in the medical services. Fifteen of these were regarding grade 3 pressure ulcers and one grade 4 pressure ulcer. Pressure ulcers are graded from 1-4 with 4 being the most severe tissue damage. Other serious incidents included 12 slips/trips/falls and one delayed diagnosis.
- Staff were encouraged to make incident reports following incidents which were considered to be 'near misses'. These were incidents that would have caused harm to patients but were narrowly missed and also included concerns regarding staffing levels. All grades of staff we spoke with were aware of and had used the reporting system when concerns had arisen.
- We were provided with an example where an incident form had been completed following an event that was classed as a 'near miss'. This was following a procedure where a swab had been lost during surgery in the cardiac catheter laboratory. As a result of the incident, a

full investigation had been undertaken and actions and recommendations made which we understood were being put into operation. The investigation report identified that no harm had been caused to the patient.

- An incident was reported to CQC from the Endoscopy department whereby a procedure had commenced on the wrong patient before staff realised they had the wrong patient. An investigation was being undertaken by the theatre/surgical team to analyse the circumstances and so remove any further risks. Investigations into incidents used the system of root-cause analysis and we were told and saw from previous investigations that appropriate qualified and competent staff from another ward or department led the investigation. This provided an independent overview of the investigation.
- Following submission of an incident report, staff were clear they received feedback. For example, an administrator had been on the receiving end of abusive and threatening telephone calls. Following the completion of an incident form the trust had taken action and support had been provided to the member of staff.
- Some staff we spoke with felt that the dissemination of information from investigations following incidents could be communicated more thoroughly to ensure learning across the trust.
- The trust held regular morbidity and mortality meetings in each of the medical specialities. Minutes of these meetings were maintained. We reviewed minutes from different medical specialities and found these varied in the content and style of recording. It was not clear from the minutes provided that the trust were enabled to identify any trends or issues arising in order to take action or learning from the meetings. This was due to the briefness of information contained within some minutes.

Duty of Candour

- Duty of Candour legislation has been in place since November 2014 and requires an organisation to disclose and investigate mistakes and offer an apology if the mistake results in a death, severe or moderate level of harm.
- The trust provided us with information regarding Duty of Candour stating that the electronic reporting system prompted staff to link any appropriate incidents to Duty of Candour. The patient safety team ran a regular search of the electronic system to ensure that all incidents (moderate or above) had Duty of Candour documentation completed. The risk and incident team ensured appropriate action had taken place following the incident and that the patient and/or their representative had been informed of the incident within ten days.
- Four members of staff told us they had completed Duty of Candour training which they had found informative and helpful.
- Not all staff were aware of the Duty of Candour terminology but all spoke clearly about the principles involved.

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. Data obtained from the National NHS Safety Thermometer showed that the numbers of reported pressure ulcers and falls with the patient experiencing harm had reduced during the time period December 2013 to December 2014.
- The trust had a performance dashboard in place for all care groups. The medical care services provided in the hospital were reflected in an overall dashboard. Each medical speciality maintained their own clinical dashboard which provided information regarding falls with harm, pressure damage, Never Events (Incidents that are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented) and the use of the WHO checklist if applicable. (The World Health Organisation (WHO) safety checklist to increase the safety of patients undergoing a procedure).
- Individual wards used a safety cross to identify numbers of falls on the ward and displayed this for patients and visitors to the ward. Information we saw during our visits to the wards and departments showed the numbers of pressure damage and falls were zero or minimal in all areas.

Cleanliness, infection control and hygiene

- The hospital carried out audits of hand hygiene on each ward and unit. The information from individual wards and departments was displayed and accessible by patients and visitors to these areas. Between February 2014 to February 2015 a total of 4357 audits were submitted which when analysed showed 99% overall

compliance with hand hygiene procedures. The audit showed 99% of staff decontaminated their hands before and after contact with patients, 99% after removal of gloves and 99% after dealing with bodily fluids or following clinical procedures.

- Staff audited the procedures in place to prevent the risk of patients contracting Clostridium difficile (a type of bacterial infection that can affect the digestive system). An audit carried out between February 2014 and February 2015 by the trust showed that 1165 surveys were completed. The analysis of these surveys showed that patients were protected as 99.66% of staff carried out appropriate hand hygiene and in 94% of cases evidence of prudent antibiotic prescribing was seen.
- The trust reported no Methicillin-resistant Staphylococcus Aureus (MRSA) blood stream infections during the period April 2014-15. Nine patients were reported as having a hospital acquired MRSA infection which was not a blood stream infection, in the medical division care group during the period April 2014 – March 2015.
- Staff were required to complete infection prevention and control training. Data provided showed 83% of staff working with acute medicine, diabetic and endocrinology services had completed this training. 74% of cardiology staff were up to date with their training. 96% of endoscopy staff, 80% gastroenterology staff, hepatology 53%, 71% oncology, 86% health care for the elderly had also completed their training.
- The trust had an internal target in that where patients required isolation due to an infectious disease, this would be achieved within two hours. An audit had been carried out regarding this and the outcomes showed that 35 patients were isolated within the standard time, 11 after the standard time and 17 were unable to be isolated due to the lack of suitable bed space. This did not ensure that infections were prevented from spreading.
- White boards on the wards clearly identified any infection control risks. For example, MRSA positive patients. This information was discussed during the staff handover to ensure all staff on the wards were aware of the risks and precautions to be taken.
- Cleaning and sterilising of multi-use equipment was carried out appropriately. We saw the endoscopes were cleaned in the central sterilising unit and this process protected patients from the risk of infection. Equipment used on wards such as commodes and hoists were cleaned after use and a green sticker identified the date and time when the equipment had been last cleaned.
- Sharps bins were used appropriately for example, not overfilled, temporarily closed when not in use, and were dated and signed when full to ensure they were disposed of in a timely way.
- Hand sanitising gel was located at the entrance to each ward with instructions on how to use this correctly. Throughout the wards and departments there were adequate hand washing facilities with additional hand gel in close proximity to sinks and throughout the wards. We observed staff used the hand gel during their duties and washed their hands in the correct manner in line with the Nursing and Midwifery Council (NMC) guidelines. All staff complied with the trust policy of 'bare below the elbows' in clinical areas to reduce risks of cross infection.
- Patients confirmed staff wore gloves and aprons when carrying out procedures and care. During our inspection this was also our observation.
- The patients we spoke with throughout our inspection were all positive regarding the cleanliness and hygiene of the wards and departments.
- Cleanliness checks of wards and departments were carried out using a peer review system with other ward managers / sisters. Audits were completed and the findings collated and discussed with matrons and ward staff at 1:1 supervision sessions and during management meetings.
- The Patient Led Assessments of the Care Environment (PLACE) 2014 scored the trust at 96 for cleanliness compared to the national average of 97.

Environment and equipment

- Information and guidance was available to staff and accessible on the trust's intranet, regarding the use of medical equipment, including servicing and maintenance procedures.
- The system in operation in the hospital identified the last date of servicing or maintenance of the equipment by way of attaching a sticker to the item. Not all equipment had a sticker identifying the last servicing date or when servicing / maintenance was next due. For

example, urinalysis testing machines, blood pressure recording machines, or sluice masters (used for the safe disposable of soiled bedpans). This may mean that they require routine attention to work in the optimum way.

- During our visit to the Endoscopy unit we observed the unit was tidy and free from clutter with the patient waiting area being light and airy. The treatment area provided five well equipped endoscopy rooms which afforded the patient privacy during their treatment and a well laid out recovery area. Staff told us there were a large number of scopes available which were sufficient for the service provided. The endoscopes were stored appropriately in temperature controlled cabinets, the temperatures of which were recorded, to ensure they were safe for use.
- Staff who worked within the cardiac catheterisation laboratories (cath lab) commented that the recovery environment did not meet the needs of the department fully in that more space was required following patient procedures as day cases. Additional comments were made regarding a co-located theatre would be beneficial to staff and patients. Senior managers of the medical division told us that a business case was being developed, which if successful, would address the environmental issues within the cardiac cath lab.
- Bracken ward had recently been refurbished and provided individual side rooms which enabled patients to feel part of the ward but had glass in the doors and windows that turned opaque to afford privacy when required.
- Hartor ward were pleased to inform us about the new equipment they were trialling to help prevent falls.
- The renal ward had good storage facilities and a maintenance programme for haemodialysis equipment.
- Some wards and departments were cluttered with equipment in the corridors and rooms. This could be a risk to patients, visitors and staff.
- Prior to our inspection we received information telling us that wards did not have sufficient linen and pillows for patient use. Staff we spoke with clarified that there was 24 hour access to bed linen, for example sheets and blankets within the hospital. Pillows were allocated to wards and if additional pillows were required they were borrowed from another ward. Patients we spoke with had not experienced problems with this but staff did comment that at times it was difficult to source sufficient pillows to meet patients' requests.
- Each ward and department had a resuscitation trolley which contained emergency equipment and medication in the event of a patient suffering a cardiac arrest. We saw these trolleys were secure to prevent equipment or medication going missing and were checked each day to ensure they were ready to use in an emergency.
- We observed a phlebotomy trolley for the taking of blood samples, left unattended within a corridor which was accessible to patients and members of the public. This did not ensure the safety of the equipment or patients who may access this trolley.
- The Patient Led Assessments of the Care Environment (PLACE) 2014 scored the trust at 89 for facilities compared to the national average of 92.
- We observed risks from unsecured chemicals and substances that are hazardous to health (COSHH) in place on a number of the medical wards. This was because cleaning materials were stored in sluices which were accessible to patients and visitors to wards as they were not locked.

Medicines

- The trust provided guidance and information to staff in a comprehensive medicines management policy, supporting policies, (for example, self-medication of medicines) and standard operating procedures (SOPs). Staff we spoke with were aware of the availability of this information.
- Regular monthly audits took place for most areas where medicines were stored, with an escalation plan in place for wards or departments which showed non-compliance with the trust's medication management policies. Regular audits were conducted of controlled drugs including the ordering, storage, records and disposal of the drugs.
- The controlled drugs were checked on a weekly basis on the wards and departments we visited. However, the process in place to identify out of date medication was not effective in all areas as we observed a controlled drug that had been out of date for three months and was still in use.
- All medical wards which we visited had drugs trolleys for use when administering medication to patients. These were locked shut and fastened securely to a wall when not in use. Observation of medication administration on

the medical wards demonstrated the system in operation protected patients from the risk of errors. We saw staff took time to explain the medication to the patient during the medication round.

- Fluids for intravenous use on the renal ward were stored in a room which was secured with a key pad. However, we observed this door did not self-close and was left ajar. This may allow access by unauthorised people and result in loss or damage to the fluids stored there.
- Incidents which had occurred with medication were reported thorough the trust's electronic reporting system. We were told that an incident had been reported regarding missing medication in one department and the investigation found the medicine cupboard key had been left in the cupboard door. A reminder was sent to all staff regarding security of medication. Another ward had discovered some missing medication and an investigation was conducted and appropriate action had been taken to reduce the risk of harm to patients and staff.
- Medication Errors were reviewed at the Medication Governance Committee and learning from previous incidents and/or errors were shared across the hospital.
- Two patients raised a concern to us that a bank nurse had taken approximately three hours to administer medication within their six bedded bay and was worried regarding the nurses competency. The charge nurse on the ward had already been informed of this and had taken action to address the situation.
- One patient admitted to a ward with a high temperature had asked for paracetamol five times. The patient told us they did not receive the medication, nor an explanation as to why they could not have it.
- Medication for patients to take home were the highest reported reason for delayed discharge. We were provided with information from patients prior to the inspection regarding medication not being ready, incorrect medication provided and incomplete medication provided. In one instance this was not discovered until after the patient had returned home and they did not have time to return to collect the medication before the pharmacy closed.
- During the working week the current temperature of most refrigerators used to store medicines were monitored by pharmacy staff. Some wards recorded the fridge temperatures on a daily basis with the information accessible on the fridge, while others did not, relying instead on the system operated by the main pharmacy department. There was an inconsistency around the trust-wide management of this check. There were clear guidelines displayed on some wards detailing the action to take if the temperature of fridges was outside of the safe parameters. Records we saw identified the temperatures had been within acceptable limits.
- Medical wards were provided with standard stock items of medication, with a system in place to obtain lesser used medications that had been prescribed for patients. Surgical wards which admitted medical patients at busy times did not have the standard stock medication as they had limited stock medication and relied on patients own drugs. One surgical ward had been changed to provide care and treatment to medical patients with one days' notice. This had impacted on the availability of medication and concerns were escalated to pharmacy who promptly provided a "starter stock kit".
- A number of medical gas cylinders were stored in an area without any medical gas signage. This may pose a risk to patients, visitors and staff.

Records

- Individualised care plans were observed to be used on the medical wards. These were in the form of generic care plans that were updated, on admission and when care needs changed, to identify the individual care needs of patients. We also saw detailed records for specific care pathways, for example, for patients completing the hospitals alcohol withdrawal pathway, which were completed appropriately.
- An admission recording booklet was in use on the health care for the elderly wards. These were completed to show detailed assessment information including mental capacity, physical ability, specialist input for example, speech and language specialist (SALT), physiotherapist and occupational therapy and discharge planning information.
- A 24 or 48 hour care diary was used to assist with the discharge planning for patients with complex needs. We were told the purpose of the diary was to reflect the care required by the patient and to ensure the patient was discharged to the most appropriate destination with the right level of care and support in place.
- A variety of risk assessment tools were in place to identify risks of thrombosis, pressure damage, moving and handling, nutritional and falls.

- Daily nursing records identified the care and treatment provided to patients in accordance with the care planning in place. Intentional rounding forms were in place and up to date to identify the contact with patients by nursing staff and the regular care provided.
- Daily fluid charts were in use on all wards to reflect the fluid intake and output for patients where concerns had been raised. There were inconsistencies regarding the completion of these charts, with some completed fully and others which did not identify all fluids taken. Some were not totalled to give an overall summary of the fluids taken in or excreted, against the fluid output. Staff we spoke with were confident this was a recording issue and not a lack of delivery of fluids.
- Lockable trolleys for storing patients' records were available on all wards and departments. When the trolleys were unattended we saw patients' confidential and personal information was stored securely.
- We observed a computer which had been left unattended. The screen displayed patients' confidential details which were visible to other patients and visitors to the ward. Information relating to patients was displayed on large interactive boards on the ward which could be viewed by visitors to the ward. The majority of this information was in a key format which staff understood clearly but visitors and patients on the ward would not understand easily and so protected patient privacy and confidentiality.
- Prescription forms for medical staff to complete for patients to fill at a local pharmacy were available in the medical admissions unit. The forms were stored securely and records of use were kept. However, these records were not audited in accordance with the trust guidelines. This meant the trust were not able to monitor the use of the prescription forms to ensure they were being used appropriately and in accordance with the legislation.

Safeguarding

- Safeguarding training was provided to all staff and was required to be updated annually. This was delivered by an electronic learning package or for Safeguarding Level 3 was delivered through face to face sessions. Data provided showed that the medical departments had achieved 84.03% of staff completing this training. Child protection training was provided to staff, the level of which was dependent on the staff member's role. Compliance with level 1 was 98.17%, level 2 92.20% and level 3 78.66%.
- Acute care of elderly training was provided to staff who worked on health care of the elderly wards and included information regarding the safeguarding of vulnerable elderly patients
- All staff we spoke with were aware of the hospitals safeguarding procedures. Staff were confident about what constituted a safeguarding incident and the action they would take to keep patients safe. The trust electronic system prompted staff to identify if an incident constituted safeguarding.
- Any safeguarding issues were consistently discussed at the multi-disciplinary meetings we attended and during ward handovers.
- Posters and flow charts for nurse actions and managing safeguarding concerns for vulnerable adults were displayed around the hospital.
- Safeguarding issues and action taken was planned to be included in the nursing assurance framework due to be rolled out at the end of April 2015 as a method of monitoring the compliance with the trust's safeguarding procedures.

Mandatory training

- A programme of mandatory training was in operation for all staff. This programme included moving and handling, safeguarding, infection control, basic life support and was required to be updated annually.
- Current mandatory resuscitation training compliance, as of January 2015, was 75.6% for staff who had completed this. The 2015 Quality Assurance Committee report recorded the risk when staff did not attend the training; this was currently 10% of the trust's clinical workforce and had been escalated to executive level via the Risk Register.
- Mandatory training completion was monitored on line by the trust's e-learning account system and Learning Management system and reporting. Information from the trust told us the target was for 95% of staff to be up to date with the mandatory training. However, the data collated from February 2015 showed that the trust-wide target was not met for the completion of moving and handling, basic life support and child protection training.

Medical care (including older people's care)

Assessing and responding to patient risk

- The trust identified patient alerts on the internal electronic system to ensure staff were aware of any general or patient specific alerts and the action to take. However, risks identified on this flagging system were not always mitigated against which could result in a risk to patient care. We were provided with one example and a reminder had been provided to all staff to be mindful of the patient alert system to prevent further incidences occurring. (For example, one patient regularly attended services to request hospital admission and specific medication. Although a clinical decision and plan for treatment had been made, which was to be followed when the patient presented to the hospital, this had not been carried out on one occasion.
- Risk assessments regarding moving and handling were in place for patients. An assessment was completed for patients on admission regarding potential risks from venous thromboembolism (VTE), although these were not consistently completed in full. We saw four VTE assessments which had not been actioned promptly as the appropriate medication was not prescribed until four days after admission thereby increasing the risk of the patients developing a hospital acquired thrombosis.
- The provider had taken action to reduce the risk to individual patients from falls. Equipment was available to reduce the risk of falls including alarmed mats, high / low beds. In some circumstances additional staff observations were put into action for example 1:1 care. A falls prevention group was in operation and reviewed the root cause analysis investigations which took place following a patient falling in the hospital. Information was provided to the weekly sisters/band 7 and 8 meeting regarding the investigation and any action/ learning that could be taken to prevent further falls.
- Following the admission of any patient with pressure damage, an electronic report was made and appropriate care documentation and equipment put in place to reduce risk of further pressure damage.
- The short stay unit had developed a handover tool which identified patient risks including patients at risk from falls, pressure damage, those with indicators on the early warning score system and ward issues such as staffing levels. This was used to inform the next shift of identified risks to patients.
- The trust had their own adaptation of the National Early Warning Score to indicate when a patient was becoming unwell and further advice or action was required. This system was knows as the 'track and trigger' chart. When the recorded observations of heart rate, respiration rate and blood pressure indicated a risk to the patient by being in amber or red areas on the recording chart, further advice should be sought. Actions that were taken were noted to be written on the forms of patients where it was necessary. Training for staff regarding the use of this system was provided at induction.
- The track and trigger document had been discussed at the matrons and senior sisters meeting the week before inspection. We were told an audit had been carried out which had found only 50% compliance rate of the tool which had not increased since the last audit in 2013. Learning was to be cascaded to staff regarding the completion of charts through team meetings and ward handovers.
- The hospital had a protocol in place for identifying patients who were at risk from septicaemia which was known as the 'Sepsis 6'. Some staff had a good understanding of the action to take when patients were showing signs and symptoms of septicaemia but not all had read the policy or were not aware of the 'sepsis 6' protocol.
- At busy times, medical patients were admitted to surgical wards if there were no dedicated medical beds available. These patients were known as medical outliers. We were told the decision to admit a medical patient to a surgical ward lay with the medical staff and was dependent on the stability of the patient's medical condition. We reviewed the medical and nursing records for approximately 30 medical outlier patients. We found the patients had received appropriate care and treatment with the exception of one patient. The patient had been admitted through the emergency department, transferred to the medical admissions unit and then to a surgical ward despite having a specialised medical condition. The patient remained on the ward for two weeks during which time the patient's medical records showed their condition had worsened. Records showed that observations had not been consistently monitored to determine the deterioration in their condition. This was addressed by staff during our inspection.

Nursing staffing

- Staff consistently told us that wards and departments were short of staff which raised concerns for them regarding the delivery of patient care.

- A full review of the staffing establishment (baseline for the numbers and skill mix of nursing staff allocated to each ward) on the medical wards was undertaken within the hospital approximately two years ago and additional staff were recruited following this exercise.
- During our inspection we identified that a number of wards were working under their staffing establishment and that a number of medical wards had vacancies for nursing staff. Ward nursing staff expressed frustration over staffing levels on the wards. For example, one ward stated that the establishment for that day should have been four registered nurses and five healthcare assistants instead of which there were three registered nurses and four healthcare assistants actually on duty that shift. Concerns were raised by staff in the two cardiac catheter laboratories and pacemaker theatre that this service was understaffed which had caused an extended waiting list for patients requiring treatment. There was no scrub nurse allocated to the pacing theatre and if this service was required a nurse was called from general surgical theatres. The ambulatory care unit had a staffing establishment of two trained nurses and two health care assistants on each shift. We were told and a review of duty rotas confirmed that often there was one trained nurse and one health care assistant on duty.
- The staff vacancies in the hospital showed a gap of 8-9% with a staff turnover of 10-11%. Staff were concerned regarding the vacancies in their staff teams and two people gave us examples of how long it took for their recruitment process to be completed so they could commence work. We heard one person waited six months from the date of their interview to starting work and another ten months.
- Staff told us that when staffing levels were not sufficient to meet the care and treatment needs of patients they contacted the matron or nurse on call for the hospital and completed an electronic incident form.
- The hospital held staffing meetings each day where senior staff attended from all wards and departments to review the staffing levels for the immediate 24 hour period and into the next week. We attended one of these meetings and observed staff were moved from better staffed wards to support other areas and that agency and bank staff were requested where necessary. The senior staff reviewed all areas and prioritised where staff were most needed. However, staff told us there were not always additional staff available either through the agency or bank to be able to work. During the winter months we saw incidents of staffing had been reported when additional beds had been opened but there had not always been sufficient or additional staff to provide patient care. Surgical wards were not always provided with additional staff to meet the differing needs of medical patients who were admitted to the ward at times of pressure. During the time of winter pressures, one surgical ward had been closed to surgical patients and converted to a medical ward. Staff told us that although it had been recognised by senior nursing staff that this required a change in skill mix and staffing levels, it had not been possible to fill the shifts with the appropriate level and numbers of staff. A benchmarking assessment had been carried out prior to our inspection regarding the numbers of health care assistant posts on surgical wards who admitted medical outliers. Three health care assistants had been appointed for one ward and were waiting for the appropriate checks to be completed as part of the recruitment process.
- Patients we spoke with during our inspection told us they considered there were sufficient staff on the wards to meet their care and treatment needs.
- Agency staff were provided with an induction to the ward at the start of their shift. An information folder was available on a number of wards to provide a reference point for agency and bank staff. Where possible agency and bank staff were booked in advance to provide consistency to the ward staff and patients.

Medical staffing

- Guidance from the Society for Acute Medicine and the West Midlands Quality Review Service (2012) suggested that a consultant should be on site or be able to reach the acute medical unit within 30 minutes. Staff confirmed that they had access to an on call consultant rota and that they were able to contact a consultant at all times for support and guidance.
- There was a shortage of consultants within the medical care group, particularly within the health care of the elderly speciality. Funding had been made available for ten consultant geriatricians but at the time of our inspection only four were in post. We saw from the consultant rota that locum staff were used to address the shortfalls whenever possible. Recruitment had taken

place but this had not been successful in appointing into the posts. The trust had sought external support in addressing this issue. For example from the Royal College of Physicians.

- The staffing establishment for medical registrars had been assessed at 20 but at the time of our inspection there were only 12 whole time equivalent medical registrars in post. To mitigate against this the trust was employing overseas registrars (MTIs).
- There was one medical registrar on call for all of the medical wards and new admissions to the medical admission unit (MAU) at night. This had raised concerns of patient safety and the trust was working with the Postgraduate Deanery to increase the number of registrars available to work at night. The Postgraduate Deanery is a regional organisation which is responsible for postgraduate medical and dental training, within the structure of the NHS.
- Medical staff informed us that they could be moved to different specialities to provide cover at very short notice due to the difficulties experienced in filling rotas.
- Doctors assistants worked on wards provide assistance with minor procedures and tests.
- The MAU held a safety brief at 8am daily which included the consultant, junior doctors and nursing staff. Following this a detailed handover regarding each patient, was carried out in each nursing bay. We saw that some patients had been admitted to a ward through MAU without being seen by a consultant. The daily safety brief identified these patients who were then prioritised on the ward for a visit from a consultant.
- Medical cover was provided to medical patients outlying on surgical wards from physicians and medical consultants. A system had been introduced for informing staff of the arrangements for the medical patients (medical outliers) who had been admitted to surgical wards. We were told by the clinical director for medicine that an email was sent to the matrons of all wards three or four times a week which outlined which consultant and medical team were to provide medical cover to each ward. We were provided with a copy of the most up to date email which clearly identified the medical cover during the week and out of hours for each ward which had medical outliers admitted to them. The system and information had not been cascaded to staff fully as a number of staff we spoke with on the wards were not all aware of this email. Therefore the process was not clear and consistent for which medical staff to contact in the event of the deteriorating or unwell patient or to arrange the patients discharge.
- The medical outlier consultants had individual bleep numbers and on the staff handover sheets we saw these numbers were included but did not specify which consultant was caring for which patient.
- Doctors and nurses gave us examples of when it had been unclear who to contact regarding the medical care of patients and time had been spent telephoning and bleeping different doctors before responsibility was clarified and had been handed over for the patient's medical care.
- The electronic bed management system in operation in the hospital identified the consultant cover for the medical outliers. However, not all staff we spoke with were aware of this or how to access this information.
- We saw the records of one patient which showed nursing staff had been unable to administer their prescribed medication for a period of 18 hours. This was due to a lack of specialist staff required to reinsert the patient's cannula which had blocked, in order to administer the intravenous medication. Overnight there had been one anaesthetist on call who had been working elsewhere in the hospital and had been unable to attend the patient.

Major incident awareness and training

- Staff were aware of the major incident policy and procedure that was available on the trust intranet.
- The hospital had an incident room which would be used during a major incident. This room was also used for bed management meetings which were held several times throughout the day to review and manage patient safety.
- Staff informed us that winter pressure arrangements had been discussed and information provided in September 2014 in anticipation of pressures on beds during the winter months.
- Over the previous three months, the hospital had experienced severe capacity pressures on beds with increased numbers of patients being admitted to hospital, in particular patients requiring medical care and treatment. Where patients were not able to be admitted to general or specialist medical wards, they were admitted to other wards for example, surgical

wards. The bed meeting reviewed the list of medical patients on other wards, known as 'outliers' and discussed the arrangements for transferring them to the appropriate ward as soon as possible.
- A senior nurse on duty each day was allocated responsibility for planning and coordinating should a major incident occur.

Are medical care services effective?

Good

Patients received good outcomes because they received effective care and treatment that was delivered in accordance with evidence-based guidance, standards, best practice and legislation. The trust participated in national audits and used the outcomes from audits to improve services.

Staff were trained and competent to deliver the care and treatment to patients on the medical wards and units. Staff worked well as part of multi-disciplinary teams to ensure a quality service to patients.

Staff used assessment tools to identify and monitor patients care needs and the effects of care and treatment.

Patients received their care and treatment from competent staff who were provided with supervision, appraisals and training.

Evidence-based care and treatment

- The hospital provided staff with information and guidance within the policies and procedures accessible through the intranet. The policies and procedures were reviewed regularly and were in line with national guidance provided by the National Institute of Clinical Excellence (NICE).
- A clinician had been asked by the trust to review practices in the hospital against national recommendations and report to the clinical effectiveness group.
- Endoscopy records were fed into national surveys through the Joint Advisory Group (JAG) accreditation system. The hospital had achieved JAG accreditation which demonstrated they had the competence to deliver against endoscopy measures.

Pain relief

- Staff had access to a pain assessment tool and we saw these in use on two wards we visited. On another ward a nurse told us how pain was assessed by observation and discussion with the patient. The pain assessment tool was not used on that ward.
- Staff were aware that the trust had a pictorial pain assessment tool available but we were told this was not used unless specifically required. The use of this tool was not indicated within the patient records we reviewed.
- Staff had access to a specialist pain team who worked across the hospital and were part of the critical care outreach team. We received positive feedback from staff who said this team responded promptly and provided good assistance to the wards and patients.
- Pain control was given regularly but we did not consistently see records which identified the patient was asked about the effectiveness of the medication following administration.
- We observed that one patient in MAU was in discomfort while waiting to be admitted to the ward. The patient told us the chair they were sitting in had caused them pain which was not related to the reason they were being admitted. The patient told us they had been waiting in the chair for two hours and needed to lie down. They had not been offered pain relief by the staff. However, once the patient had been allocated a bed they were able to lay down to relieve the pain. We visited this patient on the next day when they had been admitted to a medical ward and they told us they were comfortable and the staff had been excellent at meeting their needs.
- The hospital used a nationally recognised clinical opiate withdrawal scale (COWS). This is an assessment tool which rated eleven common opiate withdrawal signs or symptoms. The summed score of the eleven items can be used to assess a patient's level of opiate withdrawal and to make inferences about their level of physical dependence on opioids.

Nutrition and hydration

- Staff assessed patients dietary needs using a nationally recognised risk assessment known as MUST – the Malnutrition Universal Screening Tool. This identified risks and the actions staff were to take to reduce the risk to patients.
- A red tray system was in operation which indicated to ward staff that extra support was needed to be offered

to specific patients. We noted that this was not always reflected in the patient's care plan that this was in use and the specific assistance the patient required. The need for extra support around diet was also indicated for staff on the electronic board near the nurse's station.

- We observed meal times on two wards and saw nurses offered a variety of fluids and food to patients who needed help and encouragement and assisted patient to eat and drink when necessary. This was carried out in a discreet and sensitive manner.
- Protected meal times were in operation to enable patients to eat their meal without being interrupted. For example by medical staff or tests and procedures unless in an emergency. Staff respected the importance of this time. For example, the MAU staff had reviewed the mealtimes planned and had started serving the lunchtime meal half an hour later, to enable the doctors ward round to be completed so there was no encroachment on the meal time.
- There were facilities for providing food outside of planned meal times by contacting the support services who would provide a microwaveable meal.
- Hartor ward provided a 'grazer menu' which consisted of high carbohydrate diet with cooked breakfast, cooked lunch and cooked dinner with scones and cakes in-between and the use of full fat milk. This was available for people whose nutritional assessment identified such a need.
- We spent time on the wards and observed that the majority of patients had a drink within their reach. We saw four patients who could not reach their drink as it had been placed too far from their bed or chair.
- The Patient Led Assessments of the Care Environment (PLACE) 2014 scored the trust at 84 for food compared to the national average of 88.

Patient outcomes

- In the Sentinel Stroke National Audit Programme (SSNAP) for October 2013 to September 2014, the trust's stroke services attained an overall score of 'D', in September 2014, on a scale of A to E, with A being the best. The main areas identified which required improvement were speech and language therapy, occupational therapy and multi-disciplinary team working. The discharge processes were rated at 'A'.
- Data provided by the trust regarding the stroke pathway informed us that the aim of the pathway was that patients would arrive within four hours onto the stroke ward. Auditing showed that currently 56.4% of patients achieve this, with the median time of 3hrs 44 minutes. 76.2% of patients admitted to hospital with a stroke and who stay on stroke unit was 76.2%
- The trust had not contributed formally to the Myocardial Ischaemia National Audit Project (MINAP). Input into the collation of the audit had commenced this year 2014-15.
- The National Diabetes Inpatient Audit (NaDIA) outcomes from September 2013 showed 26.3% of patients with diabetes in hospital were visited by a diabetes specialist team compared to 34.7% nationally. 89.9% of patients were provided with a foot risk assessment within 24 hours of admission, compared with 36.3% nationally.
- The Cancer Patient Experience Survey 2013/2014 found the trust was in the top 20% of trusts regarding the action staff took to control the side effects of radiotherapy. They were in the middle 60% of trusts regarding explanations provided about and being involved in their care and treatment.
- Staff showed an awareness and understanding of the care needs of patients with diabetes across the medical wards and departments. Data provided by the trust informed us that there were four patients who had experienced a hypoglycaemic incident (lowering of the blood sugar which could lead to loss of consciousness) between 24 December 2014 and 24 March 2015 on the medical wards. Records maintained by staff evidenced that the blood sugars for patients with diabetes were monitored regularly.

Competent staff

- Staff reported that training was available for them to maintain their skills. Some staff reported being supported by the ward manager and the trust to undertake further training and develop skills to allow them to apply for a promotion.
- Registered nurses were provided with additional training to maintain or increase their clinical competencies. For example, the nurse led investigation unit enabled staff to complete training in occipital injections for the treatment of migraine.
- Health care assistants spoke positively of their developmental role and how training was provided to increase skills, knowledge and progression to a higher band grade. We were told the training was available to them by electronic learning which could be completed at home and the time claimed back. Staff had a clear understanding of how this worked and when they were

likely to be provided with training to increase their position at work. One health care assistant advised us they had funded their own training to move to a higher band role and another told us they had completed their training to a band four but were working as a band three while waiting for an available post.

- Clinical educators appointed at band 6 were in post and staff reported these members of staff as having a positive impact on clinical education. We heard from the renal ward that the level and frequency of training had increased greatly since the appointment of their clinical educator. The haematology and immunology wards identified frequent educational opportunities for staff and supported them to be able to attend the training sessions.
- Some staff were aware of the process for a patient presenting with sepsis named the sepsis 6. It was recognised by senior nurses that this knowledge was not trust-wide and a schedule of training was to be commenced. Information on the trust's sepsis management plan was provided to doctors during their induction.
- We talked to nurses regarding their clinical supervision and received a variety of responses. Some staff sought out their own clinical supervision from outside the hospital with others using interdepartmental clinical supervision or from their line manager. The provision and frequency of supervision was variable throughout staff teams, although all staff said their managers were approachable and informal supervision was obtained frequently with managers and senior nurses operating an 'open door system'. Formal supervision varied between one and three months in different wards and departments, although staff on one ward told us they did not have formal supervision.
- A formal appraisal system was in operation which was completed electronically. Staff commented this system was not always easy to use and included a large number of pages on the intranet to complete. Staff commented that the appraisal was a regular and positive experience.
- Medical staff who were new to the trust were required to complete an induction with training provided by electronic learning on the trust's processes and policies.
- Medical staff including consultants and associate specialists engaged in annual appraisals within the trust and re-validation process with the responsible medical officer. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice. Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by the trust and the General Medical Council.
- Junior doctors we spoke with had experienced concerns during the winter pressures regarding medical patients being outliers on surgical wards. This had led to junior doctors on a surgery rotation caring for medical patients. One doctor told us this had impacted on their learning but they had never been asked to work outside of their competencies as they were well supported by senior medical colleagues.
- The trust had recently applied to join the Royal College of Physicians initiative to recruit international trainees for respiratory and gastroenterology positions.

Multidisciplinary working

- There was evidence of multidisciplinary working within and between wards and departments in the hospital. We observed multi-disciplinary team meetings taking place on a daily basis in MAU and some medical wards. The multi-disciplinary teams included consultants, medical and nursing staff, therapists, specialist nurses such as the cardiac and oncology nurses, ward managers and a community social worker.
- We saw the patients care and treatment was discussed and action taken as a result of the meeting to progress the patient towards discharge. For example, following one meeting we evidenced a diagnostic test was immediately arranged for a patient who had experienced a delay in receiving the essential procedure.
- Information and treatment plans arising from the meetings were recorded in the patient's medical notes and reference made in the nursing notes when applicable. For example, when changes in the patients care plan agreed. The stroke ward had devised a recording tool to ensure all actions and discussions from the multi-disciplinary team meeting and ward round were captured.
- Physiotherapists and occupational therapists contributed to the single assessment process on some wards, in addition to the patient's hospital notes. The single assessment process is a record of the specific actions that are needed to support the patient on discharge from the ward.
- There was an integrated discharge team comprising of social workers, nurses and non-registered discharge

case managers employed by the local Council, Plymouth Community Healthcare and the trust, who supported ward staff with the arrangements for the discharge of patients with complex needs.
- The renal medical team provided support to other wards / specialities if they required guidance on meeting the renal care needs for patients admitted to other specialities in the hospital.
- Staff reported they had easy access and a prompt response from psychiatric liaison nurses when they needed further advice.

Seven-day services

- Consultants were available five days a week in the hospital and carried out daily ward rounds on their speciality wards. A full 7 day working system was in place for, Neurology, Renal, Gastro/Hepatology, Diabetes and endocrine, Acute Medicine and Cardiology specialities.
- Weekend ward rounds were in place 52/52 but there was a reduced presence from weekday in place for Healthcare of the Elderly and Respiratory.
- Patients who were outliers on surgical wards did not always see a consultant each day as we were told on some days the consultants were required to attend clinics as well as review patients on their speciality ward.
- There was a consultant presence in the hospital at weekends. We saw the duty rota for medical cover for the MAU and found that there was an acute physician of the day (AOPD) on duty from 08.00 to 13.00 and a medical take consultant from 8-12 and 5-8pm. Outside of these hours the consultant on call rota was available for registrars and junior doctors to contact them when required. On call cardiologists responded rapidly and came in when required by junior doctors. The cardiology registrar on duty attended MAU every four hours to review patients admitted with cardiac problems. The haematology and immunology department provided seven day consultant presence on the ward.
- A matron or senior nurse on call rota was in operation to ensure their availability by bleep at night and weekends when they were not on duty in the hospital.
- Weekend pharmacy is open routinely Saturday and Sunday 0900-1700 with on call provision outside these hours. The pharmacy provision was reduced to shorter days at weekends which we were told had resulted in delays when obtaining medication for patients or when arranging tablets for the patient to take home. MAU was provided with their own pharmacy cover over the weekend.
- There was weekend Allied Health Professional team support for assessment units and Short stay unit to support discharge.
- The ambulatory care facility for patients was increased to seven day provision when required. We saw that staff recorded patients' names in the MAU diary if they needed to attend the department for a continuation of their treatment. For example, for administration of medication such as intravenous antibiotics, or dressing changes. Their care was provided by the nurses on duty in the MAU over the weekend.
- Diagnostic services were available over seven days such as X-ray and computerized tomography (CT) scans. The pathology and blood services were also available over seven days.
- Mental health provision was available over seven days a week with psychiatric liaison nurses working Monday to Friday 8-8 and 9-9 at the weekends.
- One junior doctor reported that an out-of hours therapeutic endoscopy service was available and run by a consultant, so that if urgent endoscopy was required a consultant could be contacted through switchboard
- The trust employed one dedicated stroke nurse who worked four long days each week. At the time of our inspection there was no cover for the remaining three days. However, funding had been made available to recruit a further two specialist stroke nurses to increase the service to seven days from 7.30am to 8pm

Access to information

- When patients were admitted to wards and departments, information was available to the admitting ward from the previous care or health professional the patient had seen. For example, the MAU, Emergency department and in some cases the GP. Ward clerks collated patient records and ensured they presented the information to clinical staff in an ordered manner.
- We reviewed 40 sets of patient notes during the course of our inspection. Medical and nursing notes provided sufficient information to staff regarding the patients treatment and care planning. We observed that where

patients were admitted to wards other than the medical wards (known in the hospital as medical outliers) weekend plans were inserted in their notes to provide guidance and information for the out of hours doctors.
- The medical records did not provide information on which ward patients were seen by the medical staff. This did not provide a clear audit trail of the patient's journey through the hospital, who they were seen by and where. Nursing notes identified when patients were transferred to or discharged from wards.
- The hospital used an information document called 'Getting to know you' which was completed by patients and their representatives regarding the patients likes, dislikes, past history, preferences and choices to support the development of an individualised plan of care.
- Nursing staff had access to computerised screens which provided information about the patient. Staff could access test results, care records and other information about the patient electronically from the wards.
- A handover sheet was completed when patients were transferred from MAU. This was in addition to a verbal handover. Staff we spoke with were positive regarding the clarity of this information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had access to guidance and information on the trust's intranet regarding consent, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Policies and procedure were in place regarding restraint and a patient information leaflet was available about what restraint is and how and why it may be used.
- Staff demonstrated an understanding of the MCA and DoLS and were clear about the processes they would follow if they suspected a patient did not have capacity to make decisions about their care. However, staff were not aware of what the independent mental capacity advocacy (IMCA) service was. This was in place to support people who did not have a representative, or when they would use this service.
- We observed that verbal consent was sought from patients prior to providing personal care.
- Written consent for a medical trial was evidenced which clearly indicated the patient had been provided with a full explanation, had given consent and was signed and dated by the medical staff and patient.

Are medical care services caring?

Good

We found the service provided was caring and that the staff involved and treated people with compassion, kindness, dignity and respect.

Quality surveys showed most patients and/or their representatives would be extremely likely or likely to recommend the service they used to their family and friends. Patients identified staff promoted their privacy, dignity and wellbeing.

Information was provided to patients and their representatives regarding their care and treatment plans. Written information was available regarding specific illnesses and associated treatments.

Specialist nurses and clinicians were available to provide additional support to patients and staff when necessary.

Compassionate care

- During our inspection we saw patients were treated with kindness, compassion and respect and staff showed empathy to patients they cared for. Patients' dignity was promoted and we saw curtains were drawn when staff were delivering personal care.
- Prior to our inspection we spoke with people who had previously had experience of the medical services provided at the hospital. People commented that the wards were busy and one person said "The staff are so overstretched and overworked that the compassion the hospital once showed was now non-existent." Patients we spoke with during the inspection reported that staff were kind, caring, considerate, respectful and helpful. People said "staff are great", "they made me feel better from the moment I got here", "the nursing is brilliant, they ooze confidence and the HCAs are really good and they know what they are talking about", "care is good" and "the staff are a joy".
- The medical services used the Friends and Family test to seek feedback about patients' experiences in the hospital. Individual wards provided the outcomes of this feedback for patients and visitors to see.
- The trust monitored the response rates to the friends and families quality monitoring surveys. The medical wards response rates varied which could be attributed

to the speciality of the ward. The lowest average response rate was from a health care of the elderly ward which had an average response of 29%. The renal ward had the highest response rate of 93%. MAU responses were higher than their determined trust target of 20%. In March 2015 a 37% response rate was received with 96% of patients extremely likely or likely to recommend the service. Two of the medical wards had received a response rate of 90 and 93% which showed positive feedback about the patient experience. The audits of the surveys we saw showed that a large majority of patients were likely or extremely likely to recommend the service to their family or friends.

- The Patient Led assessments of the Care Environment (PLACE) 2014 scored the trust at 88 for privacy, dignity and wellbeing compared to the national average of 87.
- The Cancer Patient Experience Survey 2013/2014 found the trust was in the middle 60% of trusts when patients rated the care as excellent or very good and were given enough privacy when being examined or treated.

Understanding and involvement of patients and those close to them

- During our inspection we observed staff provided information to patients and their representatives regarding their care and treatment. We saw one person was provided with a leaflet regarding their condition by a member of staff who spent time discussing the content of the leaflet and provided additional information to the patient.
- The patient records showed evidence of when representatives, for example family members, had been involved in the care and treatment plan. This was particularly evident around discharge planning.
- Patients we spoke with made positive comments about the information which had been provided to them. One patient told us "staff good, always got on well with them on each admission and doctors are very good at telling me what's going on". There were also some concerns raised by patients regarding conflicting advice that had been given by different health professionals and not being provided with full information. For example one patient said they had not been told about their care and treatment plan and said they were "too nervous to ask".
- One person we spoke with was distressed that they had telephoned the ward on six occasions during the evening their relative had been admitted to enquire after their wellbeing. On each occasion they were informed the nurse was unable to come to the phone but would return their call. However, this had not happened. The following morning they did receive a telephone call during which the nurse apologised, provided an update and advised them of the complaints process.

Emotional support

- The Cancer Patient Experience Survey 2013/2014 found the trust was in the middle 60% of trusts for patients being able to discuss worries or fears with staff during their visit and receiving information about support groups.
- Clinical specialist nurses were available within the hospital and provided support to patients with asthma, sleep apnoea, home ventilation systems, chronic obstructive airways, stroke, mental health, learning disabilities and dementia care.
- Chaplaincy support was available when required.
- Doctors assistants (staff trained in specific skills such as venepuncture and catheterisation) spent time talking with patients and found patients more likely to speak to them than a nurse or doctor. They told us they became a communicator between the patient, their relatives and medical and nursing staff.
- Volunteers were seen on wards talking to patients, taking orders for the shop and liaised between the patient and nursing staff.
- There were facilities on wards for the patients and staff to meet when sharing bad news, having difficult conversations and counselling. One patient told us a consultant spent 40 minutes with them and their relative discussing their care and treatment and result of tests. They found this discussion very helpful but would have appreciated a private room for this take place in.

Are medical care services responsive?

Requires improvement

Services did not always meet people's needs. The cardiology referral to treatment times did not meet trust targets and people were waiting for longer than 18 weeks to access care and treatment. Patients experienced delays

in discharge and were unable to leave hospital when they were medically fit. A discharge team were in operation within the hospital working towards improving the discharge process for patients with complex needs.

Patients who required medical care and treatment were not always provided with a bed on a medical ward and medical outliers were admitted to surgical wards. Staff were not always aware of which doctors were providing specialist medical care and treatment to the medical outlier patients. Patients experienced transfers within the hospital wards often late at night and on more than one occasion during their stay.

Not all patients were aware of how to make a complaint should they need to do so. People provided us with information on the lack of response they had received from the Patient Advice and Liaison Service (PALS) when they had raised concerns / complaints.

Service planning and delivery to meet the needs of local people

- Additional endoscopy clinics had been provided, including at a weekend to meet additional demand for the service and reduce the waiting time for patients.
- The ambulatory care unit had been extended to enable patients to receive care and treatment over the weekend when necessary.
- The trust held regular bed management meetings throughout each day. Immediate decisions were made to manage the bed situation across the trust at these meetings. The location of the medical outliers in the hospital was discussed during these meetings and if possible plans were made to transfer them to specialised wards to continue their care and treatment.
- The complex discharge team communicated on a daily basis with external providers and commissioners of care to seek appropriate care and support for patients who were medically fit to be discharged. We were told there were delays caused by a lack of services in the community. The complex discharge team were able to prioritise patients for discharge and because they were aware of the care services and support available, ensure the patient had the most appropriate support when leaving the hospital.

Access and flow

- The trust had a bed occupancy rate of between 82 and 86% between April 2013 and September 2014 which was better than the England average. The trust had higher percentages in delayed transfer of care between April 2013 to November 2014 than the England average due to delays in completion of assessments and waiting for further NHS non acute care packages.
- The cardiology referral to treatment times were outside the trust targets. For example, the number of patients admitted within 18 weeks fell below the 90% target. Between April and December 2014 the number of patients admitted within 18 weeks ranged from 60 – 76% for seven of the eight months, with one month 81% being admitted.
- Referrals to the cardiology service without admission ranged from 77% to 90% between April and December 2014.
- Endoscopy waiting times had been reduced to between six to eight weeks following additional clinic time being put in place. Data showed that in 2013 there were 400 breaches around the waiting time while in March 2015 there had been nine.
- Data provided by the trust identified that the referral to treatment time for patients with a cancer diagnosis was within the two week wait target.
- There was a waiting list of 16 weeks for patients requiring cardiac pacing procedures. A further delay was often experienced by patients who were medical outliers as they required a cardiac bed prior to the procedure taking place.
- Medical patients were admitted by referral from their GP to the medical admissions unit (MAU) or via the emergency department of the hospital. MAU provided a single bedded triage area where the patient could be assessed and directed to the most appropriate ward area for their needs or admitted to MAU.
- There was an ambulatory care area where patients needing short term care were looked after. One patient we spoke with in ambulatory care told us they had been waiting to be seen for two hours, following our conversation with them they were seen straight after. Two other patients had been waiting for treatment for one hour each.
- Patients identified as suffering a stroke followed a pathway to speed up the effective treatment including thrombolysis. The stroke pathway in the hospital was being developed and two additional stroke nurses were to be appointed to provide a seamless stroke service to patients. There were tensions within the hospital between specialities requiring the same equipment and

environment. For example, the shared use of the CT scanner between the trauma and stroke specialities and between neurology and stroke patients in accessing beds on the specialist ward. The pressure on specialist stroke beds had resulted in patients being moved to an alternative ward to enable new patients with a stroke to be admitted to the stroke ward.

- During the winter of 2014/2015 the trust admitted to difficulties in caring for medical patients on the allocated medical wards. This resulted in a high number of medical patients being cared for on surgical and trauma wards. One ward which had previously been an orthopaedic surgical ward had been changed into a medical ward to provide continuity of medical and nursing staff to patients and provide additional beds for patients requiring medical care and treatment. The planned investigation unit (PIU) which had been nurse led provided care and treatment to medical outliers when necessary and part of another ward known as the conservatory had been opened for PIU patients who were now on the ward together with medical outlier patients.
- Other surgical wards were also used to provide care and treatment for medical patients. A buddy system was put into place to support the staff on surgical wards caring for medical patients; support was from staff experienced with caring for medical patients. Since the winter bed pressures had reduced some surgical wards were no longer required to provide medical care and treatment on the ward.
- We reviewed the records for one patient who was a medical patient admitted to a surgical ward (a medical outlier). The records showed a joint care plan by the medical teams between general medicine, general surgery, plastic surgery and dermatology. The medical registrar had agreed the patient should be transferred to a medical ward but in fact they were transferred to a different surgical ward which medical staff did not have a link with. The patient's records identified specialists offered advice but there was no clear lead for the care and treatment.
- We saw medical records for two patients who were medical outliers which showed no review by a doctor over a three day bank holiday weekend and there had been no weekend plan provided. The nursing notes identified there had been no concerns regarding their medical condition and that the nursing staff had not had reason to consult a doctor.
- We saw evidence that some patients were transferred between wards several times during their stay. For example, one patient who was admitted from the emergency department to MAU experienced two further ward moves, two of which showed the transfers took place during the night at 1 am and 12.30am. Records showed one patient was transferred twice in one night to make a bed available for further emergency admissions. Another patient had been transferred between four different wards during their stay in the hospital. This did not ensure consistency or continuity of care for the patient.
- Ward staff expressed concern at this practice and gave clear examples of how this had a detrimental effect on patients. They were concerned that beds were often available on the ward in the afternoon or early evening but due to demands and pressures on porters and poor communication, transfers did not always take place at reasonable times.
- There was a complex discharge team working within the hospital to assist patients with additional requirements following discharge. This was an integrated team which included social care staff who worked for the local council and health staff and provided a single point of contact for wards when preparing a patient for discharge. The discharge team attended multi-disciplinary meetings within the hospital and wider community. A single assessment process was used so that the patient was not subjected to repeated assessments and questions.
- Patients who were waiting to be discharged remained on the ward until medication was available for them to take home and the transport arrived to collect them. In some cases, if a patient was dressed and mobile, they were able to wait in the ambulatory care or short stay unit until they were ready to leave thus opening a bed for another patient on the ward.
- A daily report was compiled which identified the number of patients who were waiting to be discharged from hospital. This was discussed during a teleconference each day which included staff from external organisations in an attempt to process packages of care and support to enable patients to leave the hospital. Numbers of delayed discharges across the medical services had varied from 18-40 per week between January and March 2015.

Meeting people's individual needs

Medical care (including older people's care)

- All of the wards had accessible information leaflets for patients to access regarding a variety of medical conditions. All of the leaflets were in English.
- Translation and interpretation services were available and staff knew how to access these. Pictorial cards were available in the hospital to assist with communication for people whose first language was not English or had additional needs.
- Facilities were in place throughout the hospital for patients and visitors with physical disabilities for example, disabled access to all areas and the provision of toilets for the disabled. The disabled parking was located by an incline and patients told us this had caused them or their relatives problems in reaching the hospital safely.
- We saw staff provided additional care to one patient who was hard of hearing and a discreet sign had been placed at their bedside to advise all professionals. However this was not recorded in the patient's records to ensure all nursing and medical staff were aware.
- The hospital had a dementia care lead nurse and consultant who provided support to staff and patients. The Alzheimer's national dementia friend scheme was in operation. This is a programme for people to learn more about dementia and the ways in which people can help others living with dementia. The hospital also awarded wards within the hospital a plaque to show they were 'dementia friendly' once they reached the required standard. A number of the medical wards had been awarded this.
- The hospital environment was being refurbished to reflect the care and support needs for people living with dementia. We saw that thought had been given to the colour of the walls and bays and rooms on the wards and were painted in different colours to enable patients to find their bed. Signage throughout the hospital assisted patients and visitors with dementia by the use of pictures and colours.
- Patients living with dementia were identified by discreet identification on the staff whiteboard and in their notes to ensure staff were all fully aware of their additional needs.
- Learning disability resources were available on the wards for staff and provided contact details for specialist staff, communication tools and learning material for staff.
- The endoscopy unit had a clear plan when providing care and treatment to patients with a learning disability. When the patient's appointment was booked the administrative staff contacted the hospital learning disability specialist team to advise them of the forthcoming appointment, they would provide additional support to the patient prior to and during their appointment.
- One care of the elderly ward had refurbished their day room to provide a more homely atmosphere and had furnished and decorated this in the style of a 'front room'. Activities were available on the care of the elderly wards for patients to access. For example, memory boxes, reminiscence tools, dusters and socks to pair together, jigsaws, board games, television and music provision.
- There was a magazine trolley that visited all wards and departments for patients to be able to purchase reading material but there was no set time to this for patients to access this facility.
- There was no information identified in wards and departments regarding use of the free WIFI in the hospital.
- On MAU, the patients had access to a television in the ambulatory care waiting area. However the chairs in this room were upright dining style chairs and would not be comfortable to sit in for any length of time.
- Multi-cultural faith policies were available to staff on the intranet. Staff informed us of relative rooms which enabled relatives to stay overnight in the hospital and were available for private prayer. They added this was because while the hospital had a chapel there was not a multi faith area. We later established there was a multi faith area, although this was not sufficiently large enough for the numbers of people who required wished to use it. A reconfiguration plan was being discussed by the trust. Positive comments were received regarding the pastoral service available to patients and staff.
- The Acute Oncology Service provided patient assessment and support within 24 hours of emergency admission for patients with acute cancer-related complications such as toxicity arising from chemotherapy and radiotherapy.
- Call bell audits were carried out by wards and departments and showed positive outcomes. The audits were carried out from colleagues from another ward. Patient feedback we received during our inspection identified bells were answered within approximately five minutes. We rang a call bell during the inspection and found staff responded within six minutes. Staff worked

within bays and had been provided with desks within the bays to complete their paperwork. Staff made positive comments about this and said they were on hand to monitor patients, answer call bells promptly and provide care immediately.

- During our inspection we observed three wards for the accessibility of call bells for patients and found all call bells, with the exception of those for four patients, were within reach of the patient.
- Ward staff took into account feedback from patients. We saw in one clinical area equipment for transferring information around the hospital had caused distress to one patient due to the noise it made. Remedial action had been taken to reduce this noise.
- We received mixed views from patients on the quality of the food they were provided with. 12 patients we spoke with on MAU all said the food was good and they felt it was nourishing. On other wards we received variable comments with patients stating "food is good and good choice, can always find something on the menu", "excellent", "terrible", "not good" and "the food has improved over the years". Two patients who had experienced frequent admissions to the hospital commented that they had noted the "food was of better quality and was served hotter than it had previously been" and "it is the best it has ever been".
- The trust had a member of staff who was designated as the nutritional lead. This person tasted the food as part of their quality monitoring process.
- One patient told us that their meal had been cold as it had been served at the same time as their transfusion was taking place and they could not manage to eat it immediately. However, staff had provided them with a cold snack instead which they had been satisfied with.
- We spoke with one matron who had implemented the serving of the main course and dessert at different times to allow the dessert to stay at the correct temperature while the patient ate their main course and to prevent confusion in those suffering a degree of dementia. This had been introduced following the use of an observational tool which was completed to improve quality of care for patients.

Learning from complaints and concerns

- Information was available to patients on how to make a complaint. The Patient Advice and Liaison Service (PALS) provided support to patients and relatives who wished to make a complaint. PALS leaflets were seen throughout the hospital on wards and information racks, although there was a lack of posters or directions regarding how to access the PALS team.
- Prior to and during our inspection, patients and members of the public told us they had found difficulty in accessing PALS and had had received no response to telephone calls made to PALS.
- Fifteen patients we spoke with said they would not know how to make a complaint but had felt no need to do so. Two patients had heard of PALS but had not needed to use them.
- Senior nursing staff, for example at band 6 and above received complaints management training in order to conduct investigations and take action following any complaints received.

Are medical care services well-led?

Good

Medical services were rated as well-led. Quality of services was reviewed in board meetings and in other relevant meetings within the medical division. Information regarding the vision and values of the organisation was available in some areas of the hospital and senior staff were all clear of these. Not all junior staff were familiar with the aims. Staff told us there was a positive culture within the hospital and they were proud to work there.

The senior leadership team were visible on wards and departments with staff showing an awareness of the senior team and making positive comments regarding their presence on the wards.

We saw evidence of innovative practice within the medical services. Staff were confident that they were able to make suggestions and were provided with support to implement innovative practice.

Vision and strategy for this service

- The vision of the trust was to deliver excellent care, teaching, training and carry out research.
- Senior wards staff were able to tell us about the trust values which had been agreed in 2007 following consultation with staff. The values were putting patients

first, take ownership, respect others, be positive and listening, learning and improving. However, junior staff were not as familiar with these values. Information was available on some wards regarding the values.

Governance, risk management and quality measurement

- The medical care group within the trust had a risk management and governance programme to ensure that the trust board were aware of the key risks and action being taken.
- Meetings were planned to ensure risk and governance were discussed, reviewed and recorded. Each individual service line held governance meetings. These were linked into the three monthly meetings held by the medical services directorate governance care group management team, who in turn reported to the quality governance and risk manager Trust Management Executive. The clinical director of the medical care group attended senior management meetings
- Different departments and wards had their own governance arrangements. For example, the gastroenterology department held a governance meeting on alternate months, during which clinical and business issues were discussed such as adverse events (endoscopy), complaints and compliments, complex case discussions, staffing issues and strategic capacity.
- The medical care group held a consultants meeting which ward managers attended to identify and discuss any issues regarding medical cover and systems and processes in operation. Minutes from these meetings were maintained and available to staff.
- Local risk registers were in place and staff showed awareness of issues that had been raised and identified on the ward risk register. For example, one ward had identified the staffing levels against escalation of beds when numbers of beds had risen but there were insufficient staff to care for additional patients. The issue had been raised to the senior nurse for medicine and the number of beds reduced. Another ward had identified that each bedside did not have permanent oxygen and suction available. The risk had been mitigated by the provision of portable equipment.
- A partnership working agenda was in operation with the three local community health providers and three unitary providers working with the hospital to identify and address risk issues.
- Medication errors were reviewed at the Medication Governance Committee and learning shared across the hospital.
- The medical care group director and management staff were clearly passionate about delivering a quality and safe service to patients but acknowledged there were areas to be addressed. For example appointing additional medical staff. To streamline the medical intake process on MAU the Royal College of Physicians were visiting the hospital in May 2015 to give advice.

Leadership of service

- The services provided by the hospital were divided into service lines. The medical care group was led by a manager, senior nurse and clinical director and included medical specialities provided by the hospital.
- In some cases the services crossed boundaries with different managers. For example, the cardiac catheter laboratory service came within the medical service line and also the surgical service line when using theatres. The management of the facilities was with the estates and a business plan had been put forward to increase the provision for recovery within theatres.
- Staff were positive regarding local leadership, particularly from the matrons of specialities. The matrons were visible on the wards and staff consistently told us they visited the wards several times a day and were approachable.
- Two of the wards we visited provided care and treatment to patients who were admitted on a regular basis. Patients told us they had observed that the ward they frequented was more organised since a new matron had been appointed to manage both of these wards.

Culture within the service

- Staff told us they were proud to work for the trust.
- The trust had developed a celebration award for staff which required peer nomination. Staff we spoke with were complimentary about this process. Information about the award was published on the trust's website on the intranet and within newsletters. Another award scheme to recognise staff was managed by an external agency and was known as the WOW award. Staff were less complimentary and / or knowledgeable about this scheme.

- A chairman's award and a team of the year award were in place in the hospital. Staff were proud to tell us about nominations for these awards.
- We were consistently told by staff that the culture within the hospital had improved over past two years. During our conversations this was attributed to changes in senior management staff.
- The NHS staff survey 2014 identified staff experiences of harassment, bullying or abuse from other staff within the trust was within expectations and similar to other trusts. Staff we spoke with during the inspection confirmed this and said they felt supported by management at both a local and senior level and all spoken with reported there was no culture of bullying or harassment.
- Staff felt valued by the trust and we were informed by staff that they received good support from their managers and the trust when returning to work after a period of leave, for example maternity or sick leave. One member of staff was pleased to be able to have a phased retirement programme available to them. This meant they had a plan to reduce their hours gradually over a number of months leading up to their retirement.

Public and staff engagement

- Patients who attended the hospital for dialysis treatment told us they had recently set up a support group which met monthly. This was supported with a member of staff acting as liaison between the group and the trust. The chief executive officer had also attended previous meetings to discuss the groups suggestions for improvement of the service.
- The Director of Nursing had introduced 'back to the ward' days. This involved them working clinically on the wards one day a week. Staff spoke positively of working with Director of Nursing in this way and had found him to be approachable. One member of staff told us that they had appeared very interested in the staff members experience of working for the trust and had felt listened to.
- There was an allocated director from the board who visited different wards and departments in the hospital each day. Not all staff were aware of this or were confident they would know who the directors were.
- Patients and their representatives were encouraged to complete Friends and Family quality surveys and the results were displayed on wards together with any action that the trust had taken as a result.
- Following the trust's staff survey in 2013 work was undertaken to improve employee engagement within the trust. A philosophy was introduced called the Plymouth Way which aimed to improve the supervision and engagement of all staff.
- There were opportunities for staff to attend monthly information sharing presentations from the Chief Executive Officer. This was open to any member of staff but we were told it was usually senior staff who attended. Some staff said they were provided with information about this meeting but not all staff were aware of this. Information provided to us by the trust identified that an average of 20-25 members of staff made bookings for the monthly meeting.
- 'Effective team working the Plymouth way' interventions had been arranged for a number of wards and departments. Information from the trust informed us that to date 1300 members of staff have attended the above sessions.
- The trust board cascaded information and news items to staff by email and within electronic alerts and newsletters.

Innovation, improvement and sustainability

- We saw a number of areas where innovative practice had taken place. Staff told us they felt encouraged and welcomed to share ideas to improve the quality of care provided to patients and felt listened to by senior staff.
- Hexworthy ward had set up and were running reflective practice workshops for wellbeing and support to provide a debriefing and stress management programme for staff. Input into these workshops was received from the chaplain.
- Desks had been placed in nursing bays for nurses to complete paperwork. Staff believed this had correlated to a reduction in falls as patients were under frequent observation.
- A clerking and assessment booklet had been introduced for use with patients over the age of 75 but following the success of the document it was now used for all patients on elderly care wards.
- 24 and 48 hour care diaries were in use to avoid unnecessary or repeated examinations and assessments for patients with additional needs. For example, people living with dementia or learning disabilities. This documentation also provided evidence and information for families regarding the care and treatment delivered when they were not present.

Medical care (including older people's care)

- Tea with matron had been introduced which provided the patients and staff the opportunity to discuss any actions with matron over a cup of tea and cake. We spoke with two patients who had attended one of these sessions which they had enjoyed. They told us there had been the opportunity to talk about their experiences while a patient in the hospital.
- A pressure ulcer mirror had been developed to assist in the monitoring of potential pressure damage to patients heels. All of the staff in the trust had been provided with the mirror and the designer had been nominated for a celebration award in trust.
- A project known as 'project search' was in place in the trust. This was a joint initiative with external organisations with Derriford Hospital supporting an internship programme within Derriford with aim of assisting young adults with a learning disability to gain sustained mainstream employment.
- A trial with the ambulance service was due to start in May 2015. This project would enable patients assessed as having an onset time of a possible stroke within 6.5 hours, to be taken directly for a CT scan with the ambulance crew rather than via the emergency department.
- A business case had been prepared for the implementation of a thrombectomy service (the surgical removal of blood clots) based on research evidence from Sweden. The research had shown good results for patients.
- A system to enable reflective practice workshops for the wellbeing of staff to debrief after stressful situations had been devised and implemented. Staff who had attended the workshop were positive regarding the opportunity to discuss the situations they had experienced.
- The Acute Oncology Service were shortlisted in the Cancer Care category of the national Patient Safety and Care Awards in 2014.
- We were shown a nursing assessment and assurance framework which had been developed by the heads of nursing for medicine and surgery to include a nursing dashboard and assurance framework to be launched in April 2015. This was based around the trust's values and would enable monitoring of compliance with CQC's safety and quality key questions. The initial proposal was to carry out a benchmarking assessment of each ward and department which would result in an action plan where necessary. The frequency of the repeated assessment would depend on the outcome and range from between two and eight months.

Surgery

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

Information about the service

Plymouth Hospitals NHS Trust provides a range of surgery at Derriford Hospital. These include day surgery, plastic, renal transplant, cardiac, vascular, thoracic oesphagogastric, ear nose and throat (ENT), urology, trauma and orthopaedics, colorectal, neurosurgery, breast, bariatric and upper gastrointestinal. The trust is a designated cancer centre and major trauma centre.

The trust has 10 surgical wards, a day surgery admissions unit (Fal) and a day case recovery unit (Postbridge).

The theatre complex currently comprises of 31 operating theatres which include:

- Main theatres: 16 theatres and a recovery area;
- Freedom Unit: day of surgery admission unit, five theatres and one minor operations suite;
- Cardiothoracic theatres: five theatres and a recovery area;
- Royal Eye Theatres: day of surgery admission unit, two theatres and recovery area.

We visited all of the surgical wards, the preadmission clinic, the day surgical admission unit and the day case recovery unit. We spoke with 110 staff, including theatre managers, the head of nursing, matrons, ward sisters, consultants, senior doctors, junior doctors and nurses. We also talked with healthcare assistants, pharmacy staff, occupational therapists and physiotherapists. We spoke with 27 patients and six relatives. We observed care and looked at 31 sets of patients' records. We reviewed data provided in advance of the inspection

Interventional radiology is mentioned in this report, but they are not managed under the surgical care group. The management arrangements are via the diagnostic and imaging service line at the trust.

Derriford Hospital had 39,285 surgical admissions from July 2013 to June 2014. Of these 43% were day case admissions, 26% elective admissions and 31% emergency admissions.

Surgery

Summary of findings

While services were seen to be caring and compassionate across all areas, improvements were required to ensure that surgical services were safe, responsive and well led. Staff were encouraged to report any incidents on the trust's system. However, junior doctors were not consistently doing this. Learning from incidents was shared at ward and unit meetings. Staff told us the trust had an open culture and they were not blamed when things went wrong.

Prior to our inspection, the trust had increased pressures on their services where they had a very high number of unplanned admissions. This had resulted in a high number of elective operations being cancelled. Their elective orthopaedic ward had been turned into a medical ward to cope with the pressure for their beds. This had also affected their referral to treatment times on some of their surgical specialties. Due to this pressure, the number of medical and surgical outliers had increased on the surgical wards. Some staff felt they did not always have the skills or knowledge to meet the needs of these patients.

We were concerned that mistakes found with the prescribing of insulin was potentially placing diabetic patients at risk of receiving the wrong insulin or not having any at all.

The trust was not meeting its mandatory training targets. Staff told us they did not always have time to complete the training, or training was cancelled due to the increased pressures on the hospital services.

The environment in interventional radiology was not fit for purpose. Patients did not have a waiting area and they were recovered in a corridor post procedure. This meant their privacy and dignity was compromised. The trust had plans to reduce the number of beds in some of their bays on their surgical wards because of the constraints with space.

We found that not all patient records were stored securely on Fal or Postbridge units. Fal had lockable cupboards but these were not always locked. We also found that not all patients care plans and risk assessments were up to date with their current care needs.

There was good multidisciplinary working within the wards to coordinate patients' care. Information was provided for patients about their operations, and patients were able to ask questions and were kept up to date on their progress. The trust had processes in place for obtaining the consent from the patient, and other arrangements were in place for patients who were not able to consent.

Patients we spoke with praised the staff on the wards and units we visited. We found some areas where patient privacy could be improved. We saw each ward had dedicated protected mealtimes and used a system to identify patients who required more assistance. We found this worked very well on the majority of wards.

Not all staff were aware of the trust's visions and values. Staff on the wards and units told us they felt supported and listened to by their management team, surgical care group management and executive board. Governance systems were in place for monitoring their services. Any serious risks were shared with the executive board.

Surgery

Are surgery services safe?

Requires improvement

Improvement was required in the safety of the surgical service. Staff of all grades were encouraged to report any incidents on the trust's system. However, junior doctors did not consistently reporting incidents. Learning from incidents was shared with staff on wards and units.

The number of staff having completed mandatory training for all staff did not meeting trust targets.

The environment in the interventional radiology department was not fit for purpose. There was no waiting area and patients were being recovered in a corridor following their procedure, where they waited to be taken back to the ward or unit.

Mistakes found with the prescribing of insulin was potentially placing diabetic patients at risk of receiving the wrong insulin or not having any at all.

Staffing on wards were at times below their recommended safe levels and staff told us that they did not always have the skills and knowledge to meet the needs of medical patients or patients of other surgical specialities, accommodated on their wards.

We found that patients' records were being stored securely on the surgical wards, but, this was not always the case for Fal or Postbridge units. This meant unauthorised people could have had access to these records. Not all patients' care plans and risk assessments were up to date which meant patients could have been at risk of inappropriate care or their needs not being met.

Incidents

- The trust had reported two Never Events in surgical services in 2015, one in January and the other in March. Never Events are serious, largely preventable patient safety incidents, which should not occur if the available preventative measures have been implemented. Both incidents were being investigated. The longer investigations for both were in the process of being undertaken. We were told both patients involved had been informed of the incidents and were being kept up to date with the investigations.
- We were shown a team brief for theatres dated 15 April 2015 from the surgical care group. This had details about recent Never Events and serious incidents.
- We were informed of a very recent near miss incident prior to our inspection where two patients with the same name were mixed up and this was not picked up until one patient was in theatre. Correct scans and notes for the patient in theatre were able to be obtained so the operation went ahead with the correct operation for patient.
- On Postbridge unit we saw 'red' safety alert notice on display in the staff room regarding the above incident and it listed the actions staff must take to prevent this from happening again.
- Nursing staff across all grades reported they knew how to raise concerns and they regularly used the incident reporting system. They felt the trust had a no-blame culture and they learnt from any errors or incidents that had taken place. For example, we were told about the learning from a serious incident and how practice had changed. This related to the use of certain type of neck line used to deliver medication and the clamps used on these. Patients who now had these lines inserted could only be cared for on the critical care unit and not on wards. They told us the findings of their investigation was shared with the family of the patient. Junior medical staff told us they rarely reported incidents, as they felt they did not have the time to complete incident forms which were time consuming. They also felt they did not have any response from the trust about the outcome of incidents reported.
- One patient on Braunton ward told us they had sustained a post-operative complication. They were told about it promptly and staff did as much as they could to efficiently arrange their transfer to another hospital in Cornwall for emergency vascular surgery.
- We were shown copies of a newsletter for staff that detailed any incidents that had taken place and actions taken to reduce them from happening again. The newsletter was called Emmentaler and was published two monthly.
- Theatres had weekly incident meetings where any incidents were discussed in detail and any actions that were required. These were then disseminated to staff at their meetings.

- All ward or unit managers, matrons and head of nursing for each care group reviewed all reported incidents. They then fed back any learning to the ward or unit staff at ward meetings. Incidents were also discussed at the clinical governance meetings for each care group.
- Within the surgical care group there were a total of 27 incidents reported to the Strategic Executive Information System (STEIS) for the year 2014/15. These incidents were, for example, pressure ulcers, slips/trips/falls and allegation of assault by a health care professional. We saw that these were discussed in governance meetings and learning was shared with staff in ward or unit meetings.
- Staff were able to tell us about the principles of the Duty of Candour regulations. They told us it was about being open and transparent with patients following incidents and apologising to them.
- We saw records of morbidity and mortality meetings. These were held for each of the surgical specialities, for example, vascular and trauma and orthopaedics. We were shown the trust's monthly data for each speciality on their mortality ratings and targets.

Safety thermometer

- We saw the surgical wards had information about harm free care on display. There was evidence of the monitoring of pressure ulcers on all surgical wards, and this was clearly signed with displays showing the number of days since the last event.
- Wards had a grid on display indicating for that month if they had a fall or pressure ulcer. A red cross was put in if a patient had a fall or pressure ulcer otherwise it was a green cross for harm free days. For example we saw for April 2015, on Crownhill ward had no incidents of pressure ulcers and had only one patient fall.
- Lynher ward also had their harm free care on display. They had three days without a patient fall. Written on this board was their plan to reduce the number of pressure ulcers from last year. They planned to reduce this year by 50%. They had five patients last year with pressure ulcers and to April this year they had two they also had on display their saving lives audits for April 2015. There was details of an action plan on display on how they planned to do this. For urinary catheters, peripheral lines, central venous catheter (CVP) lines and hand washing they were all 100% compliant.
- Moorgate ward showed there had been four falls and one pressure ulcer in April this year; this was easily seen from the ward entrance board.
- They also had on display their saving lives audits for April 2015. For urinary catheters, peripheral lines, central venous catheter (CVP) lines and hand washing they were all 100% compliant.

Cleanliness, infection control and hygiene

- Cleanliness and control of infection was managed effectively. We observed all the ward areas, units and theatres to be clean.
- We saw on equipment in wards and units green 'I am clean stickers'. These clearly displayed the date the equipment was last cleaned.
- In theatres they had a cleaning checklist on the doors to each theatre and these were completed and signed off by the housekeeper and theatre practitioner two to three times per week.
- Compliance with screening for methicillin-resistant Staphylococcus aureus (MRSA) in elective patients and non-elective was carried out for each speciality. The trust's target was 98% which was met on all surgical wards.
- The trust had reported two cases of MRSA Bacteraemia in the surgical care services within the timescale of April 2014 to March 2015. The surgical care services also reported in this timescale 11 cases of Clostridium difficile (Cdiff). The trust-wide target for the year was 30 cases and the target for each ward was to have no cases.
- Hand hygiene audits for February 2015 demonstrated 100% compliance across surgical wards and units.
- Personal protective equipment was available and staff were seen changing gloves and aprons in between patients to prevent the risk of cross infection. We saw signage on side rooms indicating when a patient had an infection and the precautions needed. We observed all staff using alcohol hand gel when entering and exiting wards and when attending to patients.
- There was good supervision of cleaning staff to ensure cleaning standards were met. A member of the domestic staff on Wolf ward reported the cleaning service provided was very good, and that the company (Serco) had very high and exacting standards.
- A patient on Stonehouse ward reported that the ward was very clean.

- The inpatient and readmission rate for surgical site infections of knee replacements was 0.6% for the years 2009 to 2014; the national figures for this timescale were also 0.6%. For hip replacements it was 0.97% for the years 2009 to 2014 and national figures were 0.7%. The trust figure was slightly higher.

Environment and equipment

- Resuscitation equipment on each ward and in the units was checked daily, with records in place showing completion. These trolleys were secure and the tags were removed several times per week to check the trolley and contents were in date. We saw on the records where staff had noticed medication or equipment was due to expire and required changing.
- We visited Fal the surgical on the day admissions unit at 7am on one of days of our inspection to observe the patients being admitted. We found two toilets in the corridor leading up to Fal had overflowing bins with paper hand towels all over the floor. This was reported to the matron. There were only five seats outside this unit. When we arrived there were about 20 patients waiting. Patients told us this was mentioned in their admission letter and they were told not to arrive before 7am.
- Patients' notes had records of the surgical equipment or prosthesis used to enable them to be tracked and traced. This is important if any issues with patients or the equipment after surgery are identified in order that they can be followed up.
- Central Sterile Stores Department (CSSD) had clear procedures in place for the management of dirty and clean equipment. Strict operating procedures were in place to make sure patients were not at risk of cross infection. Staff told us they were able to clean an urgent request for equipment in four hours otherwise the turnaround time was 24 hours.
- Equipment provided by CSSD was also traceable. We saw the tracking stickers from this equipment in patient notes.
- Staff in CSSD told us they met with theatre staff daily to make sure there were no issues with equipment and that theatre staff had sufficient equipment available.
- The environment was crowded in many of the six-bed bays on surgical wards, and sinks were not easily accessible. The surgical care group management team told us they had identified this on a number of wards and were looking to reduce the number of beds in the bays to five. They had plans to do this once the increased pressure on their services was over.
- Sharps bins were readily available and all other waste bins were clearly labelled and adequately located in clinical areas.
- There are only three computers available across two large wards (Stonehouse and Wolf) which doctors could access. This made making requests for tests and prescribing medication for patients to take home difficult and led to delays in patient discharges. All printers on these wards were out of order on 22 April 2015, so junior doctors had not printed handover sheets, which was a potential patient safety risk.
- The surgical assessment unit had an ultrasound room which increased patient flow because they did not have to wait in the main imaging department for an ultrasound scan.
- The rooms in interventional radiology were small for complex procedures especially those that were performed under a general anaesthetic. They also had no dedicated reception or waiting area for patients on arrival and patients had to be recovered in a corridor post procedure. This had an impact on patients' privacy and dignity. Equally safety was compromised by the lack of recovery area if a patient required urgent medical review due to lack of space
- Patients attending the day surgery unit for ophthalmology were not required to change out of day clothes and walked to theatre for their surgery as the operation was performed under local anaesthetic.
- Staff told us they had specialist equipment for bariatric patients both on the wards and in theatres. This included specialist beds, hoists and larger operating tables.
- The estates department showed us their maintenance plan for 2015/2016, which covered all areas including theatres. There were systems in place to manage ongoing maintenance for ventilation, water, power systems and also for Legionella monitoring. For example, there was a water safety group in place with attendance from staff from wards, units and theatres etc. and they met monthly. There was a protocol in place for flushing out unused showers and taps this was done mainly by housekeeping and clinical staff.

- The engineering department told us they had an asset register in place that was updated about two years ago. All equipment was tested and maintained in line with the manufacturer's guidance.

Medicines

- Medication, including controlled drugs, was stored securely. Wards had locked medication cupboards and drugs trolleys were secured to the wall when not in use. We observed nursing staff locking drugs trolleys, during the medication round when they administered medication to patients. Stock of intravenous fluids were stored securely on shelving within cupboards.
- Appropriate documentation and registers were maintained for controlled drugs where they were stored on wards. This included patients' own controlled drugs. Records of balance checks on controlled drugs demonstrated that daily checks occurred.
- On the Postbridge and Lynher ward staff told us they were able to dispense certain medication directly from the ward for patients to take home. This was usually analgesia but the ward was able to dispense some antibiotics. Only nurses who had undertaken additional training and competencies were allowed to dispense these medications and there were always two trained nurses to prevent the risk of errors. Nurses told us this was to help discharge patients quicker so they did not have to wait for medication from the hospital pharmacy.
- All 20 medication charts we reviewed had adequate allergy information. However, we found that one patient's medication chart did not have prescribed the humidified oxygen which was being administered to them. Oxygen should be prescribed for patients to make sure they have the required amount for their medical needs. The ward pharmacist had reviewed the 20 charts we saw and had identified that the venous thromboembolism (VTE) assessment for one patient had not been reviewed as required by the trust protocol.
- Two nurses on separate wards raised a concern about junior doctors making insulin prescribing errors which were picked up by nurses or pharmacists. These surrounded the wrong type of insulin (e.g. long verses short acting) and in another case insulin was omitted incorrectly. The trust told us they had planned a training package for staff about insulin.
- We were told by staff that they had difficulties in obtaining liquid medications for patients who had had bariatric surgery on discharge as they were difficult to source. They were working with the pharmacy department on this issue.
- We saw in theatre that one of the oxygen cylinders by a resuscitation trolley went out of date in September 2014. Staff changed the oxygen cylinder when we pointed this out.

Records

- Not all patient records were stored securely and were accurate with their nursing needs and medical reviews.
- Nursing records were held at the end of patients' beds and at the nursing station. Medical records accompanied patients to and from theatre. We spoke with a ward clerk who told us they never had any problems with obtaining patient notes and they had a tracking system in place to monitor the whereabouts of patient records.
- Records included details of the patient's admission, risk assessments, treatment plans and records of therapies provided. Preoperative records were seen, including completed preoperative assessment forms.
- The trust had a standardised care pathway for elective surgery which was started at the pre-admission clinic if the patient had attended or was via a telephone assessment if the patient met the criteria. This documented the patient's journey from admission to discharge.
- We found that not all patient risk assessments had been reviewed following surgery or when there was a change in the patient's condition. We found five patients risk assessments that had not been updated. For example, in one patient's notes, on Crownhill ward, the patient handling form was completed preoperatively and said the patient was mobile and unaided. However, since their operation they required assistance because they had chest drains, IV lines and a catheter. Their risk assessment just said "assistance". We observed this patient being aided to walk with a physiotherapist and a member of the nursing staff. Nurses told us they did not always have time to update nursing records. This meant that patients were at risk of not receiving the correct care.
- We reviewed the nursing care plans and risk assessments of another patient on Lynher ward and found it made no reference to the patient's diabetes or

this was managed. We found a sliding scale insulin chart in their notes that was used following surgery. Their doctor confirmed they were diabetic and medication was prescribed on their drug chart. There was no care plan detailing how often this patient needed their blood glucose monitoring. This patient also had surgical drains in place following surgery. There was no care plan detailing the management of these. They had also had plastic surgery on their wound. We saw recording charts for staff to complete when they had checked the wound. Brief instructions were on the reverse of this form about the type of wound but there was no detailed management information. The form was dated as having been developed in 2005. There was no clear care plan or instructions on the frequency of these checks or the how to manage any associated risks. Nurses on the ward were aware of the specialist care required. This was reported to the ward sister. This could have potentially placed the patient at risk of not receiving the correct care from a less experienced member of staff or bank/agency staff.

- We saw for some patients there was a care plan in place for central vascular access devices. These showed that patients required at least a daily check to ensure they were safe. We saw documented on one patients care plan that they had a check x-ray and the positioning of this device was correct. This meant it was safe to use as it was in the correct place.
- On the surgical wards medical records were kept within locked (via 4 digit code) trolleys and were not left unattended in inappropriate places where unauthorised people had access to them.
- We noticed on Fal and Postbridge units that patients' notes were not always kept securely. On Fal there were cupboards in the main corridor which could be locked where notes were stored. However, when the unit was very busy and as patients arrived we saw the cupboards were mostly closed but not locked and there was a risk unauthorised people could have had access to patient records. On Postbridge patient records were stored in the unit in a non-secured trolley by the nurse's station.
- From discussion with junior doctors and nursing staff on Moorgate ward consultants saw their patients regularly, but this was rarely recorded in the notes. On the review of two sets of patient notes, we found consultant ward rounds were rarely documented.

Safeguarding

- Staff told us they were aware of their responsibilities to investigate and report any safeguarding concerns about children or adults. We observed on display in some units and wards information about the safeguarding liaison team and how to contact them. Staff also said there was a dedicated safeguarding lead that was contactable via switchboard and they visited the wards when required.
- We saw the December 2014 training figures for child protection level 1 training for general surgery, transplant and upper gastroenterology staff was at 93.3% compliance, which was rated at amber just below the trust target of 95%. Cardiothoracic and vascular staff was at 100% compliance with this training.
- The head of nursing for the surgical care group told us adult safeguarding training was part of the trust update training which all staff had to complete. The training figures for this were included in the mandatory training figures.
- On Sharp ward (fracture neck of femur ward) there was a dedicated ortho-geriatrics team (consultant and staff grade doctors) who reviewed the medical needs of their patients. The staff on this ward reported it worked very well in making sure all patients needs were met.
- The senior staff on Lynher ward did not know if all nursing staff was up to date with child protection training, even though they looked after patients aged between 16 and18 years old.

Mandatory training

- Staff told us they were mostly on target with their mandatory training. However, due to the recent pressure on the trust services and increased demand on their beds some staff told us they were not able to complete their training.
- We saw the training data for all staff for mandatory and statutory training. These were recorded for each surgical speciality on their dashboard. This demonstrated that the trust target of 95% compliance was not being met. For example, anaesthetics were at 75% compliance for their trust update (which we were told included safeguarding adults); basic life support was 72% compliance and manual handling 77% compliance. For theatres they were at 90% compliance rate for the trust update, basic life support was at 82% compliance and manual handling was at 86% compliance. All were below the trust target.

- For General surgery, transplant and upper gastrointestinal staff training they were also below the trust target. The surgical care group management team said they knew this was an area that needed to be addressed.

Assessing and responding to patient risk

- Risks to patients who were undergoing surgical procedures had been assessed and their safety monitored and maintained.
- Patients for some elective surgery attended a preoperative assessment clinic where all required tests were undertaken, for example, MRSA screening and any blood tests. If required, patients were able to be reviewed by an anaesthetist. A junior doctor was also in attendance at the clinics to undertake a background history of the patient and complete any further medical tests. They also reviewed the blood results from patients from the previous day to make sure they were within safe limits for the surgery to proceed.
- Staff told us about how they recorded patient observations. The observations chart contained areas of amber and red. Staff told us that if a patients observations were in the amber or red area the chart gave them directions on how to escalate their concerns to a medical team.
- The World Health Organisation surgical safety checklist was being used at the trust. This is an internationally recognised system of checks designed to prevent avoidable harm during surgical procedures. They had a number of differing checklists in place to cover different procedures, for example, surgical safety checklist for cataract surgery, neurosurgical and local anaesthetic. These checklist gave instruction to staff completing these, for example, it stated that questions had to read aloud and included confirmation of the patients identity and sign in and out times needed to be completed. We observed the process of WHO checklist being undertaken and staff confirmed it was a routine part of patient care
- We were shown the audit results for the World Health Organisation (WHO) checklist for February 2015. This showed the trust total was at 99.6%. This was rated as green by the trust
- We saw the audit results for interventional radiology for 2014 for the use of the WHO checklist it was 98%
- We observed a patient being seen by the consultant prior to surgery. The consultant checked with the patient which side the operation was to take place and they confirmed this with the notes. The patient was then marked on that side to make sure the correct side was operated on during their surgery.

Nursing staffing

- There were issues with the levels and skill mix of nursing staff across the service. The trust told us they used several tools to assist them with deciding the staffing on each ward, for example, Shelford Acuity Tool, National Quality Board Safer Staffing levels and NICE Guidance on safer staffing.
- On Crownhill ward we observed their staffing numbers were displayed on a poster outside of the ward. It indicated they were working under their allocated numbers of trained nurses. They should have had five qualified nurses on duty for both the morning and afternoon shift but only had four. The ward sister who was supervisory was helping the staff with patient care. They also had a patient who was very ill and needed to be transferred to the critical care unit. On 22 April 2015 they were one nurse short for the day and the night shift and on Stonehouse ward.
- Moorgate ward on the 24 April 2015 was one nurse short for two out of three shifts and one health care assistant (HCA) short for all three shifts.
- Staff on surgical wards told us they were concerned that the staffing levels and skill mix did not always meet the demand of medical outliers on their wards. For example, medical patients required additional care and different skills to meet their complex needs and they required more health care assistance support than surgical patients. Although additional staff was sought often none was available.
- Staff in theatres told us they were short staffed and that this caused them the most stress. They also said they worked long hours and then were on call. Said some theatres had been cancelled due to staff shortages.
- The theatre management board meeting minutes for March 2015 identified that there were 36 vacancies in theatre.
- A senior member of staff reported that there were difficulties with HR with very long delays of three to four months for employment checks to be done, which significantly harmed their ability to recruit high-quality permanent staff.

Surgery

- The surgical care group leadership team told us they reviewed the staffing levels a number of times throughout the day to makes sure wards and units were safe. Theatres had the largest recruitment issues and agency and bank staff were used to fill any gaps.
- They had recently appointed a new clinical nurse specialist in anal physiology due to their results in the bowel cancer audit. This nurse will be supporting the nurse led clinics as part of their role.
- An agency nurse on Wolf ward reported they were given good local induction by the ward sister on arrival, and that the ward catered well for agency staff.
- Staff told us that although staffing levels were extremely challenged, the rostering team tried to ensure the appropriate skill mix was available to ensure high-quality care was maintained, and that this was always achieved.

Surgical staffing

- Surgical staffing numbers meant patients received safe care and had access to consultant led care but out of hours this was not always by a consultant for that speciality.
- The trust was above the England average for consultant staffing with a level of 42% compared to the England average of 40%. However, middle grade staff levels were below the England average with 6% compared to 11% for the England average. For the registrar group the trust was above the England average with 44% compared to 37%. For junior doctors the trust was at below at 7% compared to England average of 13%. However surgery had the required number of junior doctors.
- In the colorectal surgical team, there was, in addition to the consultant of the week, a consultant general surgeon on call every day and night. One colorectal surgeon was on call from 8am to 8pm for two days of the week (either Monday and Wednesday or Tuesday and Thursday) with the other two days covered by an upper gastrointestinal surgeon. The two services would then take it in turn to cover the weekend, from Friday to Sunday.
- The on call general surgeon was responsible for admitting emergency patients and performing a post take ward round at approximately 5pm. They then conducted a telephone handover of patients to another consultant general surgeon who was then on call from 8pm until 8am the following day.
- The trust was below the England average for junior doctors as a whole but surgical staffing numbers were good for junior doctors. However we were told that often the surgical junior doctor was taken to a medical ward and asked to work there, which put pressure on other surgical junior doctors.
- Both doctors and nurses across surgery reported excellent consultant presence and 7 day consultant working. On Lynher ward there was a separate consultant for ENT, plastics and maxillofacial who was available and on the ward all 7 days of the week. On Braunton ward the vascular consultant saw most patients daily and we confirmed this through a review of patient notes.
- Junior medical staff reported they were well supported by consultants in surgery, and that they were always able to discuss issues with them.
- Nurses said the recent decision to dedicate a surgical specialist registrar for Marlborough surgical assessment unit (SAU) had been a significant improvement, and had resulted in more timely patient decisions.
- Staff told us handover was excellent in surgery, with a dedicated evening surgical junior doctor and senior house officer (SHO) who covered the wards from five pm to midnight. This had taken some of the workload off the night team when the acute surgical take was still busy.
- All specialties had dedicated consultant cover (specialty specific, e.g. colorectal, urology, etc.) seven days of the week. Overnight, the general surgical specialties were covered by one general surgical consultant.
- At weekends, vascular consultant cover was provided alternately by Plymouth and Truro. We spoke to one patient who had recently been transferred to Truro for emergency vascular surgery with a post-operative bleed and then returned to Plymouth. While they was upset that the surgeon who operated on them in Plymouth did not return to deal with this post-operative complication, the patient felt the nursing staff were excellent in facilitating their transfer to Truro.
- Other doctors on the neurosurgical team reported that it could sometimes take a few days to get a consultant to see a patient or a relative.

Major incident awareness and training

- Staff told us they knew the procedure to follow if a major incident was to have taken place. The trust had been

using their major incident room to hold meetings several times a day due to the high demand on their services and cancellations of elective operations due to lack of beds.

- In the event of a major incident all elective surgery would be stopped**.** Many doctors and nurses recognised the challenges which the trust experienced during 'black' escalation and winter pressures and were working as hard as they could to make sure patients received good care

Are surgery services effective?

Good

The trust participated in national and local audits, for example the national hip fracture audit, and it was above the England average for a number of the national audits. The trust had exceeded its target of operating on patients with fractured neck of femur within 36 hours. This meant patients had good outcomes.

In colorectal, hepatobiliary and oesophagogastric surgery the Enhanced Recovery After Surgery (ERAS) pathway had been converted into an 'app' which was regularly used by nurses and doctors who felt it had improved patient care. In theatres their policies and procedures were in line with professional bodies.

There was good multidisciplinary working within the units and wards to make sure patient care was coordinated and the staff in charge of patients' care were aware of their progress. We saw physiotherapists and occupational therapists assessing and working with patients on the wards then liaising with and updating the nursing and medical staff.

The majority of wards reported they had consultant cover seven days per week.

Evidence-based care and treatment

- Policies and guidelines were readily available on the trust intranet. These were seen to be up to date. Care pathways complied with National Institute for Health and care Excellence (NICE) guidelines and other professional associations for example, Association for Perioperative Practice (AfPP).
- In colorectal, hepatobiliary and oesophagogastric surgery the Enhanced Recovery After Surgery (ERAS) pathway had now been converted into a mobile phone app) which was regularly used by nurses and doctors. These pathways provided evidence-based protocols to ensure patient recovery was maximised. Nurses on Stonehouse and Wolf ward reported how the use of the electronic app has improved the use of the ERAS pathway, which was previously only written on large A3 sheets which nurses found difficult to use in wards.
- Venous thromboembolism (VTE) assessments were recorded on the drug chart and were clear and evidence-based, ensuring best practice in assessment and prevention. However, these were not always being performed adequately in a significant number of surgical patients, of a sample of 23 drug charts taken across a number of surgical wards we found nine of the VTE assessments were not completed or not completed correctly. We found patients were not being re assessed as required in the trust's protocol. We also identified an issue in the pre assessment clinic where staff were signposted to the medication chart for directions but this had not been completed. One patient needed to be prescribed anti-coagulant medication but this had not been done for two days until it was picked up by us.
- Some consultants had devised their own care pathways for certain types of surgery. For example, one consultant had their own Ivor Lewis gastro-oesphagectomy care pathway. This is major abdominal and chest surgery. Staff on Clearbrook ward showed us how they used this pathway as it gave them guidance on what care they needed to provide for that patient and when.
- Dedicated ortho-geriatrician (consultant and staff grade) worked on the fractured neck of femur ward (Sharp ward), which ensured best practice was adhered to for the medical care of these complex patients.
- Surgical trainees reported that many junior doctors were involved in audit, but most of this was local with little understanding of the national context. Junior doctors were regularly involved in initiatives to improve patient outcomes, such as the doctors in surgery who developed the ERAS app.
- CSSD worked in line with NICE guidance for example, IPG 196 for patient safety and reduction of risk of transmission of Creutzfeldt–Jakob disease (CJD) via interventional procedures.

Pain relief

- Patients pain was assessed and managed effectively.
- A member of staff on Lynher ward showed us the pain monitoring tools they had in place. One patient had a patient controlled analgesia machine (PCA) in place. The staff member told us about the details they recorded on the patients observations form, for example, how often the machine was pressed by the patient and if the patient was hallucinating on the medication. These checks were also used for patients with epidurals. Patients were reviewed by the acute pain team and they used these details to assess the effectiveness of their analgesia. Staff told us they also asked patients if they were in pain.
- Patients told us they would ask staff for pain relief if required.
- The specialist pain team were available 24 hours a day. Some specialist pain nurses were able to prescribe analgesia which speeded up the ability of ward nurses to give the required analgesia.

Nutrition and hydration

- The trust used the Malnutrition Universal Screening Tool (MUST) to assess patients' risk of malnutrition. We saw in two patients' nursing records and assessments that it was not recorded that they were diabetic. One patient had lost 13.6 kilograms in a month but there was no documented evidence in their nursing or medical notes that any action had been taken. This was reported to the ward sister to follow up
- We saw one patient who had major gastro-intestinal surgery had been assessed using MUST pre-operatively and were found not to be risk. This had not been updated post-surgery where their risk of malnutrition had increased because they were nil by mouth and were being fed by an intravenous tube. We saw on patients' medication charts that they had been prescribed antiemetic medication post-surgery to help manage any nausea and vomiting.
- We saw regimes were in place for patients who were receiving nutrition intravenously. These had been set up by the dieticians and reviewed by them.
- We saw that the management of patients fluid balance was good. Fluid charts were being used. Those we reviewed for patients who had undergone major surgery were very detailed and had totals for input and output. These also included measurements from any drains etc. they had in place. For example, staff showed us the fluid charts for one patient who was found to be in a positive balance (this was where they were retaining more fluid internally than they were passing out). They reported this to the doctor for review who had prescribed some medication for the patient.
- Some elective surgical patients depending on the type of surgery they were undergoing were given a pre-operative carbohydrate drink. The purpose of this drink was to aid the patient's recovery following their operation. Each patient was prescribed this drink and was given an information leaflet detailing when they needed to drink it.
- Patients were referred to dieticians if required. We saw on Crownhill ward details of dieticians input into patients who have had major abdominal surgery. We saw they had written this in the patient's notes and signs were on display by their beds or side room with their instructions.

Patient outcomes

- The trust had a mixed response in the national audits they had taken part in with some areas improving following actions being taken to improve the outcomes for patients.
- In the bowel cancer audit the trust was worse than the England average in two areas, patients discussed at MDT was 95.2% compared to 99.1% and seen by clinical nurse specialist was 46.6% compared to the England average of 87.8%. The trust told us they had recently appointed a new nurse specialist to address this shortfall.
- In the hip fracture audit the trust was above the England average in all areas except for, pre-operative assessment by a geriatrician this was 39.7% compared to England average of 51.6% and this was also worse than their previous year.
- The trust told us they operated on 91% of patients with fractured neck of femur within 36 hours of admission in February 2015 exceeding their target of 85%.
- The trust performed slightly better that the England average in the Lung cancer audit for 2014.
- In the Emergency laparotomy audit for 2014 the trust had for example, fully staffed operating theatres at all times, formal rota for interventional radiology and endoscopy. However the trust did not have an emergency surgical unit, policy for anaesthetic seniority according to risk or a policy for location of post-operative care according to risk.

Surgery

- The standardised relative risk of readmission for all elective admissions was slightly worse than the England average.
- The standardised relative risk of re admission for non-elective admissions was slightly better compared to the England average. Colorectal and general surgery were the same as the England average. Upper gastrointestinal surgery slight worse than the England average.
- The trust performed slightly below the England average in all four Patient Reported Outcomes Measure (PROMs) in groin hernia repairs, hip replacement, knee replacement and varicose veins.
- Closure of the MRSA-free elective orthopaedic ward has significantly affected the ability of the trust to manage their orthopaedic waiting lists, senior staff for orthopaedics reported the consultants secretaries were receiving daily phone calls from some patients awaiting their surgery. Many of the complaints were around delays to elective surgery. Senior staff for orthopaedics did not know when this ward would be re-opened for elective orthopaedic surgery as it was being used to house medical patients.
- The mean length of acute stay for all surgical specialities had increased from 12.1 days in 2013 to 15.7 days in 2014.
- The trust told us they participated in the Anaesthesia Clinical Services Accreditation scheme (ACSA). They were due to be inspected at the end of April beginning of May this year. At the time of our inspection they had not had their accreditation level.
- A relative of a patient told us about the trial they were taking part in following their cancer diagnosis and surgery. They said the consultant and specialist nurse had told them about the trial and the follow up care and support they would need. The relative said they were happy to take part in the trial.

Competent staff

- The staff had the skills, knowledge and experience to deliver effective care and treatment to patients.
- The surgical care group leadership team told us they were looking at ways of reviewing the roles of health care assistants (HCAs) to enable them to undertake more roles. For example, they were looking at reviewing the band three role of the HCA within the scrub team in theatres.
- Appraisal rates for the majority of areas within the surgical care group were below the trust target of 95%. For example, staff in general surgery; transplant and upper GI in December 2014 were at 76.6%. Colorectal surgery staff was at 89% for the same time period. The surgical care group felt this was because of the increased emergency admissions and pressure on their beds.
- Doctors on Stonehouse ward report that they were appraised as part of their clinical and education supervision, and that it happened regularly.
- Cardiac theatres told us they were at 70% for their appraisals which was also below the trust target of 95%.
- The wards staff told us they had link nurses for specific areas, for example, learning disability and older people and other staff on the wards were able to learn from them.
- Staff in CSSD had a robust training /induction in place to make sure they were safe with all areas in this department. Staff told us it can take up to three months for them to be fully operational.
- Junior doctors reported they had a one hour teaching session on insulin prescribing, but they said they still did not feel confident in this area. There have been two instances of concerns raised by surgical ward nurses about insulin errors from junior doctors.
- Nursing staff (both agency and permanent) felt well supported and adequately trained in their local areas.
- Junior doctors within surgery all report good surgical supervision, which they felt enhanced their training opportunities.

Multidisciplinary working

- Staff from all disciplines both within the hospital and from other health care locations worked together to deliver effective care and treatment to patients.
- Occupational therapists and physiotherapists on surgical wards reported good MDT working to maximise the patients opportunities for recovery.
- We observed in one patient notes that they had been referred to and seen by the acute rehabilitation team and the mental health team. They had written to the consultant in charge of the care of this patient in their notes advising them of their input and any follow up.
- A patient told us they were due to be discharged the next day to another hospital for rehabilitation. They said they had seen the physiotherapist at the trust and who had told them they had liaised with the other hospital

regarding their care. We were told by staff that the patient's hospital notes would be transferred with them. There was clear information in the patient's hospital notes about the support they had provided.
- Patients who were diagnosed with colorectal cancer were discussed weekly at the colorectal MDT meetings where consultant radiologists were present.
- A consultant urologist told us they had weekly MDT meetings where 30 to 40 cases were discussed with a radiologist and histopathologist.
- On Sharp ward staff told us there was excellent MDT working, with regular ward rounds and full discussion of all aspects of patient care between all professionals involved in the patients care.
- Physiotherapists join the daily medical ward round on Moorgate (neurosurgery) ward to ensure relevant mobility issues were discussed.
- The doctor's assistants (DAs) on Wolf and Stonehouse ward were able to perform some of the work usually allocated to the junior doctors (e.g. bloods, cannulas, catheters) which enabled them to do more other clinical tasks. The DAs felt well supported and valued members of the team, and there was scope to have DAs develop their skills to start helping doctors with their paperwork and documentation.
- We saw in one patient's medical records details that there was input from the Macmillan team who were based in the community. There was also a review of the patient's medicines by the palliative care doctor from a local hospice. They had been involved in this patient's care prior to admission and were working with the wards staff to decide with the patient and their family the best place for them on discharge.

Seven-day services

- Patients had access to consultant cover seven days per week and other support services were available if required.
- Lynher ward staff reported seven day consultant presence for ENT, plastics and Maxillofacial.
- Staff on Moorgate ward reported a consultant neurosurgeon was available at all times, but the weekend ward round was done by the specialist registrar.
- Both doctors and nurses across surgery said they had consultant presence and 7 day consultant working. On Lynher ward there was a separate consultant for ENT, plastics and maxillofacial who was available and on the ward all 7 days of the week. On Braunton ward the vascular consultant would have seen most patients daily and we confirmed this through a review of patient notes.
- Staff on Stonehouse and Wolf ward reported that consultant ward rounds occurred even on Saturday and Sunday.
- The centralised sterile services department (CSSD) told us they provided a seven day a week service. The department closed at 4pm on a Saturday but a member of staff was on call until they opened on Sunday at 8am and then on call again. During the week the department was opened day and night.
- The surgical care group leadership team told us they were not set up as yet for full seven day working.
- Interventional radiology provided an on call rota which was consultant led.
- Theatres had two emergency theatres available seven days a week.
- There was no out of hours occupational therapy cover.
- For physiotherapists, specific criteria were place for weekend visits. This included for elective orthopaedic ward patients, new patients and patients needing to be discharged. A physiotherapist was also on call at nights.
- Staff told us they had access to imaging out of hours. Pharmacy also provided an out of hour's service and they were open at weekends.

Access to information

- Staff had access to all the information they needed to deliver effective care and treatment to patients.
- Nursing staff told us when a patient was transferred to their ward from the critical care unit (CCU) records were maintained of their stay. These were stored in the patient's notes. We saw copies of these for two patients on different wards. Staff also said they received a verbal handover as well.
- When a patient was reviewed by an anaesthetist in the pre admission clinic they wrote to the consultant in charge of their care detailing their assessment and any treatment required. A copy of this letter was kept in the patients notes. We observed this in one patient's notes who were attending the Fal unit. A copy of this letter was also sent to the patients GP.
- We spoke with a physiotherapist who told us their assessments of patients were stored on the computer system; however staff on the ward was not able to access these unless they had a specific password.

- Any GP referrals could be discussed with the surgical specialist registrar and can then be seen on surgical assessment unit (SAU) if required. This functioned 24 hours a day.
- A&E handover to SAU reportedly worked well, and there was a written handover for nursing staff which ensured important information was not missed.
- Discharge summaries were sent to GPs and they should be received within 48hrs. Staff on Stonehouse ward reported that discharge summaries and take home medication were often completed very late by junior doctors. They felt this needed to improve to facilitate more timely discharges. They did not recall any patients being sent home without a discharge summary being done.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the relevant consent and decision making requirements of the appropriate legislation and guidance.
- The trust had four consent forms in use there was a consent form for patients who were able to consent, another for patients who were not able to give consent for their operation or procedure, one for children and another for procedures not under a general anaesthetic. All consent forms we saw were for patients who were able to consent to their operation/procedure and they were completed in full (contained details of the operation/procedure and any risks associated with this). Patients were also able to have a copy if they wanted.
- We also observed consent forms were in place for visual recording for example, when photographs were being taken.
- Staff told us they did not undertake mental capacity act assessments of patients' ability to consent to certain decisions about medical treatment. They said they had a specialist team in place who undertook these assessments. We heard a nurse explaining the process to a family member who was concerned about the discharge of patient who wanted to go home but they felt they would not be able to manage. The nurse had a clear understanding of the process for obtaining an assessment.
- Patients had access to a mental health review when required. For example, it was evident from the review of one patient's notes on the surgical assessment unit (SAU) that mental health review had been obtained. There was also clear documentation of the consideration of their mental health in the medical team ward round notes.
- We observed a consultant and registrar taking consent from a patient (who did have mental capacity) on (SAU). They understood the process for taking consent from an adult who lacked capacity, and knew that this would require a Consent form for patients who were not able to consent.
- Staff told us they had annual training for Mental Capacity Act and Deprivation of Liberty safeguards.
- We spoke to some staff on Shaugh ward who told us they knew the process for making an application for requesting a Deprivation of Liberty (DoLS) for patients and when these needed to be reviewed. There were no patients with an active DoLS application in place on this ward during our inspection.

Are surgery services caring?

Good

Patients and their relatives told us they received a good standard of care and they felt well looked after by nursing, medical and allied professional staff. Privacy and dignity were respected by the staff on the wards. However, we did see three examples where this could be improved.

Medical and nursing staff kept patients up to date with their condition and how they were progressing. Information about their surgery was shared with patients, and patients were able to ask questions. Relatives were able to be involved in these discussions.

Access to support from specialist nurses and teams, for example stoma nurses and a pain team, was available.

Compassionate care

- Patients were treated with dignity, respect and compassions when they were receiving care and support from staff.
- We saw on some of the wards the results of their friends and family test. On Crownhill ward they had included some of the comments. A positive comment was about how good the staff was. A negative comment was about how busy the staff was and that more assistance was required in the day room area from staff.

- Lynher ward also had their results from friends and family tests on display for March 2015. They had 54 responses which equated to a 26.6% response rate. Of the respondents 96% would recommend the ward and 4% would not recommend the ward. They had also had one positive comment which was about the staff and a negative comment about the time a patient was delayed waiting for discharge.
- We observed the staff on Moorgate ward attending to a patient who was experiencing a lot of pain. The nurse spoke with the patient and said they would administer pain relief and contact the doctor. We saw the nurse attend to these very promptly and the doctor also visited and reviewed the patient. The visitor of this patient said they received a good standard of care.
- From our observation during our inspection we observed staff treating people with respect and ensuring their privacy, for example, curtains were pulled around their beds when personal care was taking place.
- On Fal ward we observed patients having their observations taken for example, blood pressure, temperature, respiratory rate and weight taken in the main corridor just outside one of the bays. This corridor was very busy with staff and other patients moving around which meant limited space and no privacy. Individual rooms were available for patients to see the nurse, doctor and anaesthetist. We felt it may have been more respectful for patients to have their observations done in private so they would have been more room and less rushed for patients.
- On Crownhill ward we observed a notice on the outside of a side room detailing the patient's dietary needs and support. This was in the main corridor into the ward and bay areas. We felt this should have been stored in their room as they were not being barrier nursed to respect their privacy.
- All nursing staff on wards interviewed were very positive about the level of care that patients receive at this trust. They felt they provided patients with a high standard of care and treated them with kindness.
- The domestic and housekeeping staff we spoke with were very positive about the experiences of patients who they observed, for example, the staff treated patients with compassion and when asked if they would be happy for their families to be cared for here, they unanimously agreed.
- Two patients on Braunton ward were extremely complimentary about the nursing and general care on this ward. This ward has recent won the patient choice award. One patient told of how the staff were "very caring" and they "make you feel like you are a member of their family". One patient told of how the junior sister's astute judgement and quick responsiveness to his post-operative complication "saved their life".
- Most medical ward rounds occurred with curtains drawn, but on Moorgate ward, both neurosurgical ward rounds occurred with the curtains wide open (in an area where space around the bed was not constricted – L bay). The consultant neurosurgeon examined a patients arm neurologically without drawing the curtains and in full view of other patients.
- There had been some concern from patients that the neurosurgical consultants were not readily available to talk to patients and their relatives, but on observation a neurosurgical consultant was compassionate towards a patient and said that they wanted to speak to this patients relative about their discharge planning as the registrar had not spoken to her all week.
- Staff on Stonehouse ward reported that if they saw unacceptable care, they knew the correct channels to raise this and would complete an incident form.
- For patients undergoing interventional radiology procedures they had to be recovered post procedure in a corridor with no privacy for the patients.
- Staff on the surgical assessment unit told us about a transgender patient who had recently been admitted. They offered the patient a choice on where they would like to be cared for, the patient chose to have a side room.
- We received positive comments from the vast majority of patients we spoke with about their care. Examples of their comments included "I can't fault the care, the staff are fantastic", "It is a terrific hospital, the staff have always treated me well", "I felt so safe here everyone is so compassionate" and "efficient caring staff".

Understanding and involvement of patients and those close to them

- Patients and those close to them were involved as partners in their care and able to seek further information about their operation or procedure.
- We received some feedback prior to our inspection that said the cardiac doctors and surgeons were good and communicated well, involving the person with decisions.

- One visitor told us their relative had been in hospital for three weeks before the consultant spoke with them about their condition and treatment plan. They also said they felt the communication was "poor between the doctors and relatives". We checked the notes for this patient and found no record that the consultant had spoken with the relative of this patient. This patient was very ill and was not always able to communicate themselves with the doctors.
- On one of the SAU take ward round we observed a senior doctor who did not introduce themselves by name or title when seeing any of the patients. They spoke about the patient to the other staff on the round and not directly to the patient.
- We observed the neurosurgical consultant ward round and there was good evidence of explanations given to patients about their conditions, and the reasons for doing a particular type of surgery. Time was given for patient questions at the end.
- One patient told us they had very good communication with the anaesthetist who told them everything that would happen to them.

Emotional support

- Patients and those close to them were able to receive support to help them cope emotionally with their care and treatment.
- There was spiritual support available from within the hospital as the chaplaincy and a team of spiritual advisors were able to be contacted. Patients were able to have support from their own local connections and networks.
- Patients had support from nurses with additional knowledge. For example, there were nurses with link roles in matters relating to mental health, learning disabilities and dementia.
- For patients who had travelled a long way to use the services, accommodation was close by to enable their families to stay close to them and help with their recovery. While this service was not provided by this trust, they had details available for families to access this. One patient told us they found this useful as they were undergoing surgery for cancer and wanted their family near to them for support.
- For members of the armed forces who were using the services of the hospital they were able to access services for spiritual or emotional support from them.
- Patients who were undergoing bariatric surgery were referred preoperatively to a weight management programme which this provided them with access to support groups.
- Young people aged between 16 and18 years were occasionally seen on adult surgical wards. A senior sister from one ward said that if children were treated on their ward, they would try to give them a side room and would allow parents to stay all night if the young person wanted this. They had a camp bed to put next to a bed in a bay in case this is required.
- Staff on Lynher ward reported good support was provided for patients with a learning disability by the learning disability liaison team and specialist nurses. Staff on the ward told us they sometimes enabled carers to stay overnight if someone had support 24 hours a day
- The "tea with matron" initiative, was working well on surgical wards. This was where once a month the matron for that ward had an afternoon session with patients to encourage them to share their feedback on the ward and the care and support they had received. On Braunton ward the patients said that this was a good chance to interact with staff in an area away from their bed, and allowed relatives to talk to nursing staff too.

Are surgery services responsive?

Requires improvement

Before and during our inspection, the trust was experiencing a high number of emergency admissions and increased pressure on its services. The increased demands on the trust's services and beds resulted in a high number of elective operations being cancelled. In addition to the high number of cancelled operations the trust was also not always meeting the national targets for rebooking these patients within the 28-day timescale. The elective orthopaedic ward had been turned into a medical ward to meet the demand for their services and beds. Systems for booking operating theatre slots were not cohesive and had led to operations being cancelled due to overbooking. Some operations were cancelled due to lack of critical care beds. The trust was not meeting it referral to treatment time on a number of surgical specialities. The average length of stay for elective patients was higher than the England average but for non-elective patients it was lower than the England average.

Surgery

Staff raised concerns about the procedure for booking operations onto theatre lists. For example, once the lists were finalised other operations were added without informing for checking with the relevant staff. Operation lists were often too long or too short and some theatres were being underutilised. Operations were also cancelled as there was not enough time as too many had been booked or specialist equipment was not being arranged at the time the operation was added to the list.

Not all staff was up to date with the trust policy on the use of interpreters.

Patients reported it was difficult to access information on the surgical wards on how to make a complaint. Surgery had the highest numbers of complaints in the trust

Service planning and delivery to meet the needs of local people

- The trust worked with commissioners to plan and meet the needs of patients. Where these were not being met they had moved some of their patients to other health care providers. For example, patients who required cardiac surgery was moved to another hospital.
- The lack of elective orthopaedic surgery due to medical bed pressures had severely extended the waiting list for elective orthopaedic procedures, and this had resulted in a growing number of complaints from patients.
- The trust had moved some of its cardiac surgery to a hospital in London to reduce the wait for cardiac surgery.
- The trust had purchased a robot to assist with some major pelvic surgeries. This had enabled local patients to have their surgery at Plymouth and not be referred to other hospitals in the south west.
- The surgical leadership team told us about the education days they had provided for GP's in orthopaedics. The purpose of these was to assist the GP's in diverting patients to the most suitable treatment for their condition which could be the surgical option. Telephone consultations were also offered to help signpost patients early to the most appropriate treatment and support. There were some differences between support services (physiotherapy) depending on where the patient lived. The consultants involved in this worked collaboratively with their colleagues in Cornwall.

Access and flow

- Prior to our inspection the trust had been experiencing a high number of emergency admissions and this had impacted on the surgical services they were able to provide. The elective orthopaedic ward had been used to house medical patients therefore operations had to be cancelled. The trust was also not meeting its referral to treatment targets in most of the surgical specialities, and not all patients who had their operations cancelled were re-booked with the recommended benchmark of 28 days; therefore some patients were experiencing unacceptable waits for treatment.
- 1500 operations from all surgical specialties were cancelled in January and February 2015. They had 18 breaches where patients in February 2015 had not been re-booked for surgery within the 28 day timescale. The trust cancelled 119 operations 'on the day' in February 2015.
- Cancelled operations for each month for the year April 2014 to March 2015 due to non-clinical reasons ranged from 61 in August 2014 to 276 in January 2015, with a total of 1429 cancelled for the 12 month period. The main reasons for the operations being cancelled were:
  - not enough beds for patients post operation
  - theatre lists over running which meant there was not enough time for patients towards the end of the lists to receive their operations.
- Data gathered from the trust for operations cancelled from April 2013 to March 2014 were;
  - April to June 2014 (quarter one) there was 253 operations cancelled and 10 of these were not re-booked within the 28 day time. scale.
  - July to September 2014 (quarter two) there was 265 operations cancelled and 10 of these were not re-booked within the 28 day timescale.
  - October to December 2014 (quarter three) there was 290 operations cancelled and 20 of these were not re-booked within the 28 day timescale.
  - January 2015 to March 2015 (quarter four) there was 648 operations cancelled and 157 were not re-booked within the 28 day timescale.
- The trust's board papers for March 2015 stated 119 operations were cancelled on the day in February 2015 and this was 1.73% of elective admissions. Six hundred and twenty six operations were cancelled in advance of the day in this month. There were 18 breaches of the 28 day re-booking standard. Bed pressures was the main issue.

Surgery

- The board papers for May 2015 stated 100 operations were cancelled on day of admission in April 2015. This was 2% of elective admissions. Four hundred and fourteen operations were cancelled in advance of the day. There was thirty breaches of the 28 day re-booking standard. Bed pressures was also described as being the main issue.
- The trust had a yearly target of 0.8% for operations cancelled on the day of surgery or just after admission for non clinical reasons. For the year from April 2012 to March 2013 it was 1.53% this has steadily increased to 1.73% for the year April 2014 to March 2015.
- The trust's target for operations cancelled for non clinical reasons on the day of surgery or just after admission and where patients had not been re-booked within the 28 day timescale was 5%. For the year April 2012 to March 2013 it was 2.70%. This figure has increased to 8.80% for the year April 2014 to March 2015.
- The surgical care group told us they had some patients who were waiting 52 weeks for some surgery. These patients were highlighted on operation lists to alert staff to try not to cancel their surgery. The trust board papers for March 2015 stated they had only one patient who had been waiting 52 weeks for treatment. This is not acceptable for a patient to wait this long for treatment.
- The trust provided us with data about their theatre utilisation which showed there were a large number of sessions not used. For the year from April 2014 to March 2015 they had 14804 elective theatre sessions available of these 12904 were used which meant unused or cancelled were 1900 sessions (12%).
- The theatre activity reports for all surgical specialities from April 2014 to March 2015 showed the trust had cancelled 3151 patients on the day of their surgery which equated to 11.3% of their elective patients. The main reasons were cancellations by the hospital due to emergency operation taking priority or clinician unwell or unavailable.
- For cardiac thoracic and vascular surgery cancelled operation data for February 2015 was 8.1% the target was 6.2%.
- At a previous CQC inspection in April 2013 concerns had been identified with the management of surgery times as this was seen to put staff under pressure and created a risk of inappropriate or unsafe care and treatment There was also no clear mechanism in place to monitor or analyse who scheduled the surgery. On a follow up inspection in August 2013 we found the trust had made changes to how operations were added to lists and by whom and the frequency of checking of these. However from feedback at this inspection the scheduling of operations/procedures remained an issue of concern.
- We were told about the process for populating theatre lists. Each consultant's secretary's was able to add procedures to the theatre schedule up to eight weeks in advance. They needed to take in to account the type of anaesthetic required, length of time of procedure, equipment required etc. This enabled every surgical speciality to populate the theatre lists. The theatre lists were checked a week prior to the surgery by a band seven nurse and secretary from scheduling and then finalised. However other cases were added in after this without notice. This had resulted in lists being too long or too short, sometimes theatre's being underutilised or procedures cancelled as there was not enough time or specialist equipment had not been booked. The system used was not streamlined and relied upon a number of individuals to populate the lists with no one in overall charge of this process. We were told of plans to introduce new IT software to help this and re-introduce a scheduling team to take over the process.
- Another issue we were told about was what staff described as a delay in finding out if critical care or high dependency beds were available for patients. Staff said this often delayed the start of theatre lists as the bed meeting started at 8am in the mornings.
- We were made aware that two patients were cancelled for major surgery on one of the days during our inspection, as there were no critical care beds for these patients. One of these patients was a cancer patient awaiting major surgery, and this was their second cancellation due to no beds being available. This patient was disadvantaged and then had to wait to be rebooked at a later date for treatment. Therefore two theatre teams were either reallocated to other theatres or had no clinical duties and the theatre was underutilised for that session
- In the last six months overnight stays in recovery or the day surgical unit for patients due to bed pressures were low. The trust told us they had one occasion where four patients were kept in recovery overnight due to lack of appropriate beds on surgical wards. This was in December 2014. Recovery had two occasions in February 2015 where patients were kept in recovery

overnight due to the lack of critical care beds. Day surgery had only been used once overnight in the last six months to house patients when there were no beds available on wards.

- The trust was not meeting its referral to treatment time standards (RTT) for urology 68.6%, ophthalmology 80.3%, oral surgery 64%, plastic 87%, neuro 69.3%; the target was 90%. They were meeting the RTT for cardiothoracic and thoracic.
- They also told us their RTT had increased with the recent pressures on their services and beds, for example, in colorectal and neurosurgery. They had plans in place to help reduce these once the pressure on beds in the hospital had reduced.
- Average length of stay for all elective patients was longer at 3.9 days compared to the England average of 3.3. Cardiac surgery was less that the England average. For trauma and orthopaedics and colorectal surgery it was slightly higher than the England average. These figures were from June 2013 to July 2014.
- For all non-elective surgery the average length of stay was lower than the England average at 4.5 days compared to 5.2 days. Colorectal surgery and upper gastrointestinal surgery the average length of stay was lower than the England average. Trauma and orthopaedics was slightly higher compared to England average. These figures were from June 2013 to July 2014.

Surgical outliers were relatively common and nursing staff reported that the patients were generally well cared for when they were sent to other surgical wards that were not specialty specific. Staff on Lynher ward reported they often had general surgery outliers, but that their surgical teams would always look after them. For example, a patient on Moorgate ward who was a neurosurgical patient needed a colorectal review; we saw this was done promptly by the colorectal registrar.

- Surgical patients were often kept on surgical assessment unit (SAU) until they were seen by the post-take consultant. Then they were either kept on SAU or moved off the ward to another surgical ward. If patients required Level 1 or increased care they were moved to dedicated beds on a surgical ward. Staff reported this was working well, but during the increased pressures this was challenging as beds on surgical wards were taken by medical patients. The service prioritised care and treatment for people with the most urgent needs when they could for example, renal transplants were listed on the urgent surgery list, and the consultant in renal medicine reported there was never any issue getting a theatre slot for a renal transplant. If there was a live related donation planned then these happened on an urgent list where space was made for this. However we were also aware that two patients were cancelled for major surgery on one of the days during our inspection, as there were no critical care beds for these patients. One of these patients was a cancer patient awaiting major surgery, and this was their second cancellation due to no beds being available. Therefore two theatre teams were either reallocated to other theatres or had no clinical duties.

Meeting people's individual needs

- Services were planned to take into account the individual needs of patients. However these patients were not always identified as having different needs to other patients and the appropriate actions taken.
- We followed up on some feedback we received prior to the inspection about the use of the 'red' tray system for mealtimes on the wards. This was where patients who required assistance with their meals were identified with the use of red trays. On Moorgate ward we asked the staff serving the meals how many patients required red trays and we were told one. However the patient information board indicated there were three patients.
- On Lynher ward they also had protected mealtimes where visitors were discouraged from visiting unless they were assisting patients with eating. Prior to the meal being given out patients were assisted with toileting if required and helped in to a position in the bed or chair where they could eat their meal. Staff were available to ensure patients received the assistance and support they needed. We saw the red tray system in use effectively during this mealtime.
- Specialist diets were able to be provided for patients, for example, diabetic, soft and Halal. Staff told us they may need some notice to obtain Halal meals but they were able to provide other food in the meantime. One patient told us they were disappointed in the choice of cereals for patients who required a gluten free diet as they only had one option.

- Staff told us they had access to translation services in person or via the telephone system. Some staff said they used other staff who was able to speak the language of the patient to help them explain about the care and support the patient required.

The trust's policy for the use of translation services said that family members should not be used for translating between the family and staff. However, we found on two wards they were using the family to assist with talking to the patients.

- The hospital had a dementia care lead nurse and consultant who provided support to staff and patients. The Alzheimer's national dementia friend scheme was in operation. This is a programme for people to learn more about dementia and the ways in which people can help others living with dementia. The head of nursing for the surgical care group told us they had plans to improve some of the surgical wards environments to help assist patients living with dementia.
- Patients living with dementia were identified by discreet identification on the staff communication whiteboard.
- Staff told us about 'bed watchers'; these were normally health care staff but at times they were security staff. These staff were used to sit with patients who had behaviour that challenged, or were confused and trying to get out of their bed. Staff also said that at times they did not have enough bed watchers to meet the needs of all patients.
- Staff reported they did not have mixed gender bays on surgical wards, unless it was in level one care where they sometimes needed to mix genders, as these were patients who had come from a critical care/high dependency care and required extra nursing care.
- The learning disability liaison team provided a good service for surgical inpatients. Staff told us they attended the wards when patients were admitted to provide them with advice and support. Staff in the pre admission clinics told us they were encouraging patients to bring in their hospital passports. These were documents that provided staff with individual details about the patients care and support needs.

Learning from complaints and concerns

- Patients concerns and complaints were used to help improve the quality of care; however access to information about making a complaint was difficult to access.
- The surgical care group had received the most complaints at 48% of the trust's total number of complaints. Their leadership team felt this was due to the high number of cancelled operations. They told us all complaints were reviewed by the senior staff and reviewed at governance meetings. If learning from complaints was required this was shared with staff at their meetings.
- Staff told us most of the complaints they received were around the delays to elective surgery.
- None of the patients we spoke with had any complaints; however several patients said they were not sure how to complain if they needed to.
- Information was available to patients on how to make a complaint in the main hospital areas. The Patient Advice and Liaison Service (PALS) provided support to patients and relatives who wished to make a complaint. The PALS information on wards was very sparse. We saw on Braunton ward they had a PALS leaflet available, but we were unable to easily see any other PALS information on the other surgical wards.
- Senior nursing staff had undertaken complaints management training in order to conduct investigations and take action following any complaints received.

Are surgery services well-led?

Requires improvement

The surgical care group management team had plans in place to improve their services, however the current system in place for booking operations was poor which resulted in cancelled operations and lists not being filled to their capacity. Due to the recent high number of emergency admissions this had also resulted in elective operations being cancelled. They told us this was an area they needed to address immediately. The trust had not acted quickly to identify the issues which lead to this situation and actions were not having an evident impact on patient experience.

A number of staff we spoke with had been working at this trust for over 10 years and said it was a good place to work. Staff told us that if incidents took place, they wanted to be open and transparent with patients about any failings. The culture of learning from incidents was promoted among staff, and they told us they were encouraged to report incidents.

Surgery

Staff on the wards told us they felt supported and listened to by their immediate line manager, care group management level and by the executive board.

Appropriate governance systems were in place. Risks were identified and discussed at care group level, and these were recorded on their risk register and some were included in the trust's risk register. Interventional radiology had its own governance systems that fed into its management structures. Serious risks were shared with the executive team.

Vision and strategy for this service

- The surgical care group management team had a clear vision and strategy in place to deliver good quality services and care to patients. For example, offering more day case surgery or offering some surgical operations at other hospital locations. At the time of our inspection their immediate visions and goals were to reduce the number of cancelled operations due to the recent pressures on their beds. They planned to re-open the elective surgical ward when it was safe to re-start their elective orthopaedic surgery.
- The vision of the trust was to deliver excellent care, teaching, training and carry out research.
- The values were putting patients first, take ownership, respect others, be positive and listening, learning and improving. Not all staff we spoke with was aware of the trust values, some had now seen the advertised material across the trust but they reported this was a recent introduction by the trust.
- The leadership team also wanted to look at reducing the number of beds in some of the bays due to the cramped conditions; however they were not able to do this until the pressure on beds had reduced.

Governance, risk management and quality measurement

- A governance framework was in place to monitor performance and risks and to make sure the executive board were aware of these. However this had not identified concerns raised by staff about the current system for booking operations and the difficulties this had caused for patients and staff with operations being cancelled due to not enough time or equipment not being available. The care group and the trust had not acted quickly to identify the issues which lead to this situation and actions were not having an evident impact on patient experience.
- The surgical care group team had recently had the Royal College of Surgeons review of their colorectal service. This had shown the service was safe but had made a number of recommendations. These recommendations were due to be discussed and implemented.
- Clinical governance meetings were held once a month, with a half day dedicated to this in the consultant surgeon's job plans. The meetings included all of general surgery. During these meetings cases of morbidity and mortality, including all of those for which serious incident reports had been raised, were discussed.
- The head of nursing for surgery told us the matrons had a clinical day every week where they went 'back to the floor'. This was used to monitor the standards of care on the wards and to provide support to staff.
- The head of nursing for surgical care group showed us a detailed audit for a number of areas, this included falls reduction, safety equipment, nutrition and hydration. Each ward was graded on the questions between red, amber and green. If the ward had any section of the audit rated red or amber this was followed up again at a later date to make sure of compliance.
- The clinical lead and head of nursing for the surgical care group told us about their main risks. These were escalation of beds due to the pressure they were under from increased admissions to the hospital. Assessing the risk for patients who were deferred from surgery due to the pressures and concerns about staff whether they felt supported as they were working in very difficult circumstances. We saw these were on their risk register and some had been put on the trust risk register for example, the increased pressure on their services which had resulted in cancelled operations.
- The head of nursing for the surgical care group told us they had oversight of all incidents and met with the Quality Manager for Surgury to discuss these. Learning from these was shared with all staff via meetings.
- There was a clinical governance group for the surgery care group where they also discussed incidents, complaints etc.
- Theatres also had their own management board that met monthly to discuss a number of topics for example, staffing, governance, finance etc.

- CSSD was internally and externally audited and regulated to enable them to provide services to other health care providers, for example, GP's. They told us their main risk was failure of power; they now have a dual power supply on emergency backup for two machines. The risk of infection from CJD, they had separate kits available for children with confirmed or suspected CJD.
- Interventional radiology had a review of their services as part of the UK Radiology Services Review March 2015 for this hospital. This made some recommendations to improve the service which were being reviewed at the time of our inspection.
- Junior doctors told us mortality and morbidity meetings occurred regularly in all surgical specialties, and that the cases were discussed openly and candidly with junior doctors and consultants. They felt that there was beneficial learning from these meetings. We were shown minutes of some of these meetings.

Leadership of service

- The leadership within the surgical care group reflected the visions and values of the trust to promote good quality care.
- The surgical care group was led by a clinical director who had been in post for five months. They had a care group manager and a head of nursing. We met with members of the team on two occasions during our inspection. From discussions with the clinical leadership one of their main focuses was about improving the patient experience especially during the increased pressure on their services and how they can look to address the high numbers of cancelled elective operations.
- Consultant surgeons were reported as supportive and encouraging by junior doctors, in surgery. One junior doctor said their senior colleagues were "excellent" and "inspiring".
- Some members of the clinical leadership groups were not always visible to all members of staff. For example, junior doctors were not aware of who the clinical leads were, only one junior doctor could identify their clinical lead. Junior doctors were also not aware of who the trust medical director was.
- Junior doctors told us they felt well supervised by consultants, and they encouraged junior doctors to get involved with care group management and quality improvement projects to improve care in Plymouth.
- The majority of consultant surgeons were visible and regularly seen on every ward, seven days a week.
- Matrons were seen on most wards and often they were involved with direct patient care, leading by example. Staff on Sharp ward said their Matron was always visible and available to staff, this was also echoed by staff on other surgical wards. Not all staff had seen the Director of Nursing during their tours of the wards and departments.
- The junior nursing staff on all wards were unanimous in stating that their immediate nursing supervision was good, and there was clear leadership from ward managers and matrons.
- Staff told us they felt the chief executive had changed the vision of the trust to move forward and improve the patient journey.

Culture within the service

- Staff were all enthusiastic about working for the trust and how they were treated by them as a whole, as they also felt respected and valued.
- We spoke with a number of staff who had worked for the trust for over 10 years and all said they felt part of the team and enjoyed working at Plymouth hospital.
- The term "Duty of Candour" was not understood by staff but when nurses and doctors were asked about the principles of this they appeared to have a full and adequate understanding of it. Staff told us the trust encouraged them to be open with patients and to tell them when things had gone wrong.
- Staff and patients told us the staff went well above their required workload to try to deliver the best possible care for them, and staff were encouraged to truly care for their patients.

Public and staff engagement

- Patients and staff were encouraged to give their views on the services provided to help improvement and with the planning and shaping future services
- Patients were able to feed back their views on the ward via the Friends and Family Test. They were asked whether they would recommend the ward to their friends and family. We saw results of these on display in the wards. The overall response was the vast majority of patients recommended the wards.
- To encourage feedback from patients we saw advertised 'tea with matron' on one of the cardiac wards. These were also taking place on other surgical wards.

Surgery

- On the surgical assessment unit they had a routine team review that took place at every shift change. The purpose of this was to include all staff in the running of the unit and how they were meeting their objectives.
- Staff were encouraged to share their views at their team meetings.
- The trust board cascaded information and news items to staff by email and within electronic alerts and newsletters.

Innovation, improvement and sustainability

- Staff were encouraged to help with the continuous improvement and sustainability of the trust.
- The celebration awards (these were where members of staff could put forward other staff/wards or units for an award) were reported as a positive initiative by staff on Braunton ward. This ward won the patient choice award and they found that this had really motivated their team to keep improving the care they provided to patients.
- The head of nursing for the surgery had devised a badge with Plymouth College for nurses and health care assistants with the Plymouth hospital name on it. There were different colours for staff who had been there over one year and ten years. We observed some of the nursing staff wearing these. We spoke to one health care assistant who told us they had been at the hospital for over 15 years and the felt proud to wear their badge.
- Another innovation to encourage wards and staff to improve their harm free care was the Recognition Certificates for pressure ulcer reduction awards. These awards were given to wards who had the most harm free days. Stonehouse ward was also issued with a cake from the surgical care group team as they had been 100 days without a pressure ulcer.
- We were told about an initiative where the procurement team were working with the clinical staff in theatre to review the use of some equipment and to help reduce the capital spend.
- Staff told us about a group where they could put ideas forward. One of these was the use of mirrors to check patients' heels for signs of pressure ulcers as nurse were finding it hard to access patients' heels in certain situations.
- The trust had supported the purchase of a robot to assist with colorectal, urology and gynaecology surgery. This had enabled patients to have surgery locally and not be referred to other hospitals.
- The surgical care group management team told us they had to make efficiency savings but they had to balance these to make sure they benefitted both the patients and trust

Critical care

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

Information about the service

At Derriford Hospital there were two units providing critical care. The department of critical care (DCC) in Penrose and Pencarrow wards and cardiac critical care in Torrington ward. The DCC was opened in its current configuration in September 2009. It provided a service to patients who needed intensive care (described as level three care) or high dependency care (described as level two care). Patients would be admitted following complex and serious operations and in the event of medical and surgical emergencies. The unit provided support for all inpatient specialities and tertiary services within the acute hospital, and to the emergency department, including major trauma patients. The department had two linked units. One (Penrose ward) was for general intensive and high dependency care and the other (Pencarrow ward) specialised in neurosurgical advanced care. Penrose ward had 16 funded bed spaces of which 14 were being used at the time of our inspection. The reduction in bed numbers was an approved decision driven by the unit to ensure the service operated with safe staffing levels. One of these 14 beds was staffed and approved for use in an emergency rather than elective or planned admissions. Pencarrow ward had 10 funded bed spaces, all of which were in use.

The nursing teams worked mostly in just one of the areas of the unit (Penrose or Pencarrow), although they were flexible in ensuring the service was safely staffed. The medical team worked across the whole unit. The service was led by a consultant intensivist who was part of the medical physician team at the trust.

The department admitted around half of its patients from surgical procedures and the other half were non-surgical. Of the non-surgical patients, the specialities included acute medicine, neurology, endocrinology, hepatology and cardiology. Of the surgical procedures, around 30% was high-risk elective surgery and 20% emergency surgery.

At the time of the inspection the hospital was experiencing unprecedented pressure on the service. This reflected themes and trends nationally. Admission to the unit was limited by the number of bed spaces, but the service was usually busy and often full. The number of patients treated therefore had been relatively stable in the past five years. In 2014, the combined areas of Penrose and Pencarrow cared for around 1,600 patients aged 16 years and above. The Acute Care Team provided support to around 7,000 patients each year throughout the hospital. There were a small number of children under 16 years admitted either prior to retrieval to a paediatric intensive care unit, or for emergency specialist care.

The hospital provided advanced care for cardiac surgery. Torrington ward was an 18-bedded intensive care (ICU) and high dependency unit (HDU) for patients post cardiac surgery. There were a total of 16 beds currently used for admissions. Eight beds and two side-rooms located in the ICU, and six beds located in the HDU area.

On this inspection, we visited the DCC on Wednesday 22, Thursday 23 and Friday 24 April 2015. We visited Torrington ward on Friday 24 April 2015. We spoke with a full range of staff, including consultants, doctors, trainee doctors, different grades of nurses, and healthcare assistants. We met the Service Line Cluster Manager, the matron, and the Service Line Clinical Director (the lead consultant) for

Critical care

critical care. We spoke with the lead physiotherapist, nurses from the acute care team who managed, among other things, the hospital outreach team, the lead pharmacist, the practice nurse educator, two specialist nurses for organ donation, and members of the administration team. We met with patients who were able to talk with us, and their relatives and friends. We observed care and looked at records and data.

Summary of findings

We have judged the overall critical care services at Derriford Hospital as good. There were two distinct units. The general (Penrose) and neurosurgical (Pencarrow) units ran as one service called the Department of Critical Care (DCC) and there was a cardiac critical care unit in Torrington ward in another part of the hospital. The safety, effectiveness, caring and leadership of the service were good. However, the responsiveness, in terms of arrangements to discharge patients at the appropriate time, required improvement.

There was a good track-record on safety with lessons learned and improvements made when things went wrong. This was supported by staff working in an open and honest culture and a desire to get things right. Staff responded appropriately to changes in risks to patients and produced and completed appropriate assessments and care plans that were followed. There was an Acute Care Team providing an outreach service to all wards 24 hours a day, every day of the year.

There was high-quality well maintained equipment and a safe environment. The units were clean and well organised and staff adhered to infection prevention and control policies and protocols.

Bed numbers had been reduced in the Penrose general unit and Torrington cardiac unit to ensure there were safe levels of nursing staff. But to achieve this, bank staff were employed in the Penrose unit to make up for the lack of substantive staff. Active recruitment was taking place to address this. Nursing staffing on the Pencarrow neurosurgical unit was closer to required levels. The consultant and doctor cover was mostly meeting the Intensive Care Core Standards. There was a strong commitment of experienced consultant intensivists, and rarely any locum cover used. The provision for pharmacy and physiotherapy services did not meet the recommendations of the Faculty of Intensive Care Medicine Core Standards. The service provided was safe, but there was not enough staff to provide more than the minimum service.

The electronic patient records were comprehensive, well maintained, clear, and contemporaneous, although the speed of access to and reliability of the electronic

Critical care

system needed to be improved. Medicines and consumable stocks were managed, stored and used safely. There was a shortfall in staff having completed their mandatory training due to a busy winter period.

Treatment and care was delivered in accordance with best practice and recognised national guidelines. There was a multidisciplinary approach to assessing and planning care and treatment for patients. Patients were at the centre of the service and the overarching priority for staff. Good results were achieved for patients who were critically ill with complex problems and multiple needs. The mortality rates within units showed more people than would have been expected survived their illness due to the care provided. There was, however, a limited presence from the nursing team in case review and other relevant meetings in the DCC.

The DCC did not meet the Core Standards for nursing education. Only 38.5% of the nursing staff had obtained a post-registration award in critical care when the Core Standards recommended at least 50% of the nursing staff achieved this. Appraisal rates also did not meet the trust's target levels. Local audit work was not routine or prioritised to ensure outcomes and effectiveness of care were well understood, could be improved, or celebrated as necessary. The medical notes were not capturing well enough the recording of decisions around patient consent, mental capacity and the use of any deprivation of liberty.

Feedback from people who had used the service, including patients and their families, had been very positive overall. Staff ensured patients experienced compassionate care, and care promoted dignity and human rights. It was not noticed by us as a frequent problem, but unnecessary noise within the DCC did at times disturb patients.

The DCC service responded well to patient needs. But there were bed pressures in the rest of the hospital that meant a significant number of patients, were delayed on discharge to other wards and too many were being discharged at night. There was a relatively high level (when compared nationally) of elective surgical operations cancelled due to unavailability of a critical care bed. Otherwise, the unit protected a bed for admission of a patient only in an emergency. With very few exceptions, all patients who had needed emergency admission onto the unit had been admitted.

The facilities in critical care were excellent for patients, visitors and staff, and met all of the modern critical care building standards. There were no barriers to people to forward complaints, and there were very few complaints made to the department. Those that had been made were fully investigated and responded to in a timely way with improvements and learning evident. There was, however, no provision in the DCC for any support to patients with mental health needs or the anxiety they or their relatives and friends might be experiencing.

The leadership and culture in the services were used to drive and improve the delivery of high-quality person-centred care. All the senior staff were committed to their patients, their staff and their unit with a shared purpose. Elements of the governance of the DCC such as quality and safety audit results were not consolidated, and brought into the departmental meetings.

There had been some recent senior nurse appointments to the DCC who were being supported from the Service Line Cluster Manager, the Service Line Clinical Director, and the senior nurses.

Critical care

Are critical care services safe?

Good

There was a good track-record on safety with lessons learned and improvements made when things went wrong. This was supported by staff working in an open and honest culture and a desire to get things right. Staff responded appropriately to changes in risks to patients and produced and completed appropriate assessments and care plans that were followed. There was an Acute Care Team providing an outreach service to all wards 24 hours a day, every day of the year.

There was high-quality well maintained equipment and a safe environment. The units were clean and well organised and staff adhered to infection prevention and control policies and protocols.

Bed numbers had been reduced in the Penrose general unit to ensure there were safe levels of nursing staff. But to achieve this, bank staff were employed in the general unit to make up for the lack of substantive staff. Active recruitment was taking place to address this. Nursing staffing on the Pencarrow neurosurgical unit was closer to required levels. The consultant and doctor cover was mostly meeting the Intensive Care Core Standards. There was a strong commitment of experienced consultant intensivists, and rarely any locum cover used. The provision for pharmacy and physiotherapy services did not meet the recommendations of the Intensive Care Core Standards. The service provided was safe, but there was not enough staff to provide more than the minimum service.

The electronic patient records were comprehensive, well maintained, clear, and contemporaneous, although the speed of access to and reliability of the electronic system needed to be improved. Medicines and consumable stocks were managed, stored and used safely. In the DCC there was a shortfall in staff having completed their mandatory training due to a busy winter period.

Incidents

- Staff were open, transparent and honest about incidents. All staff we spoke with said there were no barriers to reporting incidents and they were encouraged and reminded to do so. An electronic incident reporting system was used to record incidents, and staff said it was uncomplicated to use. The most recent incident report for the department of critical care described a good number and a range of incidents being reported by staff. This included reporting from both medical and nursing staff. The overall trust was above (better than) the NHS England average for reporting incidents, which could be taken as an indicator of staff proactively reporting incidents as and when they should. The management of the Torrington cardiac ICU/HDU were confident that staff were open, transparent and honest about incidents. The matron and nursing sister in charge said there were no barriers to reporting incidents and they and their teams were encouraged and reminded to do so. Each time an incident was reported, staff had feedback from the matron or nurse in charge thanking the staff for reporting the incident. The nursing staff we met agreed this happened and one member of staff commented how the appreciation gave them the confidence that the incident had been seen and would be addressed.
- Staff felt they were not blamed for errors or omissions. All staff we asked in both the DCC and the cardiac unit said they were not afraid to speak up when something went wrong or could have been done better. They were listened to, able to be fully honest and open, and treated fairly by their peers and managers.
- Incidents were reviewed and, where necessary, investigated. A report of incidents recorded in the previous week were discussed at the weekly clinical risk meeting. Trends and themes were looked for. When identified, practice was changed or improved with the objective of reducing or eliminating the incidence. An example of this was following recognition of a recent increase in patients pulling out their nasal gastric feeding tubes. The clinical team identified this increase and considered if the bridles used to hold the tubes in place could be improved. The team looked at the implications of changing the bridles. This included evidence of other or best practice in using this equipment, the financial implications, and the possibility of unintended consequences. A decision was taken to use different equipment, and the bridles were changed. The clinical team were closely monitoring the incidents (which had already reduced) to ensure this been the right decision. The clinical nurse educator was also engaged with this process to ensure update training or teaching was delivered where necessary. In

the Torrington cardiac ICU/HDU incidents were reviewed and, where necessary, investigated by the senior nursing team or the lead consultant. Incidents recorded the previous week were discussed at the weekly unit manager's meeting. We discussed incidents recently investigated and heard about examples of where practice had been changed to reduce or avoid the risk of the incident recurring. This included improved practice around identification of infections, and improved communication with families.

- Staff took action on incidents quickly and in a timely way. As well as trends in incidents, one off incidents were learned from to limit repeat events. For example, the clinical risk meeting had considered a recent concern about risk of pressure ulcers for patients undergoing spinal surgery where their movement was limited. The clinical concerns about using pressure relieving mattresses had been debated among medical staff. A decision was taken to implement this equipment in all surgical cases to reduce the risk of skin and tissue damage for patients who needed specialist physical therapy after surgery.
- Incident reports were produced to identify any trends. Incidents were shown graphically by their type and severity. The majority of incidents happening caused no harm or were graded as minor. We noted an increase in incidents reported in the last three years. Staff said they felt this was attributable mostly to an improved attitude to reporting by staff, and more incidents being report. Staff also said shortages at times of experienced nursing staff in particularly 2014 and long hours worked had contributed to an increase in incidents. The Torrington cardiac ICU/HDU had identified a cluster of pressure ulcers developing with patients in 2013/2014. A change was made to the patient assessment and cream was applied to pressure points before the patient went for surgery. Pressure-relieving mattresses and inflatable boots to protect the heels and feet were introduced for all patients.
- Learning from incidents was shared between staff. Incident reports were a standing agenda item on the Critical Care Department monthly governance meeting. The incidents were not, however, discussed in the same amount of detail as at the weekly clinical risk meetings.
- The department learned from serious incidents requiring investigation. There had been one serious incident in critical care in the last two years since March 2013. The investigation report commenced with a preliminary report and continued to a root cause analysis. Learning from the case was identified and we saw how staff had been made accountable for sharing the learning and putting new or changed practice into place. There had then been a review of the investigation by the local clinical commissioning group and this raised further questions and points which had been addressed. The learning points were then presented to staff and there were changes to specific medical charts as a result of this incident. Other learning included reminding staff of the low threshold for admission to intensive care for cases of this type and the need for increased observations.
- Duty of Candour had been introduced. Staff in the critical care service line were aware of the new regulation to be open, transparent and candid with patients and relatives when things went wrong. From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2009. Although this was a relatively new requirement, senior staff in critical care were aware of their duty to inform all relevant parties of notifiable patient safety incidents. Although the serious incident discussed above was just prior to this regulation, the investigation report recorded conversations with and explanations given to the patient's family. There was, however, a further investigation report we read from 2015 where it appeared the Duty of Candour requirement had not been correctly understood or applied. This was discussed at some length with the matron who also reviewed the report for us. They agreed there were a number of factors within the comments around Duty of Candour that needed addressing with staff.
- Patient mortality and morbidity (M&M) was reviewed in the DCC. A list was maintained of patients for discussion at these meetings, which were held quarterly. We saw minutes from meetings in early 2014, but more recent minutes were not immediately located to show us. There were action points on the minutes we saw, but actions arising were not attributable to a member of the team for sharing or education. From the minutes there was no evidence of how learning was shared either locally or more widely in the rest of the hospital where appropriate.

Critical care

Safety thermometer

- Patients were assessed on admission and during their stay for the risks of harm. There were assessments in place for all patients for risks from the most common harms. These included: falls, pressure ulcers, venous thromboembolism, and urinary tract infections.
- In the records we reviewed in the DCC we found the assessments for pressure ulcer care were mostly, but sometimes not fully completed. The newly appointed matron knew this and that the incidence of pressure ulcers was an area needing focus and possibly further analysis and training. There was also a disparity of results for pressure ulcer incidence, with neurosurgical patients on Pencarrow having fewer incidents than the patients on the general unit, Penrose.
- There was a variable result in patient harms in the DCC. Patients were experiencing a low number of falls. There had been a low level of falls with harm in the department in the 12 months from April 2014. In that period there had been four falls recorded and no more than one in any one month. We were concerned, however, at there being a 'target for safe care' on the trust data for the critical care unit of one fall with harm being acceptable. The evidence supplied by the trust for critical care showed there had been a peak of hospital acquired pressure ulcers (category two, three and four) in November 2014 with 10 recorded. This had reduced to one in December 2014, three in January, four in February, and three in March 2015. The senior staff in critical care said the 'targets' were related to showing reductions from cumulated results, but agreed they were misleading and not appropriate.
- For the DCC we were not provided with some data on patient harms and it did not feature in the trust's 'Safe Care' dashboards. We therefore cannot report on incidents of venous thromboembolism (VTE) or urinary tract infection (UTIs). There was also no public display on the unit in relation to safety thermometer data.

Cleanliness, infection control and hygiene

- Rates for unit-acquired infections were low. Data reported by the DCC to the Intensive Care National Audit and Research Centre (ICNARC, an organisation reporting on performance and outcomes for around 95% of NHS intensive care units nationally) supported this evidence. All rates of infection had over time mostly been below (better than) the national average. There were no unit-acquired methicillin resistant Staphylococcus aureus (MRSA) infections in the three years to the end of 2014 (the most recent data available). There had been no unit-acquired Clostridium difficile since late 2011 until the last quarter of 2014 when there were two incidents. There had been mostly low numbers of unit-acquired bacteraemia infections (those not MRSA) in the past three years. There were extensive reports available to the department from the microbiologists on trends in a wide range of infections and bacteria. These demonstrated low numbers in these areas in 2013 and 2014.
- The DCC had not always adhered to trust policy for infection prevention and control in relation to isolation of patients and commencement of MRSA suppression therapy. In December 2014, there were two patients on Penrose ward with methicillin resistant Staphylococcus aureus (MRSA) (not hospital acquired) and suppression therapy was not started as required within two hours. There were also five patients needing isolation: three were accommodated in time, two after the standard time, and one was unable to be isolated. The reasons for these delays were not clear in the infection control report.
- Infection control was a standing agenda item at critical care department meetings. Minutes from the last three DCC monthly meetings in 2014 recorded a number of discussions about different aspects of infection control. These included: infection control risks from medical equipment, changes to cleaning routines, and learning from other areas of the hospital.
- At the time of our inspection the units were visibly clean. This included patient and staff areas and equipment used both regularly and occasionally being clean, well-organised, and tidy. Patient bed spaces were visibly clean in both the easy and hard to reach areas such as beneath beds and on top of high equipment. Bed linen was in good condition, visibly clean and free from stains or damage to the material. The cleaning of the unit was audited and checked each week. The DCC had scored above the 95% target on all but six of the weeks for the 12 months of 2014. The majority of results, at approximately 98%, showed compliance for managing infection control risks.

- Reusable and new kit and equipment was stored and, where required, sealed to prevent cross-contamination. All disposable equipment was in sealed bags in trolleys, drawers or cupboards where possible, to prevent damage to packaging.
- Patient bed areas were managed to prevent cross infection. In the DCC, staff entering bed areas, crossed a visual change in the colour of the flooring. Staff were required to sanitise their hands in that area and wear aprons and gloves that were put on and removed within the same area. There was a good supply of personal protection equipment available for staff and visitors. A small stock of consumable items and equipment for patient care were also kept within that area, and would be removed and disposed of in the event of any patient infection or other concern. There were private isolation rooms available for use for patients with infections. A higher level of control measures for staff and visitors were in place when these rooms were in use for this purpose. We saw visitors observing hand sanitising requests on entering the units, the bed spaces, and upon leaving the department.
- Clinical waste was well managed. Single-use items of equipment were disposed of appropriately, either in clinical waste bins or sharp-instrument containers. None of the waste bins or containers we saw was unacceptably full and nursing staff said they were emptied regularly.
- Hand sanitising rules were followed. We observed doctors and nursing staff following policy by washing their hands between patient interactions, using anti-bacterial gel and wearing disposable gloves and aprons at bedside. All staff were bare below the elbow (had short sleeves or their sleeves rolled up above their elbow) when they were within the units. Results for hand hygiene had scored 100% compliance in audit for almost all of the year from April 2014 until February 2015 when it dropped to 50%. There were no reports in governance meeting minutes we read or other evidence to say why.
- Visitors were required to follow infection control protocols. Information was provided and staff requested them to use alcohol gel when arriving on the unit. This was freely available and clearly visible. The DCC information booklet did not, however, request visitors to consider their own health when visiting and to not come to the unit if they were unwell or becoming unwell. There was a policy of limiting the amount of property left with the patient in the hospital, although this was highlighted more around a lack of space as opposed to infection control. Visitors were also asked not to bring flowers, although there was no explanation as to why this was request was made.

Environment and equipment

- The design of bed spaces helped to keep patients safe. The units had been built to modern critical care building standards and so each bed space was at least 25m^2 to allow for safe access to patients and equipment surrounding them. Each space could accommodate a minimum of five staff to work with a patient if required. One of the single rooms in the DCC was set up as a simulation and training room. This could be converted to a fully-equipped patient room within an acceptable 45 minutes.
- The bed spaces in the units had appropriate safe levels of equipment. The units met all the Department of Health requirements for safe equipment in a critical care unit. This included: flat-screen monitors, multi-parameter patient monitoring equipment, a minimum of three infusion pumps, and a minimum of four syringe pumps. There was other relevant equipment including a portable X-ray machine, ultrasound machines, haemodialysis machines, haemodynamic monitors, and defibrillators. We spoke with a range of staff about the safety of equipment and staff said they had no concerns. The DCC had two technicians working Monday to Friday. Their role included preparing transfer equipment and setting up and monitoring bedside equipment. Equipment was regularly serviced and maintained and was standard well-tested kit.
- Patient beds and chairs met safety requirements. The beds, mattresses and chairs for patients met the standards of the Department of Health and the Faculty of Intensive Care Medicine. Each bed was capable of attaining different positions for patient comfort and to assist staff. All beds had air mattresses to relieve pressure to the body when lying in the same position for long periods of time. There were a variety of chairs for patients to use when they were well enough to sit out of bed. There was a satisfactory level of equipment for bariatric (obese) patients.

- The DCC had appropriate adult patient equipment for use in an emergency. There were resuscitation drugs and equipment including defibrillators in a specific trolley. There was a difficult airway intubation trolley divided into different trays according to the intubation strategy and equipment to be used with the patient. The trolleys had been checked regularly. In the DCC, the resuscitation and difficult airway trolleys were not however, differentiated in appearance from other general trolleys. This would be done to ensure they were easily visible in an emergency and to staff who were not regularly working on the unit. Where they contained emergency drugs these were not in trolleys that were sealed to prevent tampering or to show equipment might have been used and not replaced. The Torrington cardiac ICU/HDU had appropriate equipment and trained staff for use in an emergency. There were resuscitation drugs and equipment including defibrillators, and equipment was available carrying out chest reopening procedures in the case of a serious emergency.
- The DCC had emergency equipment for use with children in the event of a medical emergency. However, some of this equipment, although infrequently used (but should be available at all times), was out of date and there was no routine for checking it.
- Staff were trained and competent to use equipment. The nursing staff and practice nurse educator maintained good training records for equipment and competencies. There was full training for trainee doctors on the equipment used in the departments. The competencies were reviewed and signed-off by the consultants.
- In the areas we checked in the DCC, all consumables and equipment with expiry dates were in date. The nursing sister we talked with about kit said the stores and trolleys were regularly checked by one of the healthcare assistants. They checked for evidence of damage to packaging (these were then disposed of) and for items approaching or past their expiry date. Staff said they endeavoured to use equipment first when it was approaching the use-by date. We observed consumables and equipment used in the department was kept to a minimum of those things used often in order to reduce waste and the risk of expired equipment.
- There was reasonable storage space for equipment in the DCC to enable the environment to be free from clutter and equipment used infrequently. Most equipment was stored in cupboards and storage spaces, but, as with most NHS wards, some large equipment was placed in offices, meetings rooms and corridors. This was managed well, and the areas and equipment were clean. In the Torrington cardiac ICU/HDU ward there was reasonable storage space for equipment to enable the environment to be spacious, easy to clean, and free from clutter and equipment used infrequently. Most equipment was stored in cupboards and storage spaces. Some large equipment was placed in the corridor between the ICU and HDU. This was, however, managed well, and the areas and equipment were clean.
- The units were secure on entry from the main corridors. There was swipe-card entry for authorised personnel to gain access to the clinical areas. If the reception desk was not staffed when visitors arrived, staff could admit them to the unit with camera-controlled access.
- There were facilities for isolation in both units. In the Torrington cardiac ICU/HDU the two side rooms were designed with a ventilation system which caused air to flow into the room, but be extracted externally to prevent air-borne cross contamination. The rooms were designed with entrance lobbies which had hand washing facilities and an area to change clothes, which prevented cross-contamination when staff or visitors left the room. However, the rooms were in an area of the unit which was not visible to the rest of the ward.

Medicines

- Medicines, including those requiring cool storage, were stored appropriately. Records showed medicines were kept at the correct temperature, and so would be fit for use. Refrigeration temperatures were checked each day as required and recorded. Medicines were stored in locked cupboards in a clinical area and well organised. The controlled drugs were kept in a suitable standard metal cabinet. Potassium was also stored, as required, under controlled drug requirements, and was locked away.
- In terms of time given to the units, pharmacy cover, particularly in the DCC, was insufficient. This was stated by the senior pharmacist, the clinical lead, other

consultants, and the nursing team. The department was heavily reliant for medicine management upon the experienced, knowledgeable and skilled consultant body. Also, the cover from the pharmacy team was not meeting the Faculty of Intensive Care Medicine Core Standards (the Core Standards). The recommended cover level was a consensus of critical care pharmacists, the UK Clinical Pharmacy Association, and the Royal Pharmaceutical Society. If the unit was full and patient levels of care were high, the Core Standards recommended there be two senior grade (band eight A or above) pharmacists providing a full service to the unit. There was one senior pharmacist (band eight A) working on the unit, and they were also providing services elsewhere in the hospital. Due to prioritising risks, the senior pharmacist was not always able to review every patient each day. New patients were also not always seen on the day they were admitted. The pharmacist was also not able to join the ward round each day, which was a recommendation of the Core Standards. Due to significant staff shortages across the pharmacy team, the senior pharmacist was not getting sufficient back-up from staff in technical or more junior roles. The pharmacy team provided an on-call system to make sure advice was provided at all times.

- Patient medicine records were well managed using standard drug charts. There was a mix of standard pre-printed charts for intravenous medicines which were often administered following standard protocols. The main drug charts were written-up by the medical staff. All of those we reviewed were complete, relatively legible and clear.
- Controlled drugs were recorded clearly and stocks were accurate in all those we checked in the DCC. We cross-referenced one of the drugs at random with a patient drug chart and found the drug had been administered on the occasions stated on the record.
- There was an audit each month of the safe storage of medicines. The Pencarrow unit had scored 100% on all aspects of the audit in the first four months of 2015. This included, among others, all medicine storage being locked and all drugs being in their original pharmacy packaging; the fridge temperature being safe; and there not being any medicines or injections left unattended. The Penrose unit had scored 100% for all audits with the exception of two months; in March and April 2015 scoring zero as not all drugs were in their original pharmacy packaging.

Records

- Patient notes were well organised and completed. We reviewed ten sets of patient notes in the DCC. Four sets were reviewed for their medical content, three for nursing records, and a further three for their notes from the physiotherapists. Notes were held and recorded electronically and copies of daily notes added to the patient's paper records so they could accompany them as they moved through the hospital. The electronic records had areas for medical and nursing review with clear prompts to guide staff to consider all relevant aspects of care. There were sections including diagnostic and screening information, medicines and therapy. Records demonstrated personalised care and multidisciplinary input into the care and treatment provided.
- The patients' treatment plans were clear and could be followed through the records. This included the prescription of medicines, which were then tracked to the drug chart. Nursing care plans, risk assessments, and observations were up-to-date and all interactions had been documented. Staff signed into the system so records made were attributable to the member of staff caring for the patient. We saw from one patient record, however, there was an error in terminology used by a medical student. The nurse we spoke with knew the entry was wrong, but it had not been changed. There was a risk of harm to the patient from this technical error in the notes.
- Patient paper notes were stored to ensure confidentiality and security. Each part of the unit had locked storage trolleys which were opened with a key code pad. We observed paper notes being used were supervised at times by staff. Electronic notes were also kept confidential and at no time did we see patient confidential information left visible or unaccompanied on any screens or boards.
- The electronic patient record system was not without technical problems. There had been an incident reported to the risk register (record undated) where the system had been unavailable for 12 hours due to

technical problems. This issue had been rated as a serious risk, but there was no mention of any actions to reduce or eliminate the risk of this happening again. The system could also take too much time to upload data, so quick access to a patient's notes could be subject to delays. We observed a team of doctors waiting for several minutes for the system to load when they were alongside a patient. The equipment was also moved between patients and had to be plugged in to avoid draining the short battery life.

Safeguarding

- Staff were trained to recognise and respond in order to safeguard a vulnerable patient. This included any children admitted to the unit or associated with a patient or visitor. Mandatory update training was delivered and most nursing staff were up to date with their knowledge. Compliance at the end of March 2015 was 100% for level one update training, and 92% (just below the trust target of 95%) for level two. A small number of staff were required to train to level three in child safeguarding. At the end of March 2015 the data provided said only 17% of staff had completed their update training. The practice nurse educator told us only two staff were required to have level three training and they had both completed the course. This information was therefore contradictory.
- There were policies, systems and processes for reporting and recording abuse. The policies described definitions of abuse and who might be at risk. The policies were linked with the provisions of the Mental Capacity Act 2005 in relation to deciding if a person was also vulnerable due to their lack of mental capacity to make their own decisions. Staff were correctly directed to presume a person had capacity unless, for the time a decision was needed, this was assessed as not the case. The policies clearly described the responsibilities of staff in reporting concerns for both adults and children, whom, as required, were subject to different procedures. There were checklists and flowcharts for staff to follow to ensure relevant information was captured and the appropriate people informed. The senior staff in the Torrington cardiac ICU/HDU were aware of their responsibilities to investigate and report and concerns about children or vulnerable adults. They knew who within the hospital trust could be contacted for support or to take matters further with other agencies.
- Staff were clear about reporting safeguarding. However, staff said they had cause in the past to have to make referrals for vulnerable adults directly to local authorities, as there was a limited resource in the trust to do this centrally. Staff said this often involved them having to spend several hours on the telephone trying to find the right person if the local authority in question was not local.

Mandatory training

- The DCC staff were not meeting the trust mandatory update training targets, although we were given different information about actual achievements. Training targets for staff to update mandatory subjects was approved at board level. The target for staff to have completed their 'trust update' mandatory training was 95%. Trust data for end March 2015 said critical care staff had only reached 74%. Information from the practice nurse educator said the overall results (excluding staff on maternity or adoption leave) was 86%. Mandatory update training included health and safety, fire training, information governance, and other statutory and mandatory subjects. Basic life support training was captured separately and according to the trust records, 77% of critical care staff had undertaken this training from a target of 95%. Manual handling training had been undertaken by 93% of staff from a target of 95%. The consultants were provided with a bespoke manual handling training session specifically targeted to understand the nuances of working with neurosurgical and other patients in a critical care unit. This was delivered by a senior nurse educator with specialist knowledge.
- Each member of staff was responsible for their own training being completed within the year. This was discussed at their annual appraisal and staff would not have their performance review 'signed off' unless all training had been completed. Staff from a number of different disciplines said other work-related pressures had caused them to cancel or postpone their annual

training updates in order to prioritise other work. We met a number of staff who said they were booked to complete their training in the coming weeks, or had organised time to be set aside for completion.

Assessing and responding to patient risk

- The nursing team and medical staff assessed and responded well to risk. Ward rounds took place at regular intervals. In the DCC there were two ward rounds led by the consultants on duty each day, morning and evening. There was input to the ward rounds from unit-based staff, including physiotherapists, trainee doctors and nurses, although limited input from the pharmacist due to time pressures. Other allied healthcare professionals were asked to attend when required. On a ward round we observed there was a full range of clinical indicators available within patient notes. These included blood results, radiology results, observations, and physiological data. Routine patient care was discussed in a structured manner following the clear prompts within the electronic patient records. This included the management of invasive lines, tracheostomy management, respiratory levels, neurological indicators, nutrition and fluid input and output, skin wounds, and infection control.
- There was methodical and thorough review of patient risks. This extended to all patients, even those who had been in the DCC for a long period of time, where progress was slow or minimal. Trainee doctors were completely involved with patient reviews, able to participate, and given support, feedback, and close supervision from the consultants. There was a consultant led clinical case review each Tuesday morning followed by a clinical risk review. These meetings together spanned two hours and all patients were discussed. The lead for governance on the DCC said this gave the consultants the opportunity to 'calibrate' and review unusual or challenging cases more closely. This included a review of the coding for supplying data to the Intensive Care National Audit and Research Centre (ICNARC) to ensure submissions were fully accurate for all patients. Any output from the meeting was directed to the daily safety briefing to cascade the messages.
- There were detailed patient handover sessions held each morning. In the DCC the trainee doctors handing over did so in two sessions with one for the general patients and a different session for the neurosurgical patients. This ensured the number of patients discussed was a manageable number and enabled clear recall for the doctors involved. We observed the general patient session one morning and it was comprehensive, not rushed, including for the patients discussed in the latter part of the session, and had positive challenge from the experienced consultants. The electronic records system was available in the session to check for changes, updates or results of any diagnostic or screening from the previous day or night.
- This hospital had a policy in place for monitoring acutely ill patients on the units and using critical care trained and experienced staff to respond. It had implemented and was using an adapted form of the national early warning score (NEWS) system. This used a system of raising alerts through colour coding rather than from numerical scoring of patient observations. As in many NHS trusts, the outreach team was managed by critical care, and was part of a wider team called the Acute Care Team (ACT). We met and talked with one of the senior sisters in the team and a new member of the nursing team. The ACT covered responding to deteriorating patients including cardiac arrests, the acute pain team, the vascular access team, and managed the hospital at night. The outreach and pain services were sufficiently staffed with experienced people who provided full cover to the whole hospital site 24 hours a day, every day. The hospital at night team also operated every day of the year. The specialist nurses included all grades of nursing staff including healthcare assistants. The team were a major part of the response service for acutely unwell patients elsewhere in the hospital. They also followed-up and reviewed all patients discharged from the DCC onto the wards the day after their discharge, or beyond; all patients with or post epidural use; and all patients on wards with or being weaned from tracheostomies. This provided support and reassurance to staff taking over the care of a patient who had been critically unwell or had high dependency care. We reviewed the list of patients for that day and saw how this had been put together with input from across the hospital. The outreach team also provided teaching and education services in responding

to risks to the rest of the hospital as part of their role. Staff we met on the medical and surgical wards in the hospital told us about the outstanding service they received from the ACT team.

- The ACT had audited the hospital for response to deteriorating patients. This involved members of the team 'sweeping' through the wards to look at each patient for indicators of deterioration and check if and how this was being escalated. The results were documented and reported to the director of nursing, and fed back at matron and band seven nurse meetings. Where wards were found to be not escalating deteriorating patients as they should be (and some were showing shortfalls) actions were put in place for training updates and raised awareness.
- Patients were monitored for different risk indicators. For example, each ventilated patient was monitored using capnography, which is the monitoring of the concentration or partial pressure of carbon dioxide in respiratory gases. It was available at each bed on the unit and was always used for patients during intubation, ventilation and weaning, as well as during transfers and tracheostomy insertions. Continuous end-tidal carbon dioxide monitoring was employed in all patients with an artificial airway receiving ventilatory support (as recommended by the 2011 Royal College of Anaesthetists' fourth National Audit Project report).
- Patients were handed over when discharged from the DCC (usually to a medical or surgical ward) with their risks recorded, but the accompanying paperwork did not highlight the key risks. The discharge paperwork produced by the electronic system (which in Derriford Hospital was used only in the general, neurosurgical and cardiac critical care units), was not easy to interpret. Nursing staff on the wards confirmed the paperwork was not intuitive and needed to be scrutinised to understand what was important to understand on handover admission.

Nursing staffing

- There was a safe level of nursing staff in the DCC, although staff were covering a number of vacancies of around 10% of nursing staff. Beds open on the general unit had been reduced from 16 to 14 to ensure there were safe levels of nursing cover from the established staff. The nursing staff levels were based upon the dependency (acuity) levels of patient care. This followed the Faculty of Intensive Care Medicine Core Standards' recommendations for safe nurse-staffing levels. Therefore, when a patient needed intensive care, there was one nurse for each patient. When a patient needed high dependency care, there was one nurse looking after two patients. There was an establishment (approved and agreed need) for nursing staff. Just over 73 whole-time equivalent (WTE) posts for the Penrose area and with just under 64 staff in post (in evidence provided from December 2014). In Pencarrow, there was a requirement for just over 49 WTE posts, and around 2.5 vacancies. To ensure safe staffing levels, the unit was using bank staff to cover unfilled shifts. Very few agency nurses were used as there was a shortage of critical care trained nursing staff in the local nursing agencies in the area. The nursing staff levels on the Torrington cardiac ICU/HDU were close to their planned levels and skill mix, although were stretched at times. The nursing team were flexible with their working patterns to meet the acuity and number of patients. The matron and nursing sister in charge told the staff would put the safety of patients first. The matron described the nurses as "a fantastic team."
- Patient care was not compromised by unacceptably high levels of bank of agency staff. The Core Standards recommended there was never more than 20% of any shift staffed by agency or bank staff workers. At times there could be a high number of bank staff being used on a shift in the DCC, but these were staff who were part of the critical care team working overtime shifts for the bank. There was a limited use of agency staff due to the unavailability of trained nurses locally.
- Senior nursing staff were not counted in the staffing numbers (supernumerary) in order for them to manage the nursing teams. The Core Standards recommended a supernumerary clinical coordinator on duty at all times for a unit of this size. The staff rotas demonstrated there was at least one band seven supernumerary nurse on duty at all times on both Penrose and Pencarrow areas.

Medical staffing

- The experienced consultant presence on the unit followed the recommendations of the Core Standards, although not on weekends. In the DCC there were 14 (12 whole-time equivalent) consultant intensivists (consultants trained in advanced critical care medicine)

working in rotation in critical care and on call. There was also one consultant intensivist assigned to the unit from the Royal Navy. This Royal Navy consultant was factored into the consultant rota but on the understanding they could be called away at any time. They provided good support to the unit and were regularly in attendance and part of the team.

- There was mostly a good consultant to patient ratio in the DCC, particularly on weekdays, but less so on the afternoons on the weekends. There were two consultants on duty or on call from Monday to Friday across the general ICU/HDU unit for the 14 to 16 (when all opened) beds, with one also covering the Acute Care Team. Over the same period there was a consultant on duty or on call for the neurosurgical area for 10 beds. This was significantly better than the Core Standards recommended ratio of one consultant for a maximum of 15 beds. However, on weekends, there was only one consultant on duty from 2pm on Saturday and from 1pm on Sunday for the whole unit, which could be up to 24 or 26 patients. This had been an approved establishment in the past when the unit had been able to close four HDU beds over the weekend as no elective surgery was taking place. But bed closure has been harder to achieve latterly with problems with moving patients out of critical care to elsewhere in the hospital. The weekend cover in the afternoons and on call did therefore not meet the recommendations of the Core Standards.
- The consultant staff levels on the Torrington cardiac ICU/HDU were below the recommended levels for critical care units when the ward was full. There could be up to 16 patients on the ward at any one time. The recommended level for safe care was a ratio of one consultant to 14 patients. The consultants were supported by trainee doctors and the presence of a specialist trainee with advanced airway skills in the operating theatres.
- Commitment of consultant time on the DCC met best practice. The Core Standards required consultants to have a minimum of 15 programmed activities of consultant time committed to critical care each week for eight level three beds and this was met or exceeded. There had been very low use of locum doctors in the unit. Consultants responded well when on call. Consultants said they regularly attended the units out of hours and frequently took calls from staff. When consultants were on duty or on call, this was only for critical care and not extended elsewhere in the hospital.
- There was good cover from advanced trainee doctors and registrars in the DCC. There were two or three advanced trainees working fully supervised alongside consultants. These doctors were not factored into the rota unless there were exceptional circumstances. There was then always a registrar on duty during the day (and usually two), with one for the evening and overnight rota. The registrars were those either on an ICU training block rota or anaesthetic trainees. If they were anaesthetists on call, they were only rostered to critical care and there was a separate rota for theatres, the cardiac critical care unit and obstetrics.
- The cover from resident doctors in the DCC at night had much improved and any current shortfalls were anticipated and being supplemented by internal manoeuvring. Until August 2014 there had only been one resident doctor on call at night alongside the registrar, and this was significantly below the Core Standards of one doctor covering eight patients. When the unit was full, this would represent one doctor for 13 patients. In August 2014 the unit had received approval and support from the executive team to move to two resident doctors at night. Since February 2015, due to a reduction in availability, the cover with two resident doctors had been intermittent. This had been addressed by the consultants staying later on the unit and the resident on duty being taken off the hospital resuscitation at night rota (this position being replaced with another resident) so they were dedicated to critical care.

Allied healthcare professional staffing

- There was a shortfall in the service from the physiotherapy team in the DCC due to insufficient staffing levels. There was dedicated physiotherapy support, but this did not meet the recommendations of the Core Standards. Departments were recommended to have one physiotherapist for every four beds. If the unit was full (24 to 26 beds), the department would need at least eight physiotherapists and in practice there were six in the team covering the unit for between one and half and two hours a day.

Critical care

- There were other allied health professional staff visiting when needed. An occupational therapist and speech and language therapist was available for advice and support upon requested and the speech and language therapist visited on request.

Major incident awareness and training

- The hospital had a major incident plan. Staff knew how to access and distribute the policy and in what circumstances it was relevant. Staff on the critical care unit were aware of their action card and key roles in the event of a major incident.
- In the event of a major incident, elective cardiac surgery would be stopped. Patients who could be discharged safely to wards from the Torrington cardiac ICU/HDU would be moved and the ward would be adapted to be used as a general critical care unit.

Are critical care services effective?

Good

Treatment and care was delivered in accordance with best practice and recognised national guidelines. There was a multidisciplinary approach to assessing and planning care and treatment for patients. Patients were at the centre of the service and the overarching priority for staff. Good results were achieved for patients who were critically ill with complex problems and multiple needs. The mortality rates within units showed more people than would have been expected survived their illness due to the care provided. There was, however, a limited presence from the nursing team in case review and other relevant meetings in the DCC.

The DCC did not meet the Core Standards for nursing education. Only 38.5% of the nursing staff had obtained a post-registration award in critical care when the Core Standards recommended at least 50% of the nursing staff achieved this. Appraisal rates also did not meet the trust's target levels. Local audit work was not routine or prioritised to ensure outcomes and effectiveness of care were well understood, could be improved, or celebrated as necessary. The medical notes were not capturing well enough the recording of decisions around patient consent, mental capacity and the use of any deprivation of liberty.

Evidence-based care and treatment

- The average length of stay of a patient on the DCC had, for the previous five years, been just below (that is better) than the national average. It is recognised as sub-optimal in social and psychological terms for patients to remain in critical care for longer than necessary. Length of stay was measured by the Intensive Care National Audit and Research Centre (ICNARC, an organisation reporting on performance and outcomes for around 95% of NHS intensive care units nationally). The measure was benchmarked against other similar units participating in the ICNARC programme specialising in adult general and neurosurgical critical care. The mean average length of stay for all admissions in this hospital's critical care department in the last quarter of 2014 was 4.5 days, compared with the national mean average of around five days. Over the last five years, the mean average for the department was around 4 days for the unit against a national mean average of around 5.5 days.
- The consultant team were trained in advanced clinical investigative practices. Patients in critical care were enabled to be moved to the imaging department with all appropriate portable supportive equipment taken with them. There were consultants trained in echocardiography scans and the unit was about to become accredited for this process.
- Standard Operating Procedures (SOP) followed best practice and evidenced-based guidance. For example, the DCC's SOP for tracheostomy insertion and management followed the national study and recommendations of the 2014 National Confidential Enquiry on Patient Outcomes and Death (NCEPOD): On the Right Trach?
- The DCC consultant team studied and reviewed best practice in a number of areas before making changes or reacting to incidents. This included the protocol for changing intravenous lines which was drawn up following a review of best practice and academic studies. Medical lines were therefore not routinely changed at certain rigid times, which might be an unnecessary intervention which is uncomfortable for the patient. A daily assessment was made of each line to determine if and when it needed changing. The review was documented on each daily ward round. All lines placed by one of the trainee doctors were reviewed and signed-off by a consultant intensivist.

Critical care

- The DCC followed NHS guidance when monitoring sedated patients. Each patient who was sedated was subject to a 'sedation hold' each day using the recognised Richmond Agitation Sedation Scale (RASS) scoring tool. This involved the doctor or nurse discontinuing the sedation infusion and monitoring the patient's response. Sedation was then continued or adjusted dependent upon how the patient reacted to the change. The results were recorded in the patient notes and on the daily care record used for each patient.
- Patients admitted to the DCC were formally assessed for delirium. The Faculty of Intensive Care Medicine Core Standards (the Core Standards) recommended all patients were screened for delirium with a standardised assessment tool (usually the confusion assessment method, often called CAM – ICU). Clinical staff recognised the need for delirium screening as the condition was often one of the first indicators of a patient's health deteriorating.
- The DCC participated in and led on organ-donation work for the trust. The trust had a clinical lead for organ donation and was supported by a specialist nurses for organ donation. The trust, one of the largest donors in the UK, was part of the National Organ Donation programme led by NHS Blood and Transplant. It followed NICE guideline CG135: Organ donation for transplantation. We met with two of the specialist nurses and reviewed data for the period from 1 April 2014 to 30 September 2014 (the updated six-monthly report for October 2014 to March 2015 was due for publication by NHS Blood and Transplant shortly). There had been 39 patients in critical care eligible for organ donation during this period. Of these, 19 families were approached to discuss donation. Sixteen of these families (84%) were approached with the involvement of the specialist nurse, against a national average of 78%. Evidence has shown there is a higher success rate for organ donation if a specialist nurse is involved with discussions with the family. Seven patients went on to be organ donors and 19 organs were retrieved for donation and transplanted to 18 people. This was just above (that is better than) the national average for successful organ donation in the UK. The specialist nurses commented upon the strong support for organ donation from the department and the trust.

Pain relief

- Experienced staff were available for reviews of pain management. There was a hospital-wide pain team who were part of the Acute Care Team (ACT), managed within critical care. The pain team were supported by a consultant anaesthetist. This person was the trust's lead consultant on inpatient pain management and one of the leading pain specialists in the UK. Band three healthcare assistants in the ACT were also trained in assessing pain in post-operative patients. Staff told us specialist pain review was done well, and staff were usually always available when required. There was also on the on-call anaesthetist who could attend the unit if other staff were not available and the situation required it.
- Pain relief was well managed. Patients we were able to speak with in the DCC said they had been asked regularly by staff if they were in any pain. Nursing staff said, and we observed, patients who were awake were regularly checked for pain. Observations were recorded and formal assessments made at regular intervals. Pain was managed with different protocols depending upon the patient's treatment. For example, patients who were post-operative may have been given epidural pain management which was managed by a tailored assessment. A patient may also have had a 'PCA' which was 'patient controlled analgesia' managed through an infusion pump. The three patients we met on the Torrington cardiac HDU said they were regularly asked if they had any pain. They said any pain or discomfort had been attended to and all commented that they were comfortable in both the daytime and at night.

Nutrition and hydration

- Appropriate guidance and protocols were followed to ensure patients had the right levels of hydration and nutrition. There was a guide for nutritional screening to look for specific risks, particularly around under-nutrition or excessive weight loss. A flowchart had been produced by staff with specialist knowledge in nutrition to decide whether a patient needed to be fed through a tube or line (enteral or parenteral feeding).
- For patients able to take their own fluids, drinks were available on bedside tables and within reach. Patients who were able to eat were brought menus and able to choose meals. The volumes of food and particularly fluids were monitored and recorded to ensure patients

maintained a healthy balance. Unconscious patients had their circulatory fluid volumes continuously monitored by nursing staff through central venous pressure (CVP) lines.

- Adults receiving intravenous fluid therapy were cared for by healthcare professionals competent in assessing patients' fluids and electrolyte needs. Staff were competent in prescribing and administering intravenous fluids and monitoring the patient experience. This met the requirements of the National Institute for Health and Care Excellent (NICE) QS66 Statement 2.

Patient outcomes

- The DCC produced data to determine patient outcomes against recognised national indicators. It demonstrated continuous patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC). This was in line with the recommendations of the Faculty of Intensive Care Medicine Core Standards. This participation provided the unit with data benchmarked against other units in the programme (95% of NHS hospitals) and units similar in size and case mix. The data returned was adjusted for the health of the patient upon admission to allow the quality of the clinical care provided to come through the results. This data was not provided by the cardiac critical care unit as this is not a requirement of ICNARC.
- There had been very few transfers made to other general critical care units for non-clinical reasons, such as a bed not being available at the right time. There had been almost none in the last five years to the end of December 2014, and none in the last two years. However, it was recognised that it was sub-optimal to move a patient to another hospital critical care unit without careful planning and management.
- Mortality levels of the DCC in the year 2014 were better than the national average and below expected levels. The latest ICNARC Case Mix Programme from the fourth quarter of 2014 showed a downward trend, so mortality levels were better than average and also falling. Post-unit hospital deaths were also below those of similar units. These were patients who died before ultimate discharge from hospital, excluding those discharged for palliative care.
- Statistics from ICNARC described a small percentage of patients discharged prematurely from the DCC, although the absolute data for early discharges had not been reported for the past five years. However, data showed the early readmissions to the unit (those readmitted within 48 hours of discharge) for the 12 months to December 2014 were just above the national average in each quarter. The late readmissions (those readmitted later than 48 hours following discharge but within the same hospital stay) was around 6% in the last quarter of 2014 (22 patients) which was just above the national average of around 5%. It was probable that a number of these patients returned to the unit for conditions unrelated to their original admission.
- There were not enough physiotherapists to provide recommended levels of therapy, particularly in the DCC. Most of the clinical staff we spoke with said the essential work of the physiotherapists was stretched by their availability. Patients did not get the recommended 45 minutes of each active therapy required for a minimum of five days per week. Some of the rehabilitation plans were delivered by the nurse, such as stretching tendons, but otherwise, patients were prioritised by the therapy team. The therapy delivered was to a high standard by experienced and skilled staff. But it was not delivered in terms of time dedicated to the patient along best practice guidelines.
- There was an audit calendar for measuring patient outcomes in the DCC, but it was underdeveloped and did not adhere to national guidance following the recommendations of the Faculty of Intensive Care Medicine. Each month a snapshot audit was undertaken of a number of clinical safety and quality indicators. The main results of these audits were:
  - Both Penrose and Pencarrow scored 100% in each of the last six months for catheter care.
  - Pencarrow had scored mostly 100% for the naso-gastric tube audit in the last six months, but only 40% in April 2015 for recording the time of the insertion.
  - Penrose had scored poorly on 11 of the 13 measures of the naso-gastric audit on a number of occasions in the last six months. Some measures had not scored 100% on one occasion and there was no improvement noted in the following month.
  - Both Penrose and Pencarrow scored well in the last six months for cannula care.

- Pencarrow had scored 100% for central venous catheter care in the last six months and Penrose had scored mostly 100%.

Although this data was being captured, it was not clear how it was being used in the department to make improvements to outcomes. There was no routine audit calendar on the Torrington cardiac ICU/HDU. Some audits were done by doctors with particular interests, but there was no regular review of care in line with best practice or recognised evidence-based guidance.

- A medical student research study following the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) into trauma care for patients had concluded there had been an improvement in access into critical care in 2013-2014 over 2011-2012 after Derriford Hospital became a major trauma centre. This was only on a small cohort of patients (n=96) but the time from a CT scan to admission to critical care had fallen from between three and eight hours in 2011-2012 to between two and four hours in 2013-2014.
- There were other student research studies providing useful tools for measuring patient outcomes. This included a study of non-invasive ventilation (NIV) for patients with chest-wall injuries. The study over 12 months, and analysing records of 79 patients, concluded patients who had delayed NIV were not adversely affected by the delay except they ended up staying longer in hospital. The study also concluded the hospital was correctly identifying those patients who needed early NIV in critical care and it was an effective patient management option.

Competent staff

- Appraisals for the staff team in the DCC were failing to meet trust targets. Records for March 2015 showed 70% of the staff had been appraised against the trust target of 95%. All staff knew who was responsible for their appraisal and staff in lead roles knew who was in their team and due an appraisal. This was recorded and available from the electronic staff system. Reports could be produced at any time and this included a list of all staff who were falling due for appraisal. Staff told us appraisals and training were below targets as sessions had been cancelled in order to provide safe staffing levels over a busy winter period.
- The DCC had a practice education team. There were five people in the team and three whole-time equivalent posts. The practice educator lead nurse was a fulltime post and the other four staff were part of the nursing team with lead roles in the education team. The appointments of the four nursing staff to the team was in 2013. Their roles covered research and university courses; mandatory training; bedside training; and critical care induction.
- There was a good level of training in life support. All nursing staff were trained in basic and intermediate life support and the medical staff were all trained in basic and advanced life support. Non clinical staff were all trained in basic life support.
- There were not enough nursing staff trained in post-registration critical care in the DCC. The Core Standards recommendation was at least 50% of the nursing staff achieving this award. There was a strong core of experienced and skilled nurses in the team, but the unit had not, until recently, addressed the lack of formal training for the nursing team. At the time of our inspection there were 38.5% of the nursing team with the critical care nursing award.
- One of the issues recognised by staff (and on the risk register for the DCC) was a lack of regular experience of managing children in the DCC. One of the consultant intensivists had paediatric intensive care training and was the unit lead. There were nurses also with paediatric high dependency training and one member of the nursing team was a registered sick children's nurse (RSCN). However, the unit had admitted very few children. In the 14 months from January 2014 to March 2015 there were 14 under the age of 16 years, of which seven were 10 years of age or under. The unit did not admit children unless there was an emergency or the child was being looked after while awaiting transfer to, usually, Bristol children's hospital paediatric intensive care unit. The department would therefore be able to engage one of the paediatric anaesthetists and nurses from the children's service to provide advice and guidance to supplement that available on the unit.
- Staff competence in equipment was checked and updated. The department education team ensured staff were trained and competent in new equipment. Competencies were signed off and reviewed at annual appraisals. The clinical nurse educator kept a log of staff

training and competencies. There was a good service from the unit technicians. There were two technicians in post. Their roles included bedside teaching and training on equipment.

- There were weekly protected training sessions for trainee doctors each Thursday afternoon delivered by the consultant team in the DCC. There was a wide-range of skills in the consultant intensivist team. This included a consultant intensivist physician in acute medicine; a leading expert in pain management; a leading expert in infectious diseases; the regional lead for trauma; a regional advisor in intensive care medicine; and neurosurgical intensive care medicine specialists. One of the trainee doctors said the unit was busy, but they always had colleagues around. They said they had "never had an issue when I felt on my own."

Multidisciplinary working

- There was strong and cohesive collaborative working from all staff contributing to the units. We observed a common sense of purpose among the staff. Staff proactively supported one another with a focus on improving patient care. We observed and were told there was no obstructive hierarchical structure and all staff were valued for their input and roles.
- There was appropriate support from professionals connected with the units. In the DCC there was daily support from a microbiologist (a consultant physician specialising in all aspects of infection from the laboratory medicine perspective). They visited the unit every day of the week including Saturdays. They would come to the unit on Sundays if required, but usually would provide a telephone consultation. When they were present on the unit they undertook a round with the consultant intensivist and other staff as required. There was also a lunchtime ward round by a consultant radiologist to provide support with diagnostic imaging, and a weekly round by a consultant neurological radiologist. The orthopaedic trauma team also visited the unit each day to discuss all major trauma patients being treated.
- The Core Standards recommended a dietician was part of the multidisciplinary team and there should be good support from all allied healthcare professional staff. There was a team of experienced and skilled consultants and nurses on the units with particular skills. However, the guidance of staff, particularly dieticians, was not being routinely sought in the DCC. This had been recognised by the clinical lead, although limited availability of allied healthcare professional staff was not helping this situation improve.
- Staff were involved where appropriate and their skills recognised throughout the hospital. For example, the lead intensivist and one of the consultant team sat on the resuscitation committee.

Seven-day services

- There was good cover from the consultant intensivist team out of hours. Consultants lived within a 30 minute journey of the units when they were at home but on call. If this was not the case the consultant could be resident within the hospital when on call.
- There was adequate cover from the allied health professionals across the whole week. Physiotherapists were on call when not present on the units. Pharmacists provided a service in the week and weekends, although were stretched by a shortage of established band six and seven grade staff. They were also on call at other times for any urgent prescriptions or discussions.
- Access to clinical investigation services was available across the week. This included X-rays, computerised tomography (CT or CAT) scans, electroencephalography (EEG) tests to look for signs of epilepsy, and echocardiograms (ultrasound heart scans).

Access to information

- The computer-based patient record system was good in many areas, but there were shortcomings. The system could be slow to start up, and we saw evidence of this in practice and the resultant frustration with a group of doctors. It was also either not easy to use in order to relatively simply extract certain data for more in-depth audit work.
- Access to patients' diagnostic and screening tests was good. The medical teams said results were usually provided quickly and urgent results were given the right priority.

- Patient records were usually available in good time. Staff said records were provided relatively quickly in emergency admissions (all patient records were on paper for patients coming from other wards or new admissions).

Consent and Mental Capacity Act

- Patients gave their consent when they were mentally and physically able. Staff acted in accordance with the law when treating an unconscious patient, or in an emergency. Staff said patients were told what decisions had been made, by whom and why, if and when the patient regained consciousness, or when the emergency situation had been controlled. There was a variable recording of consent in patient notes. Although it was a requirement of the electronic proforma record to complete this section, the recording by the medical staff had insufficient detail of how decisions were made.
- Patient were assessed in line with the Mental Capacity Act 2005, although the recording of how decisions were reached in the DCC had insufficient detail. Some entries around assessment for the ability to give informed consent just had 'yes' or 'best interests'.
- Care and treatment for patients who could not give valid informed consent was given in their best interests and protecting their rights. So general day-to-day care and treatment decisions, such as giving medications, giving personal care, nutrition and hydration, and performing tests were made in patients' best interests by the medical and nursing teams. If decisions on more fundamental issues were needed, staff were required to hold best interest discussions in line with the provisions of the Mental Capacity Act 2005. These involved people who knew the patient well or who were involved in their care, who together discussed all the treatment options. Staff said they had access to Independent Mental Capacity Advocates (IMCAs) should there be no one to speak independently of the department on behalf of the patient. In the medical notes we reviewed in the DCC, best interest discussions were not well documented, and staff agreed this needed improvement. Staff we spoke with were able to describe the process and confirmed it was carried out as required. In the review of a serious incident and complaint, the local clinical commissioning group had commented on a lack of either a mental capacity assessment, or documentation describing how decisions around capacity had been reached.
- Staff understood the process for assessing if a patient was being or could be deprived of their liberty. The Deprivation of Liberty Safeguards (DOLS) were, like with many other critical care departments in the NHS, under review at the time of our visit. New guidance was awaited from the Faculty of Intensive Care Medicine.
- The DCC had simple aids to protect patients if restraint was needed. There were 'mittens' for use as a last resort when a patient was known to be or assessed as at risk from pulling out their medical devices, such as tubes and lines. There was also pharmaceutical intervention available if this was assessed as safe and helped to relax the patient. The unit had care plans for use with any patient subject to a restraint. There was evidence of discussions around the use of physical or pharmaceutical restraint in the patient notes. However, some improvements were needed in documentation of the reasons why restraint was agreed and how this supported the best interests of the patient.

Are critical care services caring?

Good

Feedback from people who had used the service, including patients and their families, had been very positive overall. Staff ensured patients experienced compassionate care, and care promoted dignity and human rights. It was not noticed by us as a frequent problem, but unnecessary noise within the DCC did at times disturb patients.

Compassionate care

- Patients and relatives we met spoke highly of the service they received. Due to the nature of critical care units we often cannot talk to as many patients as we might in other settings. However, the three patients we were able to speak with in the DCC and three in the cardiac unit said staff were kind, thoughtful and caring. The many complimentary comments from the DCC patient survey in October 2014 to January 2015 included: "cannot thank the staff enough for the care they have given my mum and also for the compassion and understanding

they have given my dad, sister and I. Many thanks to everyone. All areas were just what was needed in a very stressful situation, thank you" and "I had the support of all the staff, both medical and nursing. They have been exceptional and highly appreciated. This care and support has extended both to us as family and the patient." One of the patients we met on the DCC was celebrating their birthday. The staff had given the patient a birthday card and written 'Happy Birthday' on the white board in the bed space. Both the patient and the family said they appreciated this thoughtfulness. The three patients and one relative we met on the Torrington cardiac HDU spoke highly of their care or that shown to them as a relative. Staff were described as "kind and caring", "the staff are just superb" and the care provided as "100% and even 101%." One of the patients had experienced their elective operation being cancelled the previous week. The patient said although this had been disappointing, the delay had only been for one week. They said the staff had apologised to them and explained about the cancellation and had been "true to their word" about it being rescheduled for the following week.

- Patients were treated with compassion. Senior staff told us how the matron of the Torrington cardiac ICU/HDU met with patients coming for elective cardiac surgery and personally took time to let them know about the procedure and if there were any hold ups or delays. If a procedure had to be unavoidably cancelled, the matron would meet and explain personally to the patient why this had happened.
- We observed good attention from all staff to patient privacy and dignity. We saw curtains drawn around patients and doors or blinds closed in private rooms when necessary. Voices were lowered to avoid confidential or private information being overheard. The nature of most critical care units meant there was often limited opportunity to provide single-sex wards or areas. However, staff said they would endeavour to place patients as sensitively as possible in relation to privacy and dignity.
- Visiting times were mostly restricted to set hours. This was in order to prioritise the needs of the patient, but this was one area upon which visitors commented upon in the DCC. In written feedback we saw visitors did not find restricted visiting as helpful to them. The newly appointed matron in the DCC was considering changing to a more flexible arrangement and building upon how the unit was already flexible and sympathetic towards visitors. We met one anxious family who had been told they could come at any time. As with all critical care units or other wards, there was limited space at the bedside or in visitors' rooms. Visitors were asked to restrict numbers where possible, as too many visitors had been recognised as tiring for patients in critical care. Visitors said staff had indicated when they needed time to treat or assess the patient and visitors had been asked to step outside for a short time. Visitors said the staff explained why this was necessary.
- Care from the staff team was delivered with thoughtfulness, but there could have been more awareness of noise and the impact of some 'normal' hospital activities in the DCC. Nurses talked quietly with patients and reassured them continually. The atmosphere was relatively calm and professional, without losing warmth and reassurance for everyone concerned. The Pencarrow neurosurgical unit was noticeably quieter and appeared calmer than Penrose, the general ward. At one point housekeeping staff came through the unit (we only saw them in Penrose) with two large metal linen trolleys which were empty. This caused considerable noise levels. Staff did not react to this or appear to consider it was not acceptable. A patient said: "I know they have to go about their business, but it's a bit much."
- Staff approached breaking bad news or managing expectations well. One of the relatives we met had come back to the DCC with the patient in order to tell two of the nursing team how well the patient was doing (unfortunately those nurses were not on duty). They said how staff had helped them to realise how unwell the patient was so they knew there was a chance the patient would not survive. Staff kept them informed each step of the way, particularly when the patient showed signs of a "really important breakthrough" and "the fact [the patient] pulled through was down to the care and treatment [the patient] got here, as there really was little hope at times."

Understanding and involvement of patients and those close to them

- Patients were involved with their care and decisions taken. Those patients who were able to talk with us said they were informed as to how they were progressing. They said they were encouraged to talk about anything worrying them.
- Friends and relatives of patients were kept informed and involved with decisions when appropriate. They said they were able to ask questions and could telephone the unit when they were anxious or wanted an update. One relative we met said they had telephoned the DCC often throughout the night when they were anxious and staff had been "fantastic and kept me sane. They don't know how much that meant." Staff said they were aware the unit could be overwhelming for visitors and therefore would give information as sensitively as possible.

Emotional support

- The DCC was looking to, but not yet routinely using some of the latest innovative ideas for patient support. Patient diaries had been used by one of the nurses for research purposes. Research has shown how patients sedated and ventilated in critical care suffer memory loss and often experience psychological disturbances post discharge. Patient diaries have been introduced in some units to provide comfort to both patients and also their relatives both during the stay and post discharge. Diaries are said to not only fill the memory gap, but also be a caring intervention which can promote holistic nursing. We met the patient who had been given one of these diaries and they confirmed it had helped them. They said they were able to "go back on the whole journey" and "appreciate what had happened." They confirmed it had "helped fill in the gaps."
- The DCC would welcome any patient who wanted to come back to talk about any aspect of their care or look for emotional support, but did not run formal or routine follow-up clinics. We met a patient who had arranged to meet with the clinical lead consultant intensivist and spoke with them after their meeting. They spoke highly of the care they had received and being able to come back to the unit.
- Relatives were approached with compassion when a patient was a possible eligible organ donor. We met with two of the specialist nurses for organ donation and were impressed with their knowledge, experience and genuinely warm character. This included their approach to the child or grandchild of a patient who had died, even if the nurses were not going to discuss organ donation. They had resources such as books suitable for children, and a box of equipment for making hand prints and locks of hair for families to take if they wished.
- There was good support from the hospital multi-faith chaplaincy team, but limited professional clinical psychological support. The chaplaincy team were on call at all times. The relative of a patient who spoke with us about their experience of critical care said the service from the chaplaincy was "personal, dignified and a huge comfort to us all. The chaplain stayed with us until we left, talked to [the patient's spouse] and offered to see [the spouse] again at any time."
- Outstanding compassion was shown to the relatives of people who would not survive a catastrophic brain injury. This included all patients in the previous five years, with one exception, who had been brought into the Emergency Department having suffered this injury. All these patients were brought to critical care for the final testing of brain stem activity in a temperate environment. For patients where brain stem activity had ceased, this enabled their families or loved ones, or members of the chaplaincy team to be with them when their life support was ceased.

Are critical care services responsive?

Requires improvement

The DCC service responded well to patient needs. But there were bed pressures in the rest of the hospital that meant a significant number of patients, were delayed on discharge to other wards and too many were being discharged at night. There was a relatively high level (when compared nationally) of elective surgical operations cancelled due to unavailability of a critical care bed. Otherwise, the unit protected a bed for admission of a patient only in an emergency. With very few exceptions, all patients who had needed emergency admission onto the unit had been admitted.

The facilities in critical care were excellent for patients, visitors and staff, and met all of the modern critical care

building standards. There were no barriers to people to forward complaints, and there were very few complaints made to the department. Those that had been made were fully investigated and responded to in a timely way with improvements and learning evident. There was, however, no provision in the DCC for any support to patients with mental health needs or the anxiety they or their relatives and friends might be experiencing.

Service planning and delivery to meet the needs of local people

- There was provision for a bed in the DCC to be kept free for an emergency admission. Penrose ward had 16 funded bed spaces of which 14 were being used at the time of our inspection. The reduction in bed numbers was an approved decision driven by the unit to ensure the service ran with safe staffing levels. One of these 14 beds was staffed and approved for use in emergency rather than elective or planned admissions. Staff said they were not put under undue pressure to use this bed for elective (non-emergency) surgery and were sanctioned to maintain this bed for emergencies only.
- There was a good response from consultants in the DCC when new patients were admitted. The shift patterns were established so all patients were seen within 12 hours of admission by a consultant intensivist. This included weekends and out of hours. The critical care operational policy outlined all the criteria for admissions in an emergency or otherwise. This included all admissions having to be made and/or approved by an intensive care consultant.
- The environment in the general and neurosurgical unit was designed to meet patients' and visitors' needs. As recommended by the Department of Health, there were separate entrances for visitors and patients. There was an intercom and CCTV at the main entrance. Staff were able to see patients in the open bed space areas, and there was reasonable visibility of patients in the side rooms. There was a storage area in the centre of Penrose ward. Nursing staff said they would cohort (arrange the position of) patients so those being supported by one nurse (a maximum of two patients) were close to one another and not obscured by the central storage area. Side rooms were, as recommended, square or rectangle and not L-shaped, where visibility could be reduced. When we visited the unit the air temperature was comfortable. The bed spaces and side rooms were of a good size and each had lockable storage for patients' medicines and valuables. There were suitable work surfaces and each bed space was fully screenable from the next.
- Patient and relative facilities were good. There was a large relatives/visitors waiting room in the DCC with a reception area, plenty of comfortable chairs arranged so patients could sit more privately if they wished, and information about the unit. Within the units there were visitors' rooms and toilet facilities for visitors close to these areas. The visitors' rooms had a sofa and sofa bed for one person to be able to stay overnight. These rooms could be used for more private conversations with visitors. All areas were suitable for people using wheelchairs or other aids for disabilities.
- There were good facilities for staff to work and rest. There were staff offices, a staff rest room with kitchen facilities, and changing rooms. Senior staff shared offices, but they said there was always somewhere available for private conversations.
- The hospital had the ability to temporarily increase its capacity to care for critically-ill patients in a major incident, such as a pandemic flu crisis or serious public incident. This would involve using the cardiac intensive care/ high dependency unit and the recovery unit in theatre where staff were trained in caring for critically ill patients and would be supported by the critical care team.

Meeting people's individual needs

- The patient and their family/friends were involved with personalising the care for the individual patient. There were forms completed in patient notes recording more personal details, such as what the patient liked to be called, what food and drinks they liked and disliked, and any hobbies and interests. Essential information would also be on the handover documents and communicated among the whole staff team.
- There was good support from the trust for patients with a learning disability (LD). There was a trust LD team with nurses who were experienced with supporting patients in hospital who had a learning disability. One of the sisters in the DCC told us the LD team sometimes had reason to believe a patient who was elsewhere in the hospital might need critical care at some point. In that case, a member of the LD team had given the unit

advance notice of a patient with extra needs possibly being admitted. When the patients were admitted, the LD team would attend the unit, hand over the patient, including details of their mental and physical situation, and make sure the unit had the hospital 'passport'. This is a document that should accompany patients with a learning disability, particularly if they cannot communicate or communicate differently. This had information staff supporting them should know; such as things they liked or disliked; anything they were afraid of; or specifically enjoyed.

- There were staff in the units trained in supporting people living with dementia. These 'dementia champions' among the nursing team attended workshops to enable them to be up-to-date in providing specialised care and support to both the patient and other staff working with them.
- Translation services were available. There was a telephone translation service provided for general or urgent translation needs. There were also translators available to visit the unit to provide either one-off support for a specific situation, or a more planned longer-term service. For example, the DCC had a patient who was visiting the area from overseas and was admitted for intensive care. The patient's family arrived from overseas to support the patient and did not speak English. The unit arranged for a translator to come to the unit around four times a week for an hour. They would attend the ward round and provide translation from the patient to the staff, and then on to the patient and their family. The patient and the family could record any questions they wanted to ask for the translator to ask and then record or recount the response for the family.
- There were resources for staff to use to know how to support people with different needs and diversities. This included multi-faith resources on the trust website, so staff could be aware of certain aspects of supporting patients and their relatives with their cultural, spiritual or religious practices. This extended to how to support a patient where there were specific customs and practices if the patient was at the end of their life.
- There was a range of booklets in the DCC and information for both patients and families. There was information on the trust website and a booklet that could be given to or picked up by visitors. The booklet was produced by the unit and included aspects of the environment, visiting times and arrangements, communication with the unit, and facilities within the hospital. There was a reference within the booklet about how to obtain the information in another language or format.
- Although recognised by the consultants for its importance, there was no support available to patients in critical care with psychological problems or anxieties. There is increasing evidence showing the psychological impact of a critical care admission can be severe. Patients can experience extreme stress and altered states of consciousness. Patients are exposed to many stressors in critical care and acute stress in critical care has been shown to be one of the strongest risk factors for poor psychological outcomes after intensive care. The National Institute for Health and Clinical Excellence (NICE) guideline CG83 stated that patients should be assessed during their critical care stay for acute psychological symptoms. There is also evidence that the critical care experience is difficult for families and a critical care psychologist can play a big role in communicating and working with distressed families.

Access and flow

- The discharge of patients from critical care was not always achieved at the right time for the patient. Studies have shown discharge at night can increase the risk of mortality; disorientate and cause stress to patients; and be detrimental to the handover of the patient. Intensive Care National Audit and Research Centre (ICNARC) data (1 October to 31 December 2014) for discharges made out-of-hours (between 10pm and 7am) showed the unit had been continually above (that is worse than) the national average for night-time discharge for similar units. In the last two years around 10-15% (40 to 60 patients each quarter) of all discharges from the DCC took place at night.
- Similar to most critical care units in England, ICNARC reported there was a high level of delayed discharges from the DCC. For the year to December 2014, over 70% of all discharges were delayed by more than four hours from the patient being ready to leave the unit. That was above (worse than) the national average of around 60%. Four hours is the indicator used for comparison with other units and set by ICNARC. It is used to demonstrate the ability, or otherwise, to move patients out of critical

care in a timely way. Although patients remained well cared for in critical care when they were medically fit to be discharged elsewhere, the unit was not the best place for them. This was recognised by staff, who were aware the unit could also be a difficult place for visitors. The delays were mostly less than 24 hours. However, in the last quarter of 2014, there had been a delay for one patient of a week. The rate of delayed discharges had been high for the last three years and had dropped to the national average in 2013 but this had not been sustained. Evidence from the unit supported the data on poor delays with discharges. In the eight months from August 2014 to March 2015, there had been an average of between one and four level zero patients and between one and two level one patients (neither of these categories needing to be in critical care) in the unit at 9am.

- The DCC had higher (worse than) levels of occupancy than the national average. In February 2015 the rate of occupancy published by NHS England (which included the beds on the cardiac critical care unit) for Derriford Hospital was 90.5% against an England average of 88.1%. In January 2015 the occupancy was 88.1% (England 87.6%). The Royal College of Anaesthetists recommend a maximum critical care bed occupancy of 70%. Persistent bed occupancy of more than 70% suggests a unit is too small, and 80% or more is likely to result in non-clinical transfers that carry associated risks. However, as the trust had reported minimal non-clinical transfers and had high levels of delayed discharges from critical care, the occupancy levels were likely to be due to a lack of a ward bed into which to move a discharged patient.
- Patients who needed a critical care bed in an emergency were rarely not able to be accommodated. The DCC had an emergency bed on standby as much as possible for this purpose and there was a low rate of transfers to other hospital units. The critical care operational policy outlined that elective operations were not to go ahead without the senior theatre nurse first confirming there was an available bed in critical care. This was confirmed by data from the unit showing there had been no unauthorised operations carried out when a bed was not available in at least the period from May 2014 to February 2015.
- There was a relatively high rate of elective operations cancelled due to the lack of a critical care bed in the DCC. In the last six months there were 293 elective surgical operations requiring or anticipating the need of a post-operative critical care bed. Of these, 181 (62%) proceeded with a bed; 44 (15%) proceeded without a bed but a post-operative alternative plan; 38 (13%) did not proceed due to the lack of an ICU bed, and 30 (10%) did not proceed for other reasons (such as the patient not being appropriate for surgery at that time). The 38 operations not proceeding did not include a number of operations cancelled in January 2015 due to unprecedented levels of occupancy in the hospital. Thus, the number would have been increased if these operations had gone ahead as planned. This level of around six operations on average per month (the trend for which over the six months was increasing) was against an NHS average for units of a similar size of just over two per month. The Torrington cardiac ICU/HDU had experienced high levels of elective surgery cancellations in the last six months. Almost all cardiac surgery was cancelled in January and the unit was used to accommodate medical patients.
- Admissions to the DCC were relatively stable. The number of admissions to critical care since 2012 has been around 400 patients per quarter. In the ICNARC data from 1 October to 31 December 2014, there were a small number of patients transferred into the unit from an HDU or ICU in another hospital. The rate of all transfers was below, that is better than, the national average for similar units in the third quarter of 2014. However, the rate of non-clinical transfers in (that is unplanned admissions from another adult critical care unit) had been at or above (that is worse than) the national average in the year to December 2014. There had been three non-clinical transfers into the unit in the last quarter of 2014. However, the unit was mostly managing its own patients and predictable admissions. Patients were rarely transferred to other units for clinical reasons. Usually transfers out were for patients to be accommodated closer to home or for specialist care. There were no non-clinical transfers out for the last two years to December 2014.

Learning from complaints and concerns

Critical care

- There had been very infrequent complaints relating to critical care services. There was information available in visiting areas and on the trust website outlining how to make a complaint and how it would be dealt with.
- The units were involved with the management of complaints and they were discussed in departmental meetings. Complaints, which were few, appeared mostly to be concerned with communication with families. There were actions for staff to reflect upon and improve this. This included a process having been put in place to ensure a consultant spoke with a family particularly if there had been an incident reported or occurring.
- Complaints were addressed and learned from. The Torrington cardiac HDU/ICU senior staff described how they had investigated a complaint around a serious incident. The actions arising had led to conversations with the family and learning around how different communication styles or mixed messages can be very stressful for families. There was also updated and revised learning about management of a specific medical condition which was now part of the annual two-day block training course.

Are critical care services well-led?

Good

The leadership and culture in the services were used to drive and improve the delivery of high-quality person-centred care. All the senior staff were committed to their patients, their staff and their unit with a shared purpose. Elements of the governance of the DCC such as quality and safety audit results were not consolidated, and brought into the departmental meetings.

There had been some recent senior nurse appointments to the DCC who were being supported from the Service Line Cluster Manager, the Service Line Clinical Director, and the senior nurses.

Vision and strategy for this service

- The management of the units had vision and strategy for the service, although some of this was in early development in the DCC due to staff changes. The matron had only just joined the DCC (and was matron also for the neurosurgical ward) and had ideas and plans for the future. These would be made more formal once priorities had been recognised and more experience of the unit had been gained. The part of the strategy most anticipated by the lead consultant and all senior staff was the introduction in September 2015 of a programme of training for, initially, four nurses to become Advanced Critical Care Practitioners. The ACCP programme was approved just after we visited the unit, and, when it commenced would be available for advanced healthcare professionals, nurses, and operating department practitioners in the South West, and run from Derriford Hospital. The Torrington cardiac ICU/HDU was about to take delivery of a patient simulator which would be located in the one of the side rooms (which had been identified due to infrequent use). This simulator would be included on each of the multidisciplinary team ward rounds and assigned various medical or other conditions to be investigated as a teaching opportunity.

Governance, risk management and quality measurement

- There was a critical care operational policy in place for the DCC with clear guidelines around admissions, discharges, safe staffing levels, contingency planning, organ donation, and bed closures. The policy was the responsibility of the department. It was written in 2011, amended in September 2014, and due for review in September 2015.
- There was a clear structure for clinical governance in the trust. This demonstrated how the DCC and cardiac unit fed into the service line structure and how assurance was made through the various committees into the trust board. There was time and resources given to governance and safety, quality and performance review and a dedicated consultant governance lead.
- There was a range of consultant audits and performance measures of aspects of care and safety within the units although not yet in accordance with an approved audit calendar. There were ad hoc audits and reviews of practice carried out by consultants and medical students. In the DCC there was a monthly spot check audit of certain aspects of care delivery. This included catheter care, naso-gastric tube insertions, cannula care, hand hygiene, and central venous catheter care. This information was available for extraction from the trust database. There was no

evidence of how this information was being used or any identified shortcomings being addressed. From a review of the minutes, it was not seen as part of the monthly departmental meeting. Although some audits were carried out, there was no clear calendar for regular audit of quality and safety measures, for example, those recommended by the Faculty of Intensive Care Medicine. There were other aspects of clinical governance also without standing agenda items on the monthly departmental meetings. This included a discussion of the risk register and the full suite of patient harms

- In the cardiac critical care unit there was a range of nursing audits and performance measures of aspects of care and safety within the unit. There was a monthly spot check audit of certain aspects of care delivery. This included urinary catheter care, peripheral cannula care, central venous catheter care, intra aortic balloon pump on-going actions, and the naso-gastric tube audit.
- The DCC staff understood, recognised and reported risks, and this had significantly improved in 2015. The divisional risk register we were initially provided with was not a comprehensive or well utilised document. The risks added to it were, in some cases, not dated; there was no member of staff taking the lead in addressing the risks; there was no differentiation in open or closed risks; and there was little evidence to show action was being taken. This had been recognised by the department before our visit and we were provided with an updated version. This new version recorded the date when the risk was added. There were 'owners' attached to each entry. The entries were significantly reduced to specific and not generic risks that would be associated with any hospital ward (such as latex allergy or risk of a needle-stick injury). Controls in place were recorded along with issues remaining outstanding. The risks were also graded by their severity. We were told by senior staff that the new risk register would now be discussed at departmental meetings now it was manageable.
- There were investigations into any serious incidents and actions taken to prevent reoccurrence. We saw one root cause analysis report and a preliminary report (there did not appear to be a further report) we asked to see for two incidents taken from the incident log from the DCC. One report had clear learning points and action plans and had been investigated well. The other was of concern. The Duty of Candour had not been implemented on this occasion, but the reasons given did not describe an acceptable situation to not apply the duty to explain or apologise to the family. Under the circumstances described, the conclusions drawn and actions taken were also difficult to understand. There was no clear action plan; analysis of the environmental or human factors surrounding the incident; and the grading of the incident appeared to be low.
- The DCC participated in a national database for adult critical care as recommended by the Faculty of Intensive Care Medicine Core Standards. The unit contributed data to the Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme for England, Wales and Northern Ireland. ICNARC reported the data supplied was well completed and of good quality.
- Staff were included and informed about the running of the units. In the DCC, the monthly departmental meetings were attended by a range of the senior staff including the ward sisters, and the leads for pharmacy and physiotherapy. The meetings were minuted and circulated. There were other meetings including a general 'ward' meeting (that is one for Penrose and one for Pencarrow) every eight to 12 weeks. These were a mix of an open forum with some set agenda items. Minutes were made and action plans circulated. There were team leader meetings for the band six and seven nurses to meet and discuss issues with the consultant team. These were held around twice a year.

Leadership of service

- The leadership of the DCC service by the clinical lead consultant intensivist and the team of experienced staff was strong and committed. There was a commitment to a safe and quality service. The nurses we spoke with had a high regard and well-earned respect for their medical colleagues and the allied health professionals, and worked as a cohesive team without hierarchical barriers. There was strong and committed leadership in the Torrington cardiac ICU/HDU. The matron and senior sister in charge led by example and had many years of service in the department and staff spoke of their respect for the management team.
- The nursing leadership of the DCC service was new and needed time to embed. The matron had been in post for

three weeks when we visited and some of the band seven nurses were also new into post. We could already identify a strong commitment from the matron to their staff and their patients. The matron said they already felt encouraged to have a strong voice and be a major lead within the department. The consultants we spoke with had a high regard and respect for one another and the whole nursing team.

Culture within the service

- There was a strong cohesive culture within the DCC consultant team. Decisions were taken in a collaborative or 'cabinet' approach. Colleagues felt confident to raise issues without concern, even if their views were at odds with the collective approach. There was then collective responsibility for decisions. So even if a consultant did not fully support an approach, the view of the majority carried decisions and all the staff followed agreed protocols and practices.
- There was a strong support culture in the Torrington cardiac ICU/HDU. We talked with two nurses, a trainee doctor, a consultant, the sister in charge and matron. The trained doctor told us the nursing team and consultants were warm and welcoming. They felt part of the team when they worked on the unit during rotation. One of the nurses had been a student at the hospital and had returned to a substantive post on the unit. One of the band five nurses who went to work elsewhere in the hospital came back to unit and said: "I know I want to work here."
- Staff said they were encouraged to raise concerns and had no fear for any retribution. They said they did not feel they were or would be blamed when things went wrong and were subsequently not discouraged from speaking up.
- A strong culture of teamwork and commitment was spoken about among staff in the critical care services. Staff spoke of being proud of their unit and the care they were enabled to give. We found this particularly in Torrington ward and the Pencarrow neurosurgical unit, where the staffing levels were better, and there had been a stable management from the band seven nurses.
- Trainee doctors were well supported on the units. We were told consultants were easy to contact when trainee doctors needed advice. Nurses were also supportive and helpful to trainee medical staff.
- There were support groups and individual support available for staff. The chaplain had an 'open door' policy. They would meet with staff when asked; particularly if there had been a stressful or difficult situation. There were Reflection Meetings held either on an ad hoc basis or arranged in advance for staff to attend if they wished. There were meetings where there was no agenda and staff were free to discuss and offload any issues or concerns they had without fear of being judged or the matter being discussed outside of the meeting. One of the sisters in the DCC said this helped staff not to feel isolated, and to appreciate they were not alone with how they might be feeling.

Public and staff engagement

- There was a formal questionnaire for patients and relatives to complete in the DCC, although the unit had not yet introduced the NHS Friends and Family Test or something similar.
- There was a section on the trust website for the DCC (under the heading 'intensive care'). This included a description of the unit, where it was located, the names of the consultants, visiting times and guidance, and useful links, including www.icusteps.org for former critical care patients to find support and other guidance.
- There was a monthly newsletter for all staff in the DCC called 'Critical Care Matters'. This included staff news, updates on safety alerts, forthcoming courses, and safety tips. There was also a thank-you from the organ donation team for the work done on transplants.

Innovation, improvement and sustainability

- The DCC was innovative and focussed upon quality improvements. For example, the department was one of the first units in the UK, and the first in the South West of England to introduce the use of citrate-based continuous venovenous hemofiltration for patients at high risk of bleeding. The unit was also imminently to be echocardiography (ultrasound heart scan) accredited.
- The units participated in and encouraged research. For example, one of the quality improvement projects in the DCC researched the correlation of patient height against tidal volumes: the measure of the normal volume of air

inhalation and exhalation when extra effort is not applied. Another ethnographic study project was planned with the local university on studying how staff reacted to patient alarms.

Maternity and gynaecology

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

Information about the service

Maternity and gynaecology services were managed from within the trust's women and children's care group. The trust provided a range antenatal, perinatal and postnatal maternity services in Derriford hospital or within community settings. Choice of place of birth was limited to hospital or home as the trust did not have a midwifery led birthing unit. The delivery suite at the hospital was consultant led and provided care for women with high risk pregnancies. Approximately 5,000 women from South East Cornwall and South West Devon areas used the services each year. Between April 2013 and March 2014 there were 4,422 births. The number of home births between January and March 2015 were between 16 and 25. The number of births in the hospital during the same period was between 330 and 376.

At Derriford hospital there was a 13-bed delivery suite, two of which were high dependency rooms, and one room had a birthing pool. In addition, there was a four-room triage area, one obstetric theatre and recovery room, and two inpatient wards. Argyll was a 27-bed ward combining antenatal and postnatal care. The 18-bed Transitional Care ward provided an increased level of post natal care and support to women or babies with complex care needs. This ward was located next to the neonatal intensive care unit (NICU) and four of the beds were allocated to women whose babies were in the NICU.

A range of inpatient gynaecology services was provided from Norfolk ward which had 23 beds. These included general and emergency gynaecology, uro-gynaecology, gynaecological oncology, hysteroscopy, colposcopy, infertility, and early pregnancy care and treatment. Gynaecological surgery was provided in theatres 17 and 18 and a range of gynaecological outpatient clinics and treatments were provided.

Termination of pregnancy services were provided on Norfolk ward and through the Pregnancy Advisory Centre (PAC). Self-referrals and GP referrals were directed to this department, which included the Freedom Day Case Unit. For pregnancies up to nine weeks gestation, a medical or surgical termination was available. Derriford Hospital provided surgical terminations up to 13 weeks and six days were provided. Any higher gestation period would require the patient to be referred to a specialist provider.

During our inspection we spoke with patients, relatives and a range of staff working across the gynaecology and maternity services. These included; 10 patients and seven relatives, 11 doctors (all grades and including an anaesthetist). We spoke with 21 midwives and nine nurses (band five to seven), eight health care support workers, six reception staff, two sonographers and one cleaner. In addition we spoke with the care group manager, clinical director, head of midwifery and three maternity and gynaecology matrons. We held a number of focus groups, two of which were attended by a total of 11 midwives. We reviewed 13 patient records. We looked at seven sets of records and spoke with five staff from the PAC and Freedom Day Case Unit. Before, during, and after our inspection we reviewed the trust's performance information.

Maternity and gynaecology

Summary of findings

Overall we have judged maternity and gynaecology services as good. The service required improvement for safety; effective, responsive and well-led were judged to be good; and caring was viewed as outstanding.

The maternity services needed to make safety improvements. The environment and some equipment was not conducive to the prevention and control of infections and related guidance. There were gaps in the cleaning contract schedule. These were alternatively completed by healthcare assistants; taking them away from assisting with clinical duties. Improvements were required for the safe discharge process of mothers and babies. Refurbishment was part of the trust's redevelopment plan but this did not have any agreed timescales.

The national recommended ratio of Supervisor of Midwives (SoM) to midwives is 1:15, and was not being achieved (Midwifery Rules and Standards, rule 12, Nursing and Midwifery Council, 2014). The ratio of SoM to midwives at Derriford hospital was 1:27.

There were established and thorough safeguarding systems in place and good mandatory and other training for maternity staff. Patients had risk assessments completed and reviewed regularly. Staff were knowledgeable about incidents and learning from these was demonstrated.

Both services provided effective services. Staff followed most nationally recognised policies and procedures. However, there were no specialist perinatal mental health services. There was good communication between all grades of staff and different professionals. Team working was described as good which supported staff's ability to meet the individual needs of patients.

Patients and relatives feedback on care received in gynaecology and maternity services was overwhelmingly and consistently positive. Patients told us they were involved in all aspects of their care and had been treated with compassion, kindness, dignity and respect. Patient centred care was embedded, and staff strived to provide individualised, compassionate care and support. Patients reported the care received exceeded expectations, even with emergency situations.

The maternity and gynaecology services were responsive to individual needs. There were patient access and flow issues on Norfolk ward. This was due to medical patients being admitted to manage unprecedented demand in the hospital. This had impacted by breaches in the 18-week standard of referral to treatment times.

Complaints were reviewed and appropriate actions taken. Learning from complaints was shared in meetings and within staff newsletters.

The service was judged to be good for well-led, although ward staff were not familiar with the service's vision or strategy. There were comprehensive risk, quality and governance structures in place. However, improvements should be made to processes to investigate and learn from incidents, and ensure this learning is embedded in practice.

Staff described leadership and support from ward level and above as good; with senior managers visible and approachable. The staff we spoke with were proud of the care they provided. There was good evidence of a positive working culture and innovations and actions taken to make service improvements.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

Safety improvements were required to the maternity services. The delivery suite environment and cleaning regime did not comply with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance. Improvements were required for the safe discharge of mothers and babies at the maternity reception. Not all records were stored safely on the delivery suite. The maternity dashboard was linked to other south west clinical commissioning groups and did not easily define the midwife to birth ratio. The supervisor to midwife ratio just exceeded (was worse than) recommended levels.

Gynaecological and maternity records were organised with clear plans of care, and appropriate referrals to other professions or services. Women had individual risks assessed and regularly reviewed. Staff were knowledgeable about safeguarding process and understood their responsibilities. There was a high level of consultant support available 24 hours a day to care for women with high risk health issues and pregnancies.

Incidents

- All staff we spoke with said they were encouraged to report incidents. Maternity staff were aware of what type of issues constituted a reportable incident such as third and fourth degree tears, post-partum haemorrhages and unexpected admissions to the neonatal intensive care unit (NICU). A list of reportable incidents was included in the maternity risk management framework. Staff demonstrated an understanding of the processes to follow. Staff told us feedback and learning from incidents was cascaded through team meetings and handovers and within a monthly newsletter. We saw several newsletters which highlighted learning from incidents.
- Incidents were reported on the trust's electronic reporting system. Midwives working in the community were not always able to report incidents promptly as IT access was not limited in some areas.
- There was one recent Never Event relating to gynaecology services (these are serious incidents that are wholly preventable and cause serious harm or death to patients). We saw an initial investigative report outlining immediate actions taken to minimise further risks. The head of midwifery confirmed the patient concerned had received a full explanation and apology and was being provided with ongoing support.
- Gynaecology and maternity incidents were reviewed, and risks and actions agreed during weekly service line manager meetings. These were investigated by a senior midwife and supervisor of midwives. Findings were escalated to the head of midwifery and director of nursing through the trust's monthly risk management and clinical effectiveness meetings. We looked at meeting minutes and saw learning and actions recorded. For example, we saw as a result of recent incidents, skills and knowledge gaps had been identified amongst clinicians relating to diabetes in pregnancy. This resulted in a staff training plan to update skills and competencies.
- From February 2014 to January 2015 the maternity services had reported 22 serious incidents, including 13 unexpected baby admissions to the NICU. We spoke with the head of midwifery about this who confirmed they would be undertaking an in-depth review to look for, and implement service improvements.
- Perinatal mortality and morbidity meetings were held every month. We looked at meeting minutes which detailed individual case reviews. Areas of good practice and service issues were identified for each one. Detailed discussions between the clinical staff attending the meeting were recorded to improve practice and procedures. For example, one doctor agreed to work with midwives to clarify and improve the coordination of communication of clinical observations. It was further agreed that this work would become part of future mandatory multidisciplinary skills and drills training.

Duty of candour

- Staff demonstrated an understanding of the principles related to Duty of Candour (a new regulation to be open, transparent and candid with patients and relatives when things went wrong) and told us how women were informed about incident investigations and outcomes.
- On the gynaecology ward (Norfolk) we spoke with one patient who had been readmitted following

complications with elective surgery. This patient confirmed they were given a full explanation and an apology. We saw these conversations were fully documented in the patient's records.

Safety thermometer

- The inpatient maternity and gynaecology wards (Argyll and Norfolk) participated in the NHS safety thermometer. This was a process to collect patient safety information in relation to falls, catheter associated infections, venous thromboembolism (VTE), urinary tract infections, and pressure sores. Trust-wide, these were in line with England average rates. Patient safety information was, however, not displayed in clinical areas for patients, visitors or staff to view and see how well the wards were performing and delivering on the preventable safety issues.

Cleanliness, infection control and hygiene

- All ward areas appeared clean. We observed stickers were used to indicate when equipment had been cleaned and was ready for use.
- Those patients we asked confirmed they saw staff washed their hands and wore personal protective clothing such as gloves and aprons before providing treatment or care. Antibacterial hand cleaner was available throughout clinical areas and we observed staff and visitors using this.
- Cleaning staff were employed by another organisation with the cleaning of blood or other fluids spillages being the responsibility of ward staff and was usually completed by healthcare assistants. Staff commented that the cleaning of blood and body fluids was a frequent task due to the nature of the service and therefor this could at times mean they were taken away from assisting with clinical duties such as breast feeding advice. We observed a situation where members of staff and cleaners did not wear protective footwear or routinely clean their footwear and had walked through spilt fluids. This posed risks to infection prevention and control.
- The delivery suite was not able to be cleaned to an acceptable standard. We looked in five unoccupied delivery rooms (seven, ten 11, 12 and 15), and one triage room (four) during our inspection. The rooms had ripped wallpaper and exposed or missing plaster on the walls, chipped and raw wooden shelving, unfitted and damaged skirting and exposed drilling and fixings on walls where equipment had been removed and not recovered or resealed. Two hand sinks were badly stained and none of the sinks had elbow operated taps which would have helped prevent the risk of re-contamination. These did not comply with the Health technical memorandum 64, Note 00-10: Part C – Sanitary assemblies (DoH, 2014). The radiator covers in the shared patient toilets (one between every two delivery rooms) were rusted. This meant debris and dirt collected in exposed areas and surfaces, and rusted parts could not be cleaned effectively. These did not comply with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.
- Staff confirmed the remaining delivery and triage rooms were to a similar standard, apart from the recently renovated Snowdrop suite (for bereaved parents).
- Staff said the windows on the delivery suite had not been cleaned for approximately 10 years. The main midwives station used by all staff on the delivery suite for clinical work, had exposed raw wood throughout and stained and broken chairs. This did not comply with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.
- The birthing pool (room seven) looked visibly clean. Although staff were knowledgeable about how it should be cleaned, there was confusion regarding whose responsibility this was. We looked at the cleaning contract which did not specify this as a task for cleaners. We did not see any cleaning schedule records or audits for the birthing pool and there were no stickers to say the bath was cleaned and ready for use. This did not comply with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.
- The head of midwifery told us the delivery suite was on the trust's rolling programme of refurbishment and with the five year development plan. However, there was no identified start or completion date. Infection control risks were not on the maternity risk register.

Environment and equipment

- The delivery suite equipment environment was organised, with equipment stored appropriately.
- Areas were accessible with a swipe card for staff and controlled by a buzzer for patients and visitors. CCTV was used in the maternity areas.

- Improvements of security arrangements were required for the safety of mothers and babies. The maternity reception area was staffed 24 hours a day by reception staff in a lockable office area. Women being discharged with their babies from the delivery suite or wards (Argyll or Transitional) were advised to formally check-out at the maternity reception. Information should have been passed from discharging patients to reception staff, which triggered processes for the community midwives to follow up care. However, we observed not all parents followed these processes which meant receptionist staff had to call people back to confirm their personal details. In addition, we saw the receptionist's vision was partially obscured by the desk, not always providing vision of baby carriers. We saw when reception were dealing with enquiries they were not able to fully monitor the exit. The trust did not use baby tagging or have an abduction policy.
- Emergency resuscitation equipment was accessible in all clinical areas but daily safety checks were inconsistent. On ward areas records documented equipment had been checked and reviewed as fit for purpose on a daily basis. The delivery suite had adult emergency resuscitation equipment and 12 baby resuscitaires. We saw audit information which showed 28 missed resuscitaire checks during the month of May 2015. Senior staff said they were consequently reminding staff to complete these checks every day during staff handover.
- Every delivery room had cardiotochograph equipment for fetal heart monitoring. This was linked directly to a central system and screen which meant clinicians could review and monitor recordings easily. The two rooms used for high dependency patients and the obstetric theatre and recovery area were fit for purpose.
- A range of suitable equipment was available within the gynaecology outpatients' treatment areas in order to perform clinical procedures. Other equipment used for assessments and induction of birth was stored safely on the maternity day assessment.
- All the birth rooms required urgent updating due to poor décor and equipment. We saw angle poised lamps used for suturing were loose and did not hold their positions. One en suite toilet was shared between two delivery rooms. This meant if the room was in use, the labouring woman would need to access other toilet facilities on the ward, compromising their dignity and privacy.
- Some rooms stored birth equipment such as delivery packs and suture kits in cupboards, which we saw had poorly fitting drawers and chipped wood. Birthing rooms were clinical in appearance with no fixtures or fittings to make rooms comfortable for women and their partners. Some chairs for birth partners in delivery rooms were damaged, including ripped seats.
- Birthing equipment to facilitate mobility in labour was limited. Birthing balls were available; one t**ranscutaneous electrical nerve stimulation (TENS)** machine; and one birthing pool with a ceiling mounted hoist to enable the swift evacuation of women from the pool. The pool was not available for use during our visit as the thermometer had broken.
- The geographical layout of the Pregnancy Advisory Centre waiting room did not afford privacy and dignity for people attending the clinic. The waiting room was facing the waiting room for genito-urinary medicine. While staff called patients only using first names, this would be heard and the person visible to the both waiting areas.

Medicines

- Not all medicines were securely stored. Medicines on all ward areas were stored in locked cupboards and trolleys. Medicines and controlled drugs were stored unlocked in the unoccupied obstetric anaesthetic room while the operating theatre was in use. This meant there was a risk they could be removed or tampered with. This was discussed with theatre staff at the time of our inspection.
- Oxygen and nitrous oxide used for pain relief were piped into delivery rooms. Records showed the maintenance of these gases were reviewed and monitored. Stronger analgesia was available for women in labour if they required it.
- Medicines that required storage at low temperatures were kept in a dedicated fridge, which was in a key pad locked room. The fridge temperature was checked daily.

Records

- Not all records or patient information was stored safely or confidentially. On the delivery suite we found 25 different sets of fetal blood sampling reports from 2005 to 2015. These records had been left in an unsealed envelope in an unlocked equipment room. We also observed two sheets of loose patient records left in one of the high dependency rooms. We alerted senior staff

to the security of these records at the time of our inspection. Records on wards and at the maternity reception area were stored safely, behind key coded reception areas or in lockable records trolleys. These were accessible to all staff who needed to access them.

- Colour coded magnets were used across all inpatient maternity services to identify patient conditions or outcomes. For example; 'destination home' and 'caesarean section'. Staff said this enabled them to swiftly keep updated.
- Pregnant women had hand held records which were provided at their initial booking of ante natal care and maintained through to completion of post natal care by community midwives. This enabled clinicians to have the most up to date and relevant information when reviewing care.
- In the PAC we saw a process was in place for initial assessment. The necessary risk assessments were evident and risks were recorded as discussed with patients. A record was maintained of all discussions and advice was also provided on contraception and sexual health.
- We reviewed eight sets of gynaecological and maternity records and found them to be organised with clear plans of care. Referrals to other professions or services had been made where necessary and information shared appropriately. We saw risk assessments and procedures following complications had been completed where necessary. For example; obstetric early warning charts and shoulder dystocia documentation.

Safeguarding

- Staff we spoke with were knowledgeable about the trust's safeguarding process and were clear about their responsibilities. We saw this demonstrated in patient records. For example; one midwife identified following issues for a pregnant woman related to abuse when she was a child. This midwife wrote to the local authority to check if there were any concerns that needed to be considered to ensure the woman and baby were safeguarded from any potential further abuse.
- Two midwives had specialist lead roles for safeguarding and drug and alcohol issues. We saw comprehensive documentation in records demonstrating how issues had been identified and appropriate services and professionals alerted. Staff documented how they worked collaboratively with other professionals including local authorities, community drug and alcohol services, and GPs.
- Staff said the close working relationships with community midwives enabled people in vulnerable circumstances to be identified early through antenatal clinics. Stickers were used on patient records throughout the maternity and gynaecology services to alert all staff of issues relating to vulnerability. These included fostering or adoption, parental mental health, and risk of sudden infant death syndrome.
- Staff within maternity and gynaecology services attended safeguarding level 2 training and where appropriate, level 3. Senior staff were confident the majority of staff were in date with safeguarding training although records showed the trust's compliance tolerance levels of 85% dipped to between 60- 80% for gynaecology staff during the end of 2014.
- Two midwives said the safeguarding training was excellent and multidisciplinary, including professionals from the police, charitable services and education. Staff said this prompted thought provoking discussions of issues related to practice.

Mandatory training

- Staff working in midwifery said the mandatory training was good. The whole staff team were divided into 11 groups with one group per month allocated a whole week off clinical duties in order to complete all mandatory training and annual appraisals. Staff were positive about this scheduling; stating the benefits of block training enabled increased focus and learning.
- Gynaecology staff attended mandatory training when required. Records showed less compliance with the numbers of staff in date with training at the end of last year for basic life support and manual handling. Senior staff said they planned to implement the same block booking for mandatory training as maternity staff.
- Maternity staff attended an additional annual day's mandatory skills and drills prompt training (practical obstetric multi-professional training). We looked at the programme and evaluation forms for the last session held during January 2015. Feedback and comments on the quality of training and learning were all very positive.

- The head of midwifery said they adapted the prompt training adding additional topics in response to analysis of incidents. For example; the last session had included training on diabetic emergencies and the next would likely include emergencies resulting from epilepsy.

Assessing and responding to patient risk

- The midwives delivered 1:1 care to women in established labour 97-99% of the time. We observed on one day of our inspection the delivery suite was busy, with all rooms in use. We were told 17 babies had been delivered and each woman had been provided 1:1 care.
- Staff on the gynaecological ward (Norfolk) demonstrated an understanding of the signs or symptoms of sepsis, such as increased temperature and respiration. Staff were aware of processes to follow to maximise patient outcomes.
- Staff on Norfolk ward were concerned regarding their ability to safely monitor and respond to patients admitted from medical wards due to a shortage of beds, and older patients, both of whom were regularly admitted to the ward. During our inspection, a locum doctor had responsibility for the continued review and monitoring of the medical outlier patients' (four at the time of our inspection). This doctor's placement on the ward was due to finish and there were no arrangements for a replacement.
- Norfolk ward environment was not designed to be able to easily observe patients from the nurse's station. When the ward was accommodating patients from medical wards, staff said this was not beneficial for older patients who had frailty or confusion. This had been on the gynaecology risk register (rated as high risk) since 12/11/2014, and was awaiting executive team actions.
- The maternity suite was consultant led and able to support women with high risk pregnancies or complex health. Risk assessments were completed at the initial booking and continually evaluated throughout the antenatal period. Management of high risks pregnancies would include planned caesarean sections and/or planned admission to the NICU (neonatal intensive care unit) or the Transitional Care ward. This ward provided a higher level of care, support and monitoring and was based next to the NICU. Staff said if babies deteriorated, swift and prompt support was provided by the NICU staff.
- Every delivery room had cardiotochograph equipment for fetal heart monitoring. We observed 'fresh eyes' stickers had been used to confirm trace readings had been double checked by a second midwife.
- The delivery suite had facilities to support women with uncontrolled or unpredictable risks or conditions. The suite had two high dependency rooms which were suitably equipped with additional monitoring and emergency equipment.
- Safe practice guidance was followed before patient surgery commenced. We saw the World Health Organisation (WHO) surgical safety checklist was completed as required. This guidance prompted actions for safe clinical practice before anaesthesia, before incisions, and before the patient left the operating room.
- We saw risk management guidance tools were available and used appropriately. For example; obstetric risk assessment for venous thromboembolism and guidance for women with diabetes in labour.

Midwifery staffing

- A midwifery staffing audit was performed every six months. The outcome of the last audit showed midwifery staffing levels had improved on previous years. This followed financial input from the trust, a successful recruitment programme and service redesign.
- The trust board summary staffing report dated March 2015 stated the whole time equivalent (WTE) funded midwives posts (hospital and community) was 184.73. Of these, 10.2 WTE posts were managerial or specialist roles. This left 174.73 midwives providing direct clinical care.
- The birth to midwife ratios was not calculated in an easy or consistent way, nor was this easy to identify on the maternity dashboard. The ratio was calculated by following a process defined by the local clinical commissioning group which also made comparisons with other maternity services out of the region. The process involved dividing the number of births by the number of whole time equivalent midwives, excluding the head of midwifery, matrons and specialist midwives. These calculations did not account for midwives on any form of leave or absence. This may have accounted for reports from some midwives that the ratios felt higher (that is worse than the required level) in practice. In the 'Maternity operational staffing and escalation policy',

October 2014, the midwife to birth ratio was reported to be 1:38, the head of midwifery told us the birth to midwife ratio was 1:30. It took time for senior staff to establish and confirm the ratio during our inspection, which was reported as 1:28.7. This was slightly above the RCOG (Safer Childbirth Minimum Standards for the Organisation and Delivery of Care in Labour) recommendation of 1:28.

- The daily coordination of the delivery suite and assessment of the midwife to patient ratio was reviewed each morning by the matrons. The normal allocation was two midwives to triage, six midwives to the delivery suite and two midwives to support theatre staff. During busy periods the escalation policy was used to redeploy midwives from the community, Transitional Care ward or ante and post natal ward (Argyll). The activity levels of the delivery suite and other clinical areas was kept under regular daily review by the matrons. An experienced band seven labour ward coordinator midwife was rostered on duty on every shift to advise and support other staff to provide safe care.
- On the delivery suite, midwifery handovers took place at 7:30 am, half an hour before the consultant's handover. Staff typically worked 12 hour shifts and had a multidisciplinary handover at 8pm.

Medical staffing

- The trust had a good level and range of medical staffing skill mix who worked across the gynaecology and obstetric services. A total of 37 whole time equivalent medical staff were employed. A high number were employed at consultant and middle grade (at least three years at senior house officer grade or above) compared to and thus better than the England average figures.

Medical staffing skill mix

Whole time equivalent

Plymouth Hospitals NHS Trust

England average

Consultant

43%

34%

Middle grade

11%

8%

Registrar

27%

51%

Junior

19%

7%

- In order to provide safe care for high risk pregnancies, the consultants provided 24 hour cover on the delivery suite. On call consultant cover was only provided between 6pm and 7:30pm. Consultant presence on the delivery suite was provided from 8am to 6pm, and 7:30pm to 8am.
- The resident consultants on the delivery suite were supported overnight by on on-call consultant and seven middle grade doctors. Seven specialist obstetric or gynaecology registrars worked between 8am and 11pm
- A consultant anaesthetist was available on the delivery suite Monday to Friday from 8am to 5pm. Out of hours cover was provided by the general on call consultant anaesthetist.

Major incident awareness and training

- The trust had a major incident plan in place but ward staff were not familiar with the plans.

Are maternity and gynaecology services effective?

Good

The maternity and gynaecology services have been rated as good in providing effective care. An anaesthetist was available 24 hours a day to respond to women during childbirth who chose to have an epidural for pain relief. There was good communication between the medical and nursing staff, and allied health professionals, and team working was described as good. Staff followed most nationally recognised policies and procedures. However, there were no specialist perinatal mental health services, nor were there plans in place to develop these services. Improvements were required to ensure gynaecology staff had an annual appraisal.

Maternity and gynaecology

Evidence-based care and treatment

- Policies and guidelines had been developed in line with national policy. These included the National Institute for Heath and Care Excellence (NICE) guidelines, the Royal College of Obstetricians and Gynaecologist (RCOG); Safer Childbirth (2007), The Care of Women Requesting Induced Abortion (RCOG) and the Termination of Pregnancy for Fetal Abnormality (DH, 2010) guidance.
- Policies and procedures were available on the trust's intranet and staff demonstrated they knew how to access them.
- Processes and procedures followed by staff showed women received care in line with NICE quality standards 22 (for routine antenatal care), 32 (caesarean section) and 37 (postnatal care).
- Care was seen to be provided in line with RCOG guidelines; Safer Childbirth. This included the organisation and delivery of care in labour, staffing levels, roles and equipment.
- Women were offered specialist support following tears during childbirth or after a caesarean section. One of the consultant obstetricians provided a specialised study day for clinicians on best practice for women who sustained a third and fourth degree tear during childbirth. Post natal care was also supported by specialist obstetric physiotherapists
- The midwifery service did not comply with NICE quality standards 192 for the clinical management of antenatal and postnatal mental health. The maternity services did not have a dedicated perinatal mental health team. The trust had developed a pathway but there were no personnel in place such as specialist mental health midwives or psychologists or plans to develop these services. One of the maternity matrons told us they attended the perinatal maternal and infant mental health network. Information and learning from this group was shared with staff. As a result, clinicians were only able to signpost women to external mental health services. These issues were not on the maternity risk register at the time of our inspection.
- The options for choice of birth were limited to hospital or home. This was not in line with national guidance which recommended women should be able to choose between three different options; a home birth, birth in a local facility under the care of a midwife (MLU), or birth in a hospital supported by midwives, anaesthetists and consultant obstetricians. A MLU is regarded as the safest option for low risk pregnancies (Maternity Matters, 2007, DH, Birthplace; 2011, NICE clinical guidance 190). The head of midwifery told us this was a concern for the service; the development of a MLU was on the trust's five year development plan. However, the plan did not identify when this would be addressed.
- The gynaecology services were providing effective outpatient services, particularly for colposcopy treatments (procedures to examine and treat abnormalities in the vagina or cervix). The service was in the top half of trusts nationally for activity undertaken as day case. Colposcopy services were meeting national standards, with 90% of biopsies taken being proficient for histological interpretation, and 100% of patients had histological results before further treatment. The urgent colposcopy and hysteroscopy referred patients were seen within the standard of two weeks and routine patients within the standard of six weeks.

Pain relief

- Pain relief was available on demand in the delivery unit. A TENS machine, a birthing pool and birthing balls were available to relieve and manage pain in labour. Nitrous oxide gas (Entonox) and oxygen were piped into each delivery room. Epidurals were available for women in labour 24 hours a day, seven days a week if they required.
- Patients we spoke with on both Argyll (ante and post natal) and Norfolk (gynaecology) wards told us they regularly had their pain assessed by staff and were given analgesic medicines promptly.

Nutrition and hydration

- Women were encouraged to breastfeed following best practice guidance. The maternity services had full accreditation (level 3) with the UNICEF UK Baby Friendly Initiative. This meant staff had fully implemented breast feeding standards which had been externally assessed by UNICEF. This process assessment involved interviewing mothers about the care they had received and reviewing policies, guidance and internal audits.
- There were sufficient numbers of breast pumps for expressing milk. These were available for women to use when required.
- There was a milk storage fridge for expressed milk and made-up feeds

- Midwives, nursery nurses and health care support workers had appropriate training to offer advice and support with all aspects of baby feeding.
- Patients told us they were offered plenty of hot and cold drinks and water jugs were changed and replenished frequently. Snacks and drinks were available to purchase 24 hours a day in between set meal times.

Patient outcomes

- The maternity services responded to the needs of pregnant women living in the locality who required care, treatment and support before, during and after birth. Between April 2013 and March 2014 there were 4,422 births within the community and the hospital. This was a decrease of 6.2% compared to the previous year (4,713). In the same period, there were 1,890 midwifery outpatient appointments, 99% (1, 871) of these were attended. There were also 53,599 obstetric outpatient appointments, 96.9% of these were attended (51,018).
- Patients regularly had their care and treatment reviewed. The consultants did a daily ward round on both the gynaecology and obstetrics wards. We observed one patient on Norfolk ward had been there for an extended period. This patient told us they were very happy with the care they had received. We looked at this patient's records which showed the consultant had reviewed care on 26 of the 28 days since admission. Care and treatment had also been reviewed on 13 occasions by the tissue viability and microbiology services.
- For medical terminations the treatment required a clinic appointment on day one and a visit to the Norfolk ward (gynaecology) the day after treatment for a second dose of medication. At this time patients were checked and if stable and suitable they could return home. This decision was made by the nurses with on call support from the gynaecological registrar. All patients received a pregnancy test to take home with them. A follow up telephone call was made after 12 days to offer a follow up appointment and a scan.
- During 2014, CQC intelligence identified the trust was an outlier against national data for increased numbers of maternal non-elective readmissions within 42 days of delivery. The trust had reviewed processes and identified an action plan for a number of improvements. We spoke with the head of midwifery who confirmed they had re-audited non-elective maternal readmissions for a second time. This had identified that two clinicians had made approximately 50% of the referrals for minor issues, for example the provision of simple analgesic medicines. We were told these clinicians had received further training and the maternal readmission rate had returned to acceptable levels.
- There maternity services had a low caesarean section rate. The maternity dashboard monitored and compared the performance of 11 trusts in the South West region. The caesarean section rate was consistently the lowest compared with other trusts. The percentage of babies delivered by caesarean section during January 2015 was 21.2%. Other audit information showed the percentage of emergency second stage caesarean sections had decreased. During 2011 to 2012 the rate was 12.5%; during 2013-2014 the rate was 7.2%

Competent staff

- Midwives maintained their clinical expertise to work in all areas. The midwives were split into teams and worked across the delivery suite, on the inpatient wards (Argyll and Transitional Care) and within the community on a three-year rolling programme. This ensured staff had the clinical skills and competencies to work flexibly in response to patient and service needs.
- The ratio of supervisors to midwives was not meeting recommended levels of 1:15. The regulation of midwives includes an additional layer of investigative and supervisory responsibilities provided by a supervisor of midwives (SoM). By law midwives must have a named SoM with whom they meet once a year to consider their practice. The recommended ratio of SoM to midwives was 1:15 (Midwifery Rules and Standards, rule 12, Nursing and Midwifery Council, 2014). The ratio of SoM to midwives at Plymouth Hospitals NHS Trust was 1:27. The head of midwifery said it was difficult to retain SoM due to the pending changes in law (SoM will be eventually be phased out) and the need to provide consistent out of hours cover. Plans were being developed to mitigate these issues by adding senior midwives to the on call rota and advertising for a full time SoM post. The high ratio was not on the maternity risk register at the time of our inspection.
- The impact of having high levels of consultant cover within the delivery suite had been evaluated by one of the consultants by retrospectively reviewing nine months clinical records and medical rotas. This showed not only clinical benefits (decrease in medical procedures, increase in spontaneous deliveries) but also

training and support opportunities for junior doctors were maximised. This met the Safer Childbirth (2007) standards that intrapartum care should be provided by appropriately trained staff. We spoke with junior medical and anaesthetic staff who told us they felt supported, with senior medical staff being visible and approachable. Junior staff said there were good opportunities for training, support and supervision and they had not been asked to practice beyond their level of competency.

- Processes were in place to maintain clinical skills. All on call gynaecology and obstetrics consultants had time booked during normal working hours to perform planned clinical procedures. This was done in order to effectively maintain clinical skills for procedures performed out of hours. Obstetrics and gynaecology services were supported by two teams of dedicated theatre staff. The teams rotated between the services which they said maintained their clinical competencies.
- One of maternity health care assistants was trained to assist in the triage area, by recording observations and undertaking phlebotomy duties.
- The transitional care ward had nursery nurses as part of the establishment to support and enhance midwifery care
- Staff had the necessary skills to complete new born baby checks. Approximately 97% of these were provided by appropriately trained and accredited midwives and one nursery nurse (the remainder by medics). This meant mothers and babies did not need to wait to wait to be seen by a doctor.
- There was varied compliance with the completion of staff appraisals. All maternity staff completed their supervision and annual appraisals during the annual planned week's mandatory training block. Gynaecology staff completed training when required. The percentage of completed annual appraisals for gynaecology staff was poor. Records showed between April 2014 and December 2014, the percentage of appraisals completed by due date was between 45.2% and 57.7%. This was significantly below the trust's tolerance level of 85%.

Multidisciplinary working

- Communication between medical, nursing and health care support workers was described as good within the gynaecology services.
- The maternity staff were proud of their team working. Communication between all professionals was described as excellent. Midwives said they felt their professional judgments were respected by medical staff. For example; doctors did not become involved with care with low risk women unless requested by midwives.
- Good multidisciplinary team working was provided by theatre staff. For example, we saw one patient with complex health needs. Four different surgical consultants attend the surgical procedure. Staff said this was to ensure correct care was provided by the appropriately trained surgeon.
- There were three elective caesarean section lists per week provided by a dedicated surgical and surgical recovery team. The team worked effectively with the maternity staff to coordinate and manage surgical procedures.
- There were missed opportunities for multidisciplinary working on the delivery suite. The morning nursing and medical handovers were held at different times, while the evening handovers were scheduled at the same time, so the teams were not able to benefit from each other's handover
- Information was shared appropriately with other professionals and services. Some of the records we reviewed showed clear and detailed communication for the benefit of patients. For example, we saw information shared by the safeguarding midwife with the local authority and other information shared by the specialist drug and alcohol midwife and addiction services. There was clear and detailed information shared between consultants and GPs. This promoted appropriate, consistent and safe care was provided to patients after discharge. The maternity services had been completing 'Schwartz Rounds' on a monthly basis since October 2014. These are practical tools designed to improve the culture, support staff, and improve patient care and understanding. The sessions involved discussion of a predetermined theme or case study of a sensitive nature. For example; staff perspectives on their involvement with infant death, and a patient diagnosed with a terminal illness and who became pregnant mid-treatment. Sessions were facilitated by a trained panel which included clinical and non-clinical staff. The sessions were open to all and records showed consistently good attendance levels (64 staff attended the first session, 59 staff attended the fifth session). Staff feedback was positive with staff reporting the rounds prompted refection on practice and a greater understanding of others' roles and experiences. There

was effective and cohesive team working between the Transitional Care ward and the neonatal intensive care unit, whose services were next to each other. Staff said women who needed to transition between the two services and staff worked positively together to ensure this was a smooth process for patients.

Seven-day services

- The maternity services were open 24 hours a day, all year round. The maternity reception area was staffed at all times and specialist advice and assessment was available from midwives through the triage service. Women accessed this service by telephone or attendance on the delivery suite.
- An anaesthetist was available to provide epidural pain relief at all times and the obstetric theatre was staffed and available at all times.
- There was medical presence within the maternity services at all times. This was at consultant level for 22.5 hours of every 24 hour period
- Specialist physiotherapy support was available Monday to Friday for women following complications or caesarean section. Physiotherapists provided follow- up service for women six weeks after suturing for perineal tears
- Imaging services were provided by trained sonographers and were available at all times.

Access to information

- Medical records were accessible and available for both gynaecology and maternity clinics. Reception staff told us previous medical records were requested and were supplied the day before a clinic. Reception staff told us all record requests were checked before clinics started which ensured staff had the information they needed.
- Pregnant women carried their own records which were provided when booking in. These were used by all clinicians involved with care during the pregnancy. After delivery, new records were made which included relevant information regarding the pregnancy, birth and baby. These records were carried by women and used for post natal care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Procedures to gain consent were documented. The 13 records we reviewed clearly documented discussions regarding consent before carrying out any examination or procedure.
- In PAC we saw included with the records was a follow up letter to the GP. This was produced after gaining the patient's consent to update their GP. For patients below the age of 16, a Frazer competency test was undertaken. This was done to ensure the patient had the mental capacity to understand the decisions they were being asked to make and any care and treatment being consented to.
- Case reviews had been used to identify improvements in staff knowledge and responsibilities regarding patient consent. We reviewed the perinatal governance meeting minutes dated July 2014. The trust had a policy on consent. However, additional staff learning had been identified through clinical case discussions. In response one consultant wrote additional guidance for staff in the maternity services. We reviewed this and saw it incorporated how staff should support and work with women with mental health issues and women with a learning disability. The guidance was linked to national advice and policy including; the General Medical Council, Nursing and Midwifery Council and the Mental Capacity Act 2005. This guidance was emailed to all maternity staff.

Are maternity and gynaecology services caring?

Outstanding ☆

Patients and relatives feedback on care received in gynaecology and maternity services was overwhelmingly and consistently positive. Patients told us they were involved in all aspects of their care and had been treated with compassion, kindness, dignity and respect. Patient centred care was embedded, and staff strived to provide individualised, compassionate care and support. This was recognised by patients who told us staff encouraged them to ask questions and care given was responsive and personalised. Patients' said the high level of care, attention and support provided had exceeded their expectations and

experiences had been positive, even for emergency situations. Staff routinely accounted for the emotional needs of patients and additional specialist counselling and support service were accessible and available.

Compassionate care

- We spoke with 10 patients and seven relatives within the gynaecology and midwifery services. Feedback was overwhelmingly positive, with patients and relatives stating all staff, from reception through to consultants, had provided exceptional care. One patient told us; "the staff are wonderful; a joy. Everyone is very obliging and helpful. I don't think I have used my buzzer once. I have been extremely well looked after and I cannot find fault with anything." Another patient told us they felt other new parents, who had not come into the hospital had missed out by not having had the personal expert care and advice they had received. This patient told us their confidence had soared solely because of how staff had taken the time to really listened to their worries and provided reassurance
- Patients and relatives told us they had felt respected, listened to and supported in ways which increased confidence. One patient explained this as staff always listening to concerns, giving helpful advice and allowing time for questions. This patient said staff frequently checked how they were feeling and if there were other things they could do to support them. Other patients told us how they had been personally welcomed on wards by staff who made them feel relaxed and confident.
- Some patients told us they had been anxious about admission and treatment but the kindness and care they had received and observed others receiving had exceeded their expectations. One patient told us this was the first time they had been in hospital in 34 years and they had been delighted to find the experience; "faultless and entirely and completely positive, the staff have all been wonderful to me and everyone else here."
- Another patient told us how they had observed staff care for another patient who was confused and anxious, and they had been impressed with the care given. We were told staff had treated this person with kindness, respect, patience and encouragement at all times.
- We observed compassionate, dignified and person-centred care was provided to patients. Staff demonstrated a familiarity with how patients preferred to receive their care. Regardless of this understanding, we heard when staff wished to provide care, they explained what they would like to do and why. Ward areas were relaxed and staff had developed friendly but respectful relationships with both patients and relatives, checking if all needs were being met.
- The monthly Friends and Family Test results for inpatient care on the Norfolk (gynaecology) and Argyll (ante and post natal) wards was consistently positive. The Friends and Family Test information displayed on Argyll ward at the time of our inspection showed 90% of patients had contributed, of which 99% was positive feedback. We observed recent letters and cards from patients of grateful thanks for the care received.

Understanding and involvement of patients and those close to them

- All the patients we spoke with told us they felt fully involved in their care and information had been presented in meaningful and understandable ways. Patients said they were encouraged to ask questions and had been given time to consider information before making decisions about their care and treatment.
- Patients told us staff had discussed information leaflets with them during consultations, and they had found this helpful. In addition, staff signposted patients to related information and videos on the trust's website and provided contact information to other local and national services. Patients said this helped their understanding further.
- Two patients and two relatives told us about their individual circumstances which had led to emergency admissions. One patient told us; "I feel privileged to have received the expert care I did. While the situation was frightening, within ten minutes my partner and I felt completely confident in the medical and nursing staff. They explained everything clearly and took control, we actually felt calm in the end, and it was almost like it had been planned from the beginning. I am so very grateful for the care I received I would dearly like to find the staff who were with me and thank them properly."

Emotional support

- We heard midwives provided emotional support to women calling the triage service. Women's individual concerns were promptly identified and responded to in a reassuring and positive manner. If appropriate, they

suggested women come into triage in order to provide personal reassurance. Women were encouraged to call back with any concerns however minor they perceived them to be.
- Confidential professional counselling from a qualified therapist registered with the British Association of Counselling and Psychotherapy was available for women using the termination of pregnancy services. Consultations were available before and after procedures. The Pregnancy Advice Centre also offered post termination counselling for up to a year after the procedure which women could access independently, without the need for a referral.
- The midwives provided a 'birth afterthoughts' service for women who had unresolved issues. For example; if the birth was experienced as traumatic, if the woman had poor memory of events, or remained confused regarding some processes or actions taken. The service provided an opportunity for the woman and partner to talk all the events through and ask questions.
- A specialist bereavement midwife post had gone out to advert at the time of our inspection. Chaplaincy care and support was available and contact details were available throughout the maternity unit. We were told occasionally bereaved parents chose not to have photos or mementos at the time of their baby's death. Staff collected these things for families in case they later changed their minds. We saw evidence of this in records.

Are maternity and gynaecology services responsive?

Good

The maternity and gynaecology services were responsive to individual needs, and women were supported to make choices on where to have their babies. There were patient access and flow issues due to a steady number of medical patients placed on the gynaecology ward (Norfolk). This had impacted with breaches in the 18 week standard of referral to treatment times. Complaints were kept under regular review. There was evidence these were reviewed and appropriate actions taken. Learning from complaints was shared in meetings and within staff newsletters.

Service planning and delivery to meet the needs of local people

- The community midwives (employed by the trust) provided care in more than 30 venues across an approximate 500 square mile radius. The midwives were often based in community children's centres which provided additional opportunities to engage with local people.
- For women whose first language was not English; maternity information was provided in other languages. Staff said interpreters were used regularly to support women in the hospital and community.
- The community midwives adapted how care was provided in response to local knowledge. For example; an increase in the Polish community in Devonport had been positively responded to. Community midwifery services were increased at the associated children's centre. Interpreting services were secured and used to advertise this within the local community.

Access and flow

- Gynaecology services were not compliant with the standard 18 week referral to treatment time (RTT). Senior staff said medical patients had had been frequently admitted to Norfolk ward since the winter pressures, and on occasions this had accounted for 20 of the 24 beds. This had impacted on meeting the RTT standards of 18 weeks. The trust RTT accepted target for gynaecology was 90%. Breaches of this target were documented for every month of the previous year.
- Women using the pregnancy advice service (PAC) were able to self-refer using a form available from the trust's website, or telephone and request an appointment. Women were given timely appointments in order to comply with regulations and guidance for medical and surgical terminations.
- The delivery suite had not closed between July 2013 and December 2014. There were contingency plans for the delivery suite in the event of the unit becoming full. Staff said additional rooms could be utilised in an emergency; one in the triage area and another being used as a store room. Both rooms had suitable beds and monitoring equipment.
- Most routine antenatal care was provided by community midwives. They completed risk assessments with women and gave advice and support with choice of place of delivery and birth plans. Women also attended the hospital for antenatal care. Those with high risk pregnancies attended consultant-led clinics.

Maternity and gynaecology

- The maternity triage service was open 24 hours a day, all year round for pregnant women to call or visit with concerns or queries. This service supported effective flow through to the different maternity services.
- Discharge from the postnatal ward (Argyll) was coordinated and efficient. Women had an individual breast feeding consultation and were then invited to a group discharge session. These lasted approximately an hour and were provided twice a day by a trained heath care assistant. Women were provided refreshments and given all their discharge advice and information. Women were able to remain in the lounge until their transport arrived.
- Discharge summary information was communicated to GPs and community midwives when women were discharged from the hospital. This prompted continuity of care support following discharge.

Meeting people's individual needs

- We spoke with one patient who had a learning disability. This person told us all staff had been kind, helpful and reassuring during pregnancy, birth and with post natal care. This person said information had been presented in a way they understood so they had been able to make choices about their care and treatment.
- We spoke with the clinical director regarding how care and support was provided for transsexual patients within the gynaecology services. We were told clinical advice was always sought from a specialist provider in Exeter before consultations. Patients were contacted in advance of any appointments to discuss where they would prefer to receive their care and treatment. This was done to promote respectful, individualised care.
- The delivery suite had two newly refurbished rooms set aside for bereaved parents. These enabled parents to stay together and have extended family visit in privacy. The Snowdrop rooms were occupied during our visit. Staff told us charitable funds had provided comfortable facilities and cold cots which enabled families to have extended time with their baby. Staff provided personalised memory boxes for bereaved parents. We saw the Snowdrop rooms were located close to other delivery rooms where new born babies could be heard crying. Midwives told us this was upsetting for bereaved parents but there had been no other options.
- None of the midwives had specialist bereavement training. Senior staff told us a specialist midwife was currently being recruited.
- The trust provided a termination of pregnancy service. Information was available which supported women to choose how they accessed these services and what processes would be followed. Information was provided on choices for fetal remains and counselling was provided as or when required.

Learning from complaints and concerns

- Complaints were reviewed by the head of midwifery and the gynaecology and midwifery matrons. We saw complaints were investigated, actions recorded and learning identified as part of clinical governance meeting minutes. Learning points were disseminated more widely during staff meetings and the monthly obstetric staff newsletter.
- We spoke to the head of midwifery regarding a recent complaint which included issues regarding how the family had been kept updated on the investigation. We saw documentation to show this had been achieved to some degree. The family had been contacted but they had not been informed of the investigation findings. The head of midwifery said learning from this complaint had included improvements in processes to ensure complainants were kept updated in a more timely manner.
- Staff on the transitional care ward told us partners of women could visit at any time, while visiting times for other visitors were set between 4pm and 7pm. Staff said, in response to concerns from patients and relatives about these restrictions, the ward was reviewing how they could safely provide open visiting for family and friends.

Are maternity and gynaecology services well-led?

Good

There were comprehensive risk, quality and governance structures in place. However, improvements could have been made to processes to investigate and learn from incidents. Staff described leadership and support from ward level and above as good; with senior managers visible and approachable. The staff we spoke with were proud of the care they provided and spoke of positive team working between professionals and across. There was evidence of

positive working cultures and innovations and actions taken to make service improvements. There was gynaecology and obstetrics five year strategy but ward staff were not familiar with this vision or its key objectives.

Vision and strategy for this service

- The vision and strategy had been developed by senior staff. Both the gynaecology and midwifery departments had five year service line strategies. These identified the local market and finances, future development plans, workforce planning, and key actions points. Ward staff told us they had not been involved or consulted about these and were not familiar with service visions or plans that had been prioritised.

Governance, risk management and quality measurement

- Staff demonstrated varied understanding with regards to learning from reported risks and incidents. For example, ward staff on the gynaecology ward (Norfolk) remembered facts about recent incidents but could not recall outcomes or learning. Other staff gave examples of changes or improvements to practice as a result of learning from an incident. For example, the colour of hats worn in theatre was changed to make people identifiable. Staff said this had benefited patients, their relatives and staff.
- Senior staff (Matron and above) demonstrated an understanding of current service risks. We looked at incidents recorded within the maternity and gynaecology services. We spoke with senior staff who demonstrated an awareness of what issues had been currently reported and subsequent actions planned to reduce further risks.
- Maximum learning from incidents may not have been achieved. We observed how obstetric incidents were initially reviewed by the risk midwife and a consultant. A clinical risk management form was completed summarising what went well, areas of concern, learning points, recommendations and actions taken. Responsibilities under Duty of Candour were not documented as part of these processes. Discussions focused on how issues had been responded to at the time and the overall outcome for patients. We observed a lack of interrogation and analysis into the cause of incidents. Learning opportunities may have been further reduced as the wider multidisciplinary team did not participate in these initial incident discussions.
- Some processes followed for investigating midwifery practice incidents or issues were not fully effective. The supervisor of midwives investigations were not linked to any trust risk management or governance processes. This meant two different investigations and management plans could be created for the same incident or issue. In addition, these separate processes did not adequately describe who was responsible for change when things went wrong.
- We saw the majority of maternity and gynaecology policies and procedures were in date and ratified. Most were stored and accessible to staff online. We observed the trust's IT system was slow, and took in excess of 10 minutes for staff to be able to access documents. This could potentially impact on patient care if staff needed prompt access to policies or procedures.
- Regular governance and risk management processes were in place across both gynaecology and maternity services. Obstetric and gynaecology services sat within the trust's women and children's care group. We met with the care group's manager, clinical director and head of midwifery who told us a number of governance and clinical meetings were arranged on a weekly, monthly or quarterly basis. These included an obstetric clinical effectiveness and governance meeting. The gynaecology governance committee had not met for the past eight months as a consequence of winter pressures and staffing issues. Alternatively, senior staff said they regularly took responsibility for monitored and escalating risks as required. Clinical and governance risks and issues were fed into the trust's quality assurance committee, and then escalated to the trust board. We saw meeting minutes for various clinical risk and governance meetings which recorded appropriate reviews and actions to be taken. In addition, the care group manager had a weekly meeting with both senior staff and the trust management executive. We were told this meeting enabled rapid communications of risk issues and actions from ward to board.
- Auditing took place of all terminations having taken place and any performance data including any failed terminations or incidents of infection. A multidisciplinary meeting took place every three months to review care and risks. These were attended by the consultant for PAC, the contraception service, and staff from the Freedom surgical day case unit and the Norfolk ward.

- National guidance was followed by the termination of pregnancy service. The notification and grounds for carrying out an abortion forms (HSA1 and HSA4) were completed correctly and submitted to the Department of Health (DH) as required. However, there were incomplete audit processes for surgical terminations. For medical terminations an audit trail was evident, with the date the HSA4 form was sent to the DH. Surgical terminations took place in a different area. A system was evident to ensure that at the end of each theatre list the forms were delivered to PAC but the date the surgical terminations were sent to the DH was not recorded.

Leadership of service

- Staff told us matrons working in maternity and gynaecology and the head of midwifery were approachable and good to work for. All had 'open door' policies.
- The matrons and head of midwifery were visible and present in clinical areas. They demonstrated a good understanding of current clinical activity and priorities on the days of our inspection. The matrons working on the delivery suite and Norfolk ward worked in clinical areas every week to strengthen their senior nurse and midwifery leadership.
- The clinical lead for gynaecology and maternity services was respected by junior medical staff for their experience and comprehensive understanding of the services. Staff said the clinical lead was accessible and visible.

Culture within the service

- Staff across gynaecology and maternity services were proud of the care they provided. Staff spoke positively about good team working between professionals and across services.
- Most staff we spoke with felt well supported and happy to come to work; also stating the culture was friendly, supportive, open and honest. Staff talked about organisational change and how this had at times been difficult to adjust to. However, staff staid they felt able to speak up and were listened to. Staff were aware of whistle blowing policies.
- Gynaecology staff felt frustrated by repeated changes in ward management during the past six months, and slow recruitment into staff vacancies.

Public and staff engagement

- Staff were kept updated on and encouraged to provide ideas or contribute to the monthly maternity or monthly trust newsletters.
- Community midwives worked within local children's centres and had good relationships with GP practices. Staff said these provided opportunities to engage with community groups and bring back information to staff meetings.
- Patients staying on the delivery suite and Norfolk and Argyll wards were encouraged to complete the Friends and Family test (FFT). Feedback from this was used plan and deliver care and services. For example, FFT feedback dated March 2015 on the delivery suite showed 113 patients had left comments of which 99% were positive. There was one negative comment regarding the time it took to get a baby weighed. Staff were familiar with this feedback and said while they tried hard to provide a timely service during busy periods, they needed to ensure patients were kept better updated.
- A number of midwives told us staff meetings were not always well attended due to the distance many lived from work. However to mitigate this, a lot of information was shared via emails which staff were able to access at home.
- The head of midwifery provided student midwives with support for interview planning.

Innovation, improvement and sustainability

- The improvement of specific midwifery skills had been identified as requiring improvement and innovative actions had been taken in response. The head of midwifery recognised there was no specialist midwifery high dependency training available locally for staff. In response, they wrote a Masters' modular training course with support from Plymouth University. This course had recently been accredited by the Nursing and Midwifery Council (NMC). The training would be available to midwives during the autumn of 2015.
- Staff looked for creative ways to make service improvements. The 'Curvy Mums' service had been set up to provide bespoke antenatal care for pregnant women with a BMI above 35. We spoke with the midwife who had developed this service. We were told it was in response to reported negative experiences of some women using some aspects for the maternity service. The key objectives of the service were to improve patient experience, achieve a pregnancy weight gain of

between five and nine kilogrammes, and minimise risks at birth. We were shown records of the last four women who had used the service and delivered their babies. The total weight gain was between two and four kilogrammes and all four women had normal vaginal births with no complications. We were told patient feedback was extremely positive. The service had been running for approximately six months but a full audit and evaluation had not yet been completed at the time of our inspection.

- Improvements had been made to the maternity service which ensured midwives could work safely and competently in all areas of care and practice. The head of midwifery had introduced a rotational three year working programme. This ensured staff had clinical experience working in the community, on the delivery suite, and within ante and post natal impatient wards. The head of midwifery had won a Florence Nightingale award for Nursing Leadership Scholarships 2013-14 for this work and had been asked to be a pilot site for NICE guidelines on safe staffing.
- The gynaecology services had put systems in place to sustain services and contribute to financial savings. Some surgical procedures were being offered alternatively to patients in outpatient clinics. These treatments included sterilisations, endometrial ablation and removal of polyps. This provided increased patient choice and reduced recovery times and was in line with best practice guidance (Best Practice Tariff, DH, 2013). In addition, a rolling programme for training nurse specialists in gynaecology specialties was available. This included colposcopy and hysteroscopy. Increasingly, nurse specialists were leading outpatient clinics which enabled consultants to provide more specialist services.
- The Royal College of Midwifes had recognised and praised midwife-led initiatives for improving public health and reducing health inequalities. Two projects had won awards in recent years: The safeguarding and substance misuse midwives for setting up systems to which established strong engagement and information sharing with other agencies, and antenatal care through the 'Great Expectations' programme of support and advice for families.

Services for children and young people

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

Information about the service

The paediatric service provided general and specialist children's services for the children and young people in the local population of Plymouth and surrounding areas of West Devon and East Cornwall. All inpatient services were at Plymouth Hospital (Derriford) along with paediatric A&E services. Outpatient services were held in Derriford, at the Child Development Centre (situated in Plymouth) and at a range of clinics held in local community hospitals run by neighbouring trusts but using Derriford employed staff. The Child Development Centre and Community Paediatric Services were inspected at the same time as the acute hospital site and the report is merged with the acute hospital report for paediatric services.

Paediatric services were located at Plymouth Hospital (Derriford). There were 14 inpatient beds on Woodcock Ward caring for children aged 10 days to 10 years. The play centre was located within Woodcock Ward. There were 13 inpatient beds on Wildgoose Ward caring for children and adolescents aged between 10 and up to their 16th birthday. Wildgoose Ward also provided inpatient oncology services. The child assessment unit had 10 beds and provided services on a 24 hour basis. There was a dedicated outpatients department (CYPOD) which also provided a day care facility for children receiving chemotherapy, sweat tests for diagnosis of cystic fibrosis and a venepuncture service. There was a four bedded high dependency unit adjacent to Woodcock Ward. All on level 12.

There were 22 cots in the level 3 neonatal intensive care unit (NICU) – consisting of 14 intensive or high dependency cots and eight special care cots. NICU services were supported by an 18 bed transitional care ward (TCW) (where babies and mothers stayed together, babies were looked after by neonatal nurses and mums by postnatal ward staff). There was an outreach service that provided care and support to babies and parents who had been discharged from NICU. NICU also hosted the Peninsula Neonatal Transfer Service that transported infants to and from units within the South West Regional network (level 9).

Plym Unit (level 6) provided paediatric surgical services including elective and non elective surgery in a dedicated theatre suite.

There was a dedicated paediatric emergency department, adjacent to the adult emergency department (reported on under the A&E section of the report). There was also a school on site.

The trust is a level three Paediatric Oncology Shared Care Unit (POCU) and a designated Teen and Young Adult (TYA) cancer hospital.

We spoke with 63 staff, including nurses, consultants, medical staff and support staff, 12 parents and three children and young people during our inspection. We visited all of the paediatric wards and departments within the hospital and observed care, looked at care records and other documents in each of the areas visited.

The Child Development Centre is based on the Scott Business Park site in the west of the city at Plymouth and provides assessment and intervention to children from across the Plymouth Hospitals NHS Trust area who show

signs of atypical development. The unit is a designated children's outpatient facility. The Children's Community Nursing Service is located off site and delivers clinical work in the child's home, school or outpatient setting.

Professional groups, working within the development centre provide multidisciplinary services for children and young people who require assessment, support and intervention to ensure their wellbeing and development.

The centre provides ten general outpatient rooms, specialist outpatient rooms for audiology and ophthalmology, a therapy gymnasium and an assessment facility for pre-school children.

The following services are provided at the Child Development Centre by Plymouth Hospitals Trust:

Community Medical Services (Community Paediatricians)

Psychology

Specialist Nursing Teams (specialist assessment group, continence service and community nurses)

Physiotherapy

Occupational Therapy

Speech and Language Therapy

Audiology

Distinct work also takes place to support the statutory work undertaken in relation to the medical care of 'children in care', 'adoption and fostering' and 'children with special educational needs'.

Community paediatrics provides multidisciplinary specialist assessment and intervention to support individual children to stay healthy while living with a range of long term conditions. These include children living with a neuro disability, Autistic Spectrum Disorder and Down's Syndrome. The service is provided on two sites. The Child Development Centre and Children's Community Nursing Service at Bircham House.

The Children's Community Nursing Service care for children and their families in their own homes who have a wide range of conditions including cancer, epilepsy and conditions associated with prematurity. The service also provides specialist advice and assessment to Plymouth County Council for children with Special Educational Needs and adoption and fostering services. Safeguarding the health and wellbeing of these children was a high priority for the team.

We spoke to 35 staff which included nurses, doctors, therapists, teachers and administrative staff. We also spoke to five children and 15 parents and relatives.

Services for children and young people

Summary of findings

Paediatric services were provided across the Plymouth Hospitals NHS site. They provided effective and responsive planned and emergency care and support to children and young people and their families. People who used the services told us they felt safe.

We found without exception that staff at all levels were caring supportive and very keen to do the best job they could.

People who used the services told us they felt safe. There were some aspects of the system that did not assure us that children and young people were always safe in some areas of the paediatric services: staffing levels were often below recommended levels on the paediatric wards and neonatal unit, although recruitment was ongoing. The rooms used for recovering children following procedures under general anaesthetic on the Children's and Young Peoples Outpatient Department (CYPOD) did not allow for constant line of sight by a trained nurse. The paediatric wards were seeing an increase in admissions of young people with mental health issues. The lack of clarity about how the internal security team could help and access to Devon, Cornwall and Plymouth Children's and Adolescents Mental Health Services (CAMHS) teams at weekends meant that these young people remained vulnerable while in the hospital setting.

We found the paediatric services were well-led at a local level and the staff felt engaged with the trust-wide senior team. They said the Chief Executive Officer and the Director of Nursing visited their wards and departments. Staff felt able to raise issues with local and senior management and felt they were listened to and their concerns understood.

We found community paediatrics provided a caring and effective multidisciplinary and multiagency service for children and young people who required assessment, support and intervention to ensure their wellbeing and development.

Services were provided in a child friendly environment by a highly skilled and empathetic workforce across the Child Development Centre and the Children's Community Nursing Service. Services accessed at the Child Development Centre, or when clinically required included visit's to a child's home, nursery, school or other locality setting. This enabled the development of holistic packages of care for each child and minimised the need for multiple appointments and duplication of history taking and documentation. There were concerns with regard to the small number of child assessments and care plans that had been completed in the Children's Community Nursing Team. Services were well-led and staff were aware of the wider vision of the trust and felt supported in their roles.

Services for children and young people

Are services for children and young people safe?

Requires improvement

Some aspects of safety require improvement.

We were told and saw not all children admitted to the paediatric services had care plans. We noted there had been recent changes in patient documentation in the community nursing team and patient assessments and care plans were either absent or incomplete. There were larger caseloads than the recommended average (RCN 2013) in the diabetes service.

Recovery rooms used for children following procedures under general anaesthetic meant that children would not always be in line of sight of a trained nurse.

Staffing levels on the general paediatric wards were not always in line with RCN Guidelines 2013.

The safety of children and young people with mental health needs was not always assured. We saw the details of three incidents reported in April 2015.

The service was safety aware and there was a strong emphasis on ensuring children were cared for by staff trained in hygienic care practices.

All staff had received safeguarding training at Level 2 or Level 3 and knew how to report the signs and symptoms of potential abuse. Staff were aware of the relevant safety policies for lone working and the provider had made every attempt to maintain the safety of staff who were working in community settings.

Incidents

- The paediatric departments had appropriate systems in place to make sure that incidents were reported and investigated appropriately. Staff told us they received feedback after reporting an incident.
- Staff gave us examples of actions that had been taken to reduce the risk of similar incidents occurring and how patient safety had been improved – for example the Neonatal Intensive Care Unit (NICU) has its own medicine management system "developed in conjunction with the paediatric department and pharmacist in response to increasing errors". The system was introduced, following a pilot, in October 2013 it included staff focussing on system problems rather than individual errors, an accountability sheet signed at the cot side to ensure any errors were detected within 12 hours and minor incident (white card) report. The system has seen a drop in errors.
- We looked at the investigations around incidents. They were thoroughly investigated with identified learning and actions to reduce the risk of similar incidents in the future. Information was disseminated via department meetings and safety briefings.
- In the acute paediatric services a recent safeguarding incident had occurred and we were not assured systems were in place to prevent the same thing happening again. This was partly due to external issues with accessing the Devon, Cornwall and Plymouth Children's and Adolescent Mental Health Services (CAMHS) teams at a weekend. We saw details of three incident reports involving young people with mental health issues from April 2015. Internal issues were around the security team, although present, not being able to provide practical assistance due to not been trained in dealing with young people. The matron of the paediatric services was in negotiations with the internal security team around where their responsibilities lay. The practice educator had begun a programme of training for paediatric ward based staff in the use of restraint and conflict de-escalation training. The training programme had begun prior to this incident and we were told it would be three years until all required staff were trained up to an appropriate level.
- CHDU staff attended and participated in an annual Paediatric Intensive Care Unit (PICU) roadshow where they reviewed cases that were transferred to the regional PICU. We saw minutes of the last meetings. If there was a significant concern about an individual case where there was felt to be a need for more urgent sharing of the learning that gets scheduled for the next governance meeting and was reviewed as an individual case. Every year the paediatric services held a mortality meeting with their anaesthetic and emergency department colleagues.
- Staff across all paediatric disciplines at Derriford Hospital and the Child Development Centre recognised the term "Duty of Candour" the regulation introduced for all NHS bodies in November 2014, meaning they should act in an open and transparent way in relation to care and treatment provided).Their description about

how complaints and concerns were managed assured us they were implementing the principles of the Duty of Candour and kept families and children informed about how their concerns and complaints were being managed and outcomes shared. We were told senior staff had received some training around Duty of Candour and saw a document available to staff entitled "Adverse Event Reporting and Duty of Candour". It explained the principles of Duty of Candour and the process of ensuring it was met.

- Staff in the Child Development Centre and the Community Children's Nursing Service used an online reporting tool to record accidents, incidents or "near misses" that occurred. Staff told us they had received training in the incident reporting system and knew how to report an incident to the manager of the service. Incident reports were reviewed monthly by the Child Development Centre manager to identify any trends and to share the learning across community teams. For example where children had experienced a minor bump or fall staff reviewed the environment and made reasonable adjustments.
- The Women's and Children's Care Group provided clinical leadership for the governance of paediatric services at the trust. Failings around the inability of the Devon, Cornwall and Plymouth Child and Adolescent Mental Health Service (CAMHS) teams to accept referrals in a timely manner from the Child Development Centre community paediatric services had been entered onto the paediatric risk register as a significant risk. Following the intervention of the service lead director from the Child Development Centre community paediatric services and the lead director from the Women's and Children's Care Group, regular meetings had been established. All referrals to the Devon, Cornwall and Plymouth CAMHS teams were now being triaged and kept under review. This ensured that children were able to receive the care and support they required and demonstrated that the community Child Development Team had taken the appropriate action to improve the safety of children beyond their service.

Cleanliness, infection control and hygiene

- In all wards and units we visited, we observed staff at all levels washing their hands and using hand sanitiser according to the trust's policy. We observed the appropriate use of personal protective equipment such as aprons and gloves. There were sufficient hand-washing sinks and hand gel dispensers in each area. All the ward and department areas we visited looked clean and tidy and individual cleaning schedules were being maintained.
- Hand hygiene audits between January 2015 and March 2015 showed the NICU to be 100% compliant with hand hygiene. The infection control report within the NICU Clinical Governance meeting minutes (April 2015) discussed infections managed within the last three months and outcomes of those cases. The theatre suite had hand hygiene audits displayed which showed 100% compliance in the last month. Other information we saw showed the wards and departments had regularly achieved 100% compliance also. There were systems in place to reduce the risk and spread of infection in the Child Development Centre. We saw monthly hand hygiene audits had scored 100% for the months of January February and March 2015 and 'bare below the elbow' was in place in clinical areas. We observed staff in the Children's Community Nursing Service using good hand washing and / use of gel techniques when caring for children in their own homes and were aware of the infection control policies and guidance.
- We met the infection control nurse, who covered paediatric services, on their routine visit to the ward. Paediatric ward staff reported good working relationships with them and said they had regular communications between their routine visits to the wards. There were infection control link staff on the wards and units. They acted as a resource for staff within their clinical area. An infection control link nurse had recently been appointed to the team who acted as a resource for staff and had direct links with the infection control lead nurse for paediatrics to ensure infection control practices in the Children's Community Nursing Team were safe.
- Where children or young people were potentially suffering from or had an infectious condition or had a poor immune system, single side rooms were used to reduce the risk of cross-infection.
- The dedicated paediatric theatre suite, which included two operating theatres, pre assessment rooms, recovery areas and waiting rooms, were clean and tidy. Daily cleaning checklists were used and reviewed weekly for compliance. Equipment was stored in dedicated storage areas. We saw staff using appropriate personal protective equipment such as gloves, aprons and masks.

- The play specialist team leader has developed a policy for maintaining the cleanliness of toys used by the play service. The policy is due to be ratified in the near future and the play specialist team leader has a plan of how the policy is to be implemented. The Child Development Centre manager told us about the importance of maintaining the cleanliness of children's toys to minimise the risk of infection to children. We noted the policy for the cleanliness of toys conformed to British Safety Standards and we observed the toys were clean.
- Parents visiting the Child Development Centre told us the centre was cleaned to a high standard as all the clinic rooms and the communal areas were always clean and tidy and they saw where cleaning schedules had been completed daily in toilets and washrooms. We observed in the main outpatient waiting area the clinic rooms and corridors were clean and free from clutter and noxious odours.
- NICU had two cleaning staff who were reported as being "very good". Staff told us when they were occasionally taken of NICU to other areas the cover provided was not as good as they did not always understand the particular needs of the unit.
- There were no reports of Methicillin resistant Staphylococcus aureus (MRSA) and Clostridium difficile (CDiff) related infections in either the acute of community services settings.

Environment and equipment

- All the wards and units we visited had a mixture of two and four-bed bays and single rooms. Separate toilet facilities were available for children, parents and staff. The NICU had a separate facility for parents to use overnight so they could be near their babies. It included a sitting area, a kitchen and shower facilities. The NICU staff were involved in fundraising activities to improve the current facilities available to parents. Feedback from parents we spoke with on NICU said they appreciated the accommodation available. Staff said there were not enough rooms available but in some cases parents/ families can use a purpose built facility for relatives/ carers near to the hospital.
- Each ward/unit had secure access to maintain the safety of the babies, children and young people. Exit from units was via a press button and did not stop children and young people tall enough to press the button from leaving the ward. This meant children and young people were not always safe.
- Each ward/unit had resuscitation equipment appropriate for babies, children and young people. We saw that this equipment was checked daily and that this checking was carried out consistently.
- Equipment was serviced according to the manufacturer's instructions. We spoke with the neonatal technician who told us their role included maintenance of equipment, simple repairs and involvement in tendering and procurement of new equipment. The technician also contributed to the NICU monthly newsletter and subjects covered included information about new incubators the unit was introducing, new saturation monitors and reporting of defective consumables. Staff spoken with told us how highly they regarded the service the technicians were able to offer.
- We visited the paediatric wards, NICU the high dependency unit and recovery in the theatre suite and found that each bed space had the necessary equipment. Machines with batteries were plugged in to the mains to make sure that the batteries were charged.
- We saw equipment required for use with the NICU transfer service was charged and ready for use at all times.
- The milk kitchen used by the High Dependency Unit (HDU) and Child Assessment Unit (CAU) was not locked meaning any of the milk in the fridge or bottled baby milk could be tampered with unnoticed. We bought this to the attention of the staff on duty. During an unannounced visit to the area on 30 May between 6pm and 7.30 pm we saw the milk kitchen remained unlocked.
- We saw daily equipment checks were undertaken in the Child Development Centre and we saw documentary evidence of this. We observed resuscitation equipment was in place. For example, a defibrillator and oxygen and suction equipment were clean and well maintained. We saw daily equipment checks had been undertaken and were clearly documented. The PAT testing of equipment was last completed in 2014. This demonstrated emergency equipment had been appropriately tested and maintained and was deemed fit for purpose.
- Staff in the Children's Community Nursing Service told us if they required equipment to care for children in their own home simple equipment was stored locally and was accessible to staff. If more specialist equipment

needed to be ordered the response was always prompt and waits were minimal. The lead nurse told us an incident form would be completed if there were delays in obtaining specialist equipment.
- An audit had been undertaken in the Child Development Centre in 2014 which had identified that clinic rooms were not properly equipped and not all equipment was fit for purpose. Actions to address the failings of the equipment had been implemented and the audit would be repeated in 2015.

Medicines

- On all the wards/units we visited, we found that medicines were securely stored. Medicines were kept within a locked room accessible only by staff. Controlled medicines were stored in separate locked cupboards and were checked daily by two qualified nurses.
- Where medicines needed to be kept in fridges, the temperature of the fridges was checked daily. The temperatures were within acceptable ranges.
- We saw allergies recorded on prescription charts and no missed medication doses were seen.
- In the theatre where only emergency and out of hours paediatric surgery was undertaken, a selection of a number of paediatric strength medicines were not kept. When we raised this with staff they contacted pharmacy to review their stock lists.
- There was good access to medicines resources, including current children's drug formularies. Apart from paediatric theatres whose formulary was out of date. This was rectified as soon as it was pointed out.
- Where medication administration errors had taken place, we saw evidence to show that they had been reported and investigated in line with the trust's incident-reporting procedures. Where necessary, appropriate action had been taken to prevent their recurrence. NICU had introduced their own medicine management system, in 2014, designed to reduce the number of medicines errors. Information produced showed the system had led to a reduction in errors.
- We spoke with the paediatric pharmacist who described the service they provided to the paediatric departments and the seven-day and overnight on-call pharmacy arrangements. Staff told us the support from the paediatric pharmacist was "invaluable".
- There were no medicines stored at the Child Development Centre. There was a secure system in place for the use of prescription pads (FP10's) by the doctors and nurses who had completed their nonmedical nurse prescribing training. We saw the storage and recording system in use was secure and documentation was legible and up to date

Records

- Medical and nursing records were stored in locked trolleys at strategic points on the ward areas. Monitoring charts such as fluid charts and observation charts were kept at the end of each baby/child's bed or outside their side rooms.
- In the records we looked at, we saw that core screening had been completed for each child; this included risk assessments for the patient's safety, infection control, pressure areas and moving and handling. We saw that where care plans were in place some contained generic paediatric core care plans that were individualised for each child depending on their needs. The 10 sets of records we looked on the paediatric wards were not all up to date. Staff told us when they were busy and short of staff they prioritised the care of the child and ensured their observations, food and fluid charts and pain assessments were up to date. They said that as a result care plans were sometimes not written or updated if they were written. We were assured that all children with complex needs would have comprehensive care plan and we saw this to be the case. We were told children with less complex needs would not always have a care plan unless their condition deteriorated. The deterioration would be picked up on the Paediatric Observation Chart.
- Observation charts (temperature, pulse etc.) were available for children and young people of different ages. These charts were comprehensive and included a Paediatric Early Warning (PEW) score section, a pain management and assessment section and a handover section. The observation charts had been completed consistently.
- An acuity tool was in use on the paediatric wards to establish the dependency of the children and young people the results of which were to be used to ensure the correct minimum staffing levels were set.
- The paediatric wards/units used standardised admission, assessment and observation charts across all the wards and departments. Care pathways were used within day case surgery and incorporated

preoperative checklists and anaesthetic care through to postoperative care. This showed that risks for the child and young person were reduced due to consistent practices.

- We saw the World Health Organisation surgical safety checklist was in use for all surgical procedures. There was an adapted version for use with procedures requiring general anaesthetic carried out on the paediatric ward such as intrathecal procedures for administration of chemotherapy. We saw there were audits carried out to ensure their use with all procedures and spot checks carried out in between audits. Results of the audits we were shown showed 100% compliance with the checklist.
- Children's records at the Child Development Centre were paper based and were completed by each member of the multidisciplinary team which enabled children to be cared for safely and appropriately. We reviewed eight sets of case notes. Each professional had recorded their entries appropriately: documentation was accurate, complete and legible and was up to date. The booking team at the Child Development Centre undertook mandatory management of case notes training every two years to enable them to manage children's case notes safely and securely. We saw in the eight case notes we reviewed there was a selection of risk assessment tools. For example, nutrition and hydration assessment tool (MUST) and a pain control assessment tool.
- We reviewed eight case notes in the Children's Community Nursing Service. There was only one care plan and one nursing assessment in the eight sets of care records we reviewed. We noted in the eight sets of case notes some patient information had been omitted. For example, NHS numbers, staff signatures were not printed and some entries were not timed. We were told by a children's community nurse that individual care plans were not routinely completed for each child or young person. This could lead to an inconsistent delivery of nursing care which could affect patient outcomes and ultimately the wellbeing of the child or young person.

Safeguarding

- The trust had a safeguarding team that included a nurse and doctor. The team were involved in safeguarding referrals within the hospital and serious incident investigations that included safeguarding issues. They were also available for support and advice to staff who had any safeguarding concerns or questions. The team sat on internal groups/committees and worked with external providers such as the Devon, Cornwall and Plymouth Children and Adolescent Mental Health Services (CAMHS) teams to ensure good working relationships developed and were maintained.
- A recent incident with an adolescent highlighted the rising difficulties of managing adolescents with mental health needs on a general paediatric ward. Although patients would have one to one support, often a parent present and the trust's security team present the patients were still able to leave the ward and attempt suicide. The safeguarding team were involved in an ongoing investigation and have referred the case to be considered as a serious case review.
- Records showed that 92.8% of medical and nursing staff had received level three safeguarding training. Health care assistants were 85% trained and play therapists 100% trained.
- The patients' notes had a system to alert practitioners to any child where safeguarding concerns were already known. This made staff aware of additional things that might need to be considered for that individual child.
- Where children or young people failed to attend two clinic appointments, either as a new referral or a follow up appointment, a referral would be made to the children's safeguarding team and contact would be made with the child's GP and health visitor to find out if there were any issues for concern. Staff had access to the Did Not Attend (Was Not Brought) Policy for Children and Young People – including planned surgery/ investigations July 2014 that contained a flow chart of actions to take.
- With the appointment of two extra paediatricians the paediatric service was about to start running five day a week safeguarding clinics to ensure children at risk do not have to wait long to be seen and assessed.
- The majority (96%) of care and support staff at the Child Development Centre and the Children's Community Nursing Service had attended safeguarding training for children at Level 2 or Level 3 which was dependent on their role. Staff demonstrated they knew and understood the risks of potential abuse to children and would report any concerns to their line manager. Staff said they were able to access supervision from the Children's Community Nursing Service lead nurse or the learning disabilities nurse (LD) who were easily

accessible. Monthly safeguarding supervision sessions were held at the Child Development Centre and staff were able to access the paediatric ward at the acute hospital site if they required additional support.

Mandatory training

- The trust held central mandatory training records for all wards and departments, including the paediatric departments. We looked at the training records for paediatrics and they showed that all staff across the paediatric acute and community services were either up to date with their training or had training days scheduled. The Child Development Centre line manager had an electronic tracking system in place to ensure all staff from the service met their mandatory training requirements.
- There was a clinical educator for general paediatrics and two for the Neonatal Intensive care Unit (NICU) and Transitional Care Ward (TCW). The practice educator we spoke with had carried out a training needs analysis that included all mandatory training required by nursing and care staff including child protection and paediatric life support. At the time of the inspection the number of registered nurses in women's and children's services who had attended manual handling training was 95.7%, health care assistants was 95% and play specialists was 80% (this was due to manual handling trainers cancelling two sessions). Staff that attended basic life support training was 94.2% for registered nurses, 100% of health care assistants and 100% of play specialists.
- The staff we spoke with all confirmed that they were up to date with their mandatory training. They said that very occasionally they had to cancel attendance due to work pressures but they were usually able to attend soon afterwards. They added the block week training they attended once a year was a really good idea and they found the format useful and helpful as they knew most of their mandatory training would be covered in that week each year.

Assessing and responding to patient risk

- Each child had a paediatric nursing assessment on admission. These included risk assessments in relation to manual handling, nutrition, pain and pressure ulcer risk. These were completed in most of the records we reviewed during the inspection.
- All the wards and departments used an age specific paediatric observation chart. They included a paediatric early warning (PEW) score that helped staff recognise when a child's condition was deteriorating and when to seek further help and support from medical staff. The staff we spoke with were all very familiar with PEW scores and problems had been escalated appropriately in the records we looked at. It also included a Situation, Background, Assessment, Recommendation (SBAR) area. SBAR is a recognised communication tool to ensure that appropriate information is handed over verbally and an adequate response is received.
- World Health Organization (WHO) surgical safety checklists were used in theatres and for anaesthetic procedures carried out on the paediatric wards for example intrathecal chemotherapy. The staff we spoke with were all aware of the checks that needed to be done to make sure that consent had been obtained for each child for the correct procedure.
- When children were moved to the recovery area after their operation, the staff followed discharge criteria to make sure that children were safe to return to the wards. Parents were allowed to be with their child once they were awake. If the child was going to a paediatric ward post operatively a qualified nurse escorted the child back to the ward with the parent(s).
- Procedures under general anaesthetic took place in a designated procedure room on the Children's and Young People's Outpatient Department (CYPOD). The room had the required equipment for administering general anaesthetics, a dedicated drug storage fridge and immediate recovery facilities. The rooms used for ongoing recovery of children undergoing the procedures were not in line with the Association of Anaesthetists of Great Britain and Ireland (AAGBI): Immediate Post-Operative Recovery 2013 recommendations. The written standard in place followed the standards stated in the Good Practice in Anaesthetic Services: Paediatric Anaesthesia (RCOA, 2015) and referenced UK National Core Competencies for Post Anaesthetic Care (AAGBI, 2013) and Recommendations for Standards of Monitoring During Anaesthetic and Recovery (AAGBI, 2007) .It stated that in stage 2 recovery this should occur in an assigned room and the child should have five minutely observations. On some days the team would carry out three of these procedures with an expectation that the first child would be fully recovered by the time the third child was beginning their recovery. We were

not assured that due to the geography of the recovery rooms used that there would always be a trained nurse available to take observations every five minutes and have constant line of sight of the recovering children.
- Community paediatrics was not an emergency service. Children's families were advised if their child became acutely unwell or their condition deteriorated they were required to contact their GP or to attend the nearest emergency department.
- Lone working was recorded on the Women's and Children's risk register as being a significant risk for the Children's Community Nursing Service as no security devices were in use across the trust which put all lone workers at risk. A security device was being trialled by the team and the lead nurse was required to report the findings in May 2015 to the paediatric governance committee.

Nursing staffing

- Staffing levels on the paediatric wards had been reported as falling short of recommended guidelines. The matron had started an audit using a recognised acuity tool which had been ongoing for two weeks prior to the inspection. The matron showed us the data collected for the two week period which confirmed consistently low trained nurse numbers. The audit information however, was not valid until a months' worth of data had been collected. The matron told us she would be able to use this data to conform where their staffing shortfalls were.
- The paediatric wards had vacancies for paediatric trained nurses. Regular adverts were placed for skilled paediatric nurses and the trust was exploring new and innovative ways to attract and keep staff. The trust was running a recruitment day in May 2015 and the paediatric team were hoping this would attract some potential new staff.
- The NICU and HDU staffing of 1:2 for the HDU and 1:1 in NICU intensive care areas were compliant. The Royal College of Nursing (RCN) document 'Defining Staffing levels for children and young people's services' states: the shift supervisor in each clinical area will be supernumerary to ensure effective management, training and supervision of staff. The duty rotas showed the ward manager was often performing clinical duties when on shift. However NICU had described their issues with staffing in a briefing document to the Trust Management Executive (TME) in November 2014. This included concerns about the shortfall of available clinical neonatal nursing staff, high rates of sickness, maternity leave and a large group of part time workers which is was described as disproportionate to the training time burden.
- We were told there were no current vacancies in the dedicated paediatric theatre team. On the wards the expected staffing levels for 14 patients would be three trained paediatric nurses and one health care assistant. Rotas showed and staff reported the number of trained nurses was usually two.
- Where there were shortfalls in staffing due to maternity leave, sickness or annual leave, staff within the particular clinical area would be flexible and cover shifts. Where this was not possible, bank staff were used and, as a last resort, agency staff would be employed. Most of the trained nurses we spoke to said they had been regularly asked to work extra shifts to cover shortfalls.
- Each department had a designated nurse in charge of each shift. Qualified advanced neonatal nurse practitioners and neonatal nurses on the NICU were complemented by healthcare assistants and nursery nurses with additional skills and training. They also had a community outreach neonatal team supported by nursery nurses and healthcare assistants. Qualified paediatric nurses on the wards were complemented by a small number of healthcare assistants and a team of play specialists, also with additional skills and training. The paediatric departments had clinical nurse specialist links who would visit children on the wards and attend some paediatric outpatient clinics.
- We saw there was time built into shift changes to allow for half an hour handover on each ward or unit. We were not able to observe a handover but later saw comprehensive notes made during a handover. Staff told us their current system of handover worked well.
- The clinical director of the neonatal service was a senior advanced neonatal nurse practitioner.
- The nursing establishment in the Child Development Centre nursing team was calculated using the service specification for each clinical service in the community paediatric service and supported using guidance from professional bodies. For example the number of face to face contacts, other consultations and travel time.
- The caseload for the continence service was approximately 500. The caseload was managed by a band 6 nurse and supported by an advanced paediatric

nurse practitioner and a band 4 associate practitioner. This busy service had been supported by additional nursery nurse hours to provide an acceptable level of service. The lead nurse who managed the continence service constantly reviewed the caseload and was managing the complex cases to ensure children received safe care and treatment at all times.

- The nursing team at the Child Development Centre was up to establishment and the turnover rate was low at 8% and paediatric nurses were not difficult to recruit into the team. Sickness rates were low across community paediatrics (3.5%) but the number of small teams presented a risk to the service as they were vulnerable to absences. This was managed through a series of short term contracts to cover sickness and maternity leave to ensure the continuity of care for children and their families.
- Caseloads in the Children's Community Nursing Service were variable across the range of services: children with long term conditions, life limiting conditions, learning disabilities and children born prematurely the lead nurse constantly reviewed the caseloads of each community nurse to ensure children were receiving safe and treatment at all times. A children's community nurse told us they had a caseload of 38 patients and covered a wide geographical area. The nurse said there were sufficient staff within the team with the appropriate skills to meet the needs of patients.
- The diabetes team in the Children's Community Nursing Service had a large caseload of 200-220 children who were all active. The caseload was covered by three band 6 nurses and a half time health care assistant (HCA). A band 5 nurse had been appointed to the team to cover maternity leave but was not yet in post. The RCN (2013) recommendation is for one nurse to 70 patients. The team manager had reviewed the caseload and where appropriate had implemented patient initiated follow up referrals (PIFR) to enable the current caseload to better match the service plan and needs of patients.

Medical staffing

- Each specialty within the paediatrics departments had their own team of specialist consultants. In September 2013 the paediatric departments had a higher proportion of consultants (43%) compared with the England average of 34%. There were more middle grade doctors (16%) than the England average of 7% but there were fewer registrars (24%) than the England average of 51%. Junior doctors made up 17% of the workforce compared to 7% for the England average. Recruitment was ongoing to ensure the skills mix among the medical staff was able to meet the needs of the patients they saw.
- Every specialty developed its own medical staff rotas to maintain cover for their specialty. The consultants were supported by registrars, middle-career doctors and junior doctors. Consultants were available overnight (4.30 pm until 08.30 am) and at weekends (after 3pm) via on-call arrangements. There was also an emergency rota to ensure emergency cover when required.
- The neonatal team described their issues with medical staffing in a briefing document to the Trust Management Executive (TME) in November 2014. The document described the skill mix of the medical staff as non –compliant with the British Association of Perinatal Medicine (BAPM) standards. Adding there would become a non-sustainable consultant delivered service. We were told the unit did use locum medical staff to cover shortfalls. They would be staff who had worked on the unit before to provide some consistency.
- Two paediatricians were about to commence in post. This meant the paediatric service could start to run five day a week safeguarding clinics from the Children's and Young People's Outpatient Department (CYPOD).
- We were told children often had a long wait on the clinical assessment unit waiting to be seen by a paediatrician. This had then led to all of the beds being full and some children having to wait on chairs in the corridor.
- We were told about the formal handovers that took place between the medical staff. The one we observed in part was detailed and well organised.
- We were told when locum medical staff were required they were staff who had worked within the paediatric departments before (where possible) to enable some consistency.
- The medical team in the Child Development Centre had experienced a period of long term sickness and staff retirements. To ensure that children continued to receive safe care and treatment locum medical staff had been deployed and the learning disabilities (LD) nurse had provided additional support to the medical team. All waiting lists had been validated to ensure there were no risks to children. Two staff had been appointed but had yet to take up post.

Services for children and young people

Major incident awareness and training

- Staff we spoke with were aware of the trust's Major Incident Plan (2005) and the Paediatric Supplementary Major Incident Plan (2011). Staff understood their roles and responsibilities
- The Child Development Centre was not required to be part of the immediate response to the trust Major Incident Plan. Paediatricians and nursing staff who also worked in the acute trust had received training in major incident awareness.

Are services for children and young people effective?

Good

Parents told us the paediatric services in the hospital and community enabled their children to live full and active lives within the constraints of their clinical condition. Parents told us "The support from the nurses and doctors is wonderful and my child is now leading a more normal and happy life".

Evidence-based practice was clearly evident. The implementation of the pre-school and school age Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) pathways was supporting a multidisciplinary approach to the clinical assessment of children at the Children's Development Unit (CDC).

We saw good examples of multidisciplinary working in the hospital and community settings developed around the needs of the children and young people.

The Child Development Centre and the Children's Community Nursing Service were providing an effective service to children and their families. Parents told us the community paediatric service they received had enabled their children to live full and active lives within the constraints of their clinical condition. Parents told us "The support from the nurses and doctors is wonderful and my child is now leading a more normal and happy life". Evidence-based practice was clearly evident. The implementation of the pre-school and school age Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) pathways was supporting a multidisciplinary approach to the clinical assessment of children at the Child Development Centre.

Evidence-based care and treatment

- Policies, procedures and guidelines were developed in line with national best practice where available, for example, Children and Young people with Cancer NICE Quality Standard (QS55) (February 2014), Constipation in Children and Young People Nice Quality Standard (QS62) (May 2014) and NICE Guidelines in Neonatal Jaundice (CG98) (May 2010).
- Policies, procedures and guidelines were available to all staff via the trust's intranet. Staff we spoke with knew how to access them when necessary.
- There was an acuity tool used to determine the dependency of the patients they saw. This was based on a model used in Bristol Children's Hospital.
- Documents and pathways of care we saw throughout the paediatric departments had been developed in line with guidance from a variety of sources, for example: the Royal College of Anaesthetists Good Practice in Anaesthetic Services; Paediatric Anaesthesia Guide (2015).
- Evidence-based guidance, standards and best practice were used to deliver effective care and treatment to children through needs assessments and care planning arrangements to support good outcomes and promote a good quality of life. We saw relevant National Institute for Health and Care Excellence (NICE) guidance were in place at the Child Development Centre and in the Children's Community Nursing Service. For example, continence services, diagnosis management and treatment for children with ASD (Autism Spectrum Disorder) and ADHD (Attention Deficit Hyperactivity Disorder)
- Staff talked with confidence about the national guidance and how this had helped to support and inform the development of the multidisciplinary assessment pathway for ASD and ADHD implemented in 2014. Pathway audits had been ongoing. Changes had been made as a result of early audit findings to ensure the assessment pathway was more realistic and flexible in meeting the needs of children and their families.
- Themes from the diabetes paediatric audit were being implemented; diabetes nurses to access more meetings, development of a training and educational pack for families and children, and to consider the implementation of a transition clinic for 16 year old young people. The national paediatric diabetes audit

had identified the Children's Community Nursing Service as being one of the top performing units in the country. A contributory factor to their success was the number of home visits undertaken

Pain relief

- There was a paediatric pain and rheumatology nurse in post. They were responsible for acute pain management on the wards and for children with chronic pain under consultant care, in the outpatients department. They also worked with the physiotherapists and psychology team to help with pain management in children. The paediatric pain and rheumatology nurse said they were working on developing the service with another member of staff so when the specialist nurse is off patients will still be seen.
- All the wards and departments used an age specific paediatric observation chart. The 1 - 4 years and 5 -11 years chart included Wong Baker FACES Pain rating scale. (the use of happy and sad faces) and paediatric pain management recommendations and a visual analogue scale (scale of 1 to 10) was used for older children and young people.
- The specialist nurse was part of the Paediatric Pain Travel Club. A national network group that represents paediatric acute pain teams throughout the UK and Ireland. This group helped to inform and develop new practice.
- The use of Patient Controlled Analgesia (PCA) pumps for pain management in children as young as three and a half was described as very successful by the pain and rheumatology nurse.
- The specialist nurse described working successfully with the Bath Adolescent Pain Service for teenagers. A national specialist NHS centre (Bath Centre for Pain Services) that works within national frameworks and directives including National Service Framework for Children, Young People and Maternity Services: Standards 1-10 and Department of Health (DH) Every Child Matters: The five key outcomes.
- In the Children's Community Nursing Services pain relief was managed using a pain control tool to help children (where possible) to be involved in the management of their own pain. Where children required treatments which could be potentially painful an assessment of the child's pain score was undertaken and analgesia was administered by the Children's Community Nursing Service prior to treatment being commenced.
- No pain control medication was administered at the Child Development Centre. Therapeutic physiotherapy sessions at the Child Development Centre were attended by children with long term conditions to help increase their endurance and better manage a potentially painful condition.

Nutrition and hydration

- Children and young people were able to choose what they wanted to eat from a menu. Snack trolleys were available on the wards and older children (once assessed) could help themselves to drinks and snacks throughout the day.
- The paediatric departments had access to paediatric dieticians who were available for specialist advice and support with diets and food. The staff were aware of how and when to access the dietician service. The staff were also aware of how to order specialist menu choices such as vegetarian or gluten-free meals.
- The records we reviewed showed that any fluid or dietary intake was monitored and recorded where necessary.
- There were weekly nutritional ward rounds on NICU which included parents, dietician, speech and language therapists, physiotherapists, medical staff and nursing staff.
- The children and young people thought the food was generally good. One parent told us the food "is not tasty" and that their child had been offered three choices for lunch but has often not been asked what they wanted for tea.
- The Neonatal Intensive Care Unit (NICU) and the Transitional care Ward (TCW) benefitted from peer support workers who were women volunteers supporting Mums to establish breastfeeding and helping Mums with expressing milk and using breast pumps.
- The Child Development Centre routinely provided healthy finger foods and drinks for children attending the service. This helped staff to observe their eating habits and identify any potential swallowing difficulties and make referrals to the appropriate clinical team. We saw information and advice on children's nutritional requirements in relation to specific service groups.

Patient outcomes

- The number of multiple emergency admissions (July 2013 to July 2014) for children with asthma and diabetes

was slightly higher than the national average. The number of multiple emergency admissions (July 2013 to July 2014) for children with epilepsy was lower than the England average.

- Data for July 2013 to June 2014 showed there were no emergency readmissions after elective surgery among patients in the under one age group, or the one to 17 age group.
- Data for July 2013 to June 2014 showed there were 5.6% of emergency readmissions following non-elective surgery in the under one age group against the England average of 3.3%. It showed there were 3.1% of emergency re-admissions following non-elective surgery in the one to 17 age group compared to the England average of 2.8.
- The paediatric diabetes audit (2012/13) published in October 2014 showed children with an HbA1c (a blood test that is able to show the average blood sugar levels have been over a period of weeks/months) below 7.5% was 21.6% compared to the England and Wales average of 15.8%. The median HbA1c (mmol /mol) was 65 compared to the England and Wales average of 69.
- The NICU had an established neonatal community outreach team who visited families once they had been discharged home, usually after a long stay on the NICU. They helped families adjust to looking after their babies at home, sometimes using equipment or administering medications.
- Outcome's for babies receiving care and treatment on the NICU were below the national average across a range of measures in the National Neonatal Audit Programme for 2013 as follows:
  - The unit scored 97% for all babies below 28+6 weeks gestation having their temperature taken within the first hour after birth against the national standard of 98-100%.
  - Mothers who delivered babies between 24 and 34+6 weeks gestation given any dose of antenatal steroids was 80% against the national standard of 85%.
  - 87% of all babies with a gestational age of below 32+0 weeks or below 1501g at birth undergoing 1st Retinopathy of Prematurity (ROP) screening in accordance with the current national guideline recommendations against national standard of 100%.
  - The proportion of babies below 33+0 weeks gestation at birth receiving any of their mother's milk when discharged from a neonatal unit was 58% against the national benchmark from 2012 of 69%.
  - There was a rate of 85% of documented consultation with parents by a senior member of the neonatal team within 24 hours of admission against the national standard of 100%
- Two multi-agency assessment pathways for preschool and school age children with ASD and/or ADHD based on NICE guidance were implemented in 2014. The aim of the pathways was to enable children to be assessed using a multidisciplinary approach by staff based in one location. This would provide a more timely diagnosis, prevent duplication and enable appropriate interventions at the earliest opportunity.
- The Child Development Centre had worked with GPs to improve the referral processes into the pathways through weekly meetings and briefing sessions. This was seen as being a key success factor of the assessment pathway initiative.

Competent staff

- Student nurses told us that they were mentored by experienced staff and supervised in their practice. They said that they had received an orientation to the ward before they started their placement and had all received good support from the paediatric staff while on the wards and departments. All of the student nurses we spoke with told us they were enjoying their placement.
- Nursing and support staff at all levels told us about the supervision arrangements in their own ward/unit areas. Most of the staff we spoke with told us their appraisals were up to date or they had dates booked. Staff on all of the wards and departments told us they "felt well-supported and worked really well as a team" and as a result, they were flexible in order to cover shifts if necessary.
- There was a paediatric clinical educator who had introduced block week training in March 2013. This meant staff could access their mandatory training in the same week each year. The training week was also adapted each year to incorporate other role specific training. The 2015 programme included conflict de-escalation and breakaway training in response to the rising numbers of adolescents admitted to the

paediatric wards with mental health issues. Other training included naso gastric (NG) tube insertion and management (three yearly) and annual paediatric intravenous drug updates.
- The clinical educator had created a training file for each staff member and containing certificates for previous training to be used as a working document that formed the basis of ongoing continuing professional development.
- The clinical educator for general paediatrics offered bespoke training and had performed a comprehensive training needs analysis to ensure staff were able to access training to meet their needs. Staff spoke very highly of the service offered and how supportive the practice educator was.
- The medical staff we spoke with all confirmed that they had received an appropriate induction to the trust and to the paediatric departments. Medical students told us there were good teaching sessions on the wards/units.
- We were told all of the medical staff had job plans.
- Staff at the Child Development Centre and in the Children's Community Nursing Service told us they were supported by experienced staff and encouraged to develop within their roles. One staff member said "My manager is very supportive and has helped me to develop my knowledge and skills in the continence service. I now feel more confident in my abilities and I know I am giving better care to my patients". We saw examples of where staff had gained promotion or had been able to undertake enhanced roles in care, for example in the continence and diabetes service.
- All support staff at the Child Development Centre and in the Children's Community Nursing Service had a Diploma in Health Care relevant to their role and told us how they were supported to develop. There was a clear framework in place for the management and support of staff. Staff had an annual appraisal and the appraisal rate for the community paediatric service was 96%. Clinical supervision and one to one meetings were in place across both services which demonstrated that staff were supported, their performance was monitored and assessed and they were able to access the appropriate training to enable them to deliver effective care and treatment to children and their families.

Multidisciplinary working

- We saw examples of multidisciplinary team working across the paediatric wards and departments. We attended the weekly children's cancer service multidisciplinary team (MDT) meeting. It was structured and well attended by 14 staff including a CLIC Sargent (a charity helping children and young people with cancer) Social Worker. The meeting also included an adult cancer consultant who was able to hear about children in transition between child and adult services (16 to 18 year olds).
- We were told about and observed good working relationships with other health professionals for example infection control staff, physiotherapist, dieticians and speech and language therapists. We were also told of good relationships with other specialist nurses, for example diabetes, respiratory and oncology.
- The NICU was part of the South West retrieval network which transferred babies to and from intensive and special care baby units and were part of the ongoing rota. This meant they worked well with other units and were able to discuss and share good practice.
- The ward rounds were attended by a multidisciplinary team and reviewed each child. Discussions were documented in the medical notes.
- Wildgoose Ward team told us they had good working relationships with the local Child and Adolescent Mental Health Services (CAMHS) operated by the local authorities (Plymouth, Devon and Cornwall) but, as nationally there was a shortage of suitable beds, children and adolescents were often admitted to Wildgoose Ward until more suitable accommodation could be found for them. Staff told us they could access the CAMHS teams for advice as necessary.
- The paediatric services at the trust looked after babies' right through to the age of 16. There were systems to help adolescents transition to adult services. This was well-established for diabetic patients. Sixteen to 18-year-olds were given the choice if they wanted to be admitted to a paediatric ward or adult ward.
- We saw a urology surgeon visit the paediatric ward to see children he had operated on that day. The staff said he always visited his patients post operatively and fed back any concerns to the nursing staff or paediatricians.
- Adult and paediatric clinical nurse specialists were available for advice and support in areas such as respiratory care, diabetes and pain.

- We saw that allied health professionals such as physiotherapists, dieticians and speech and language therapists were available for ward and clinic patients as necessary. We were told they all worked together well as a team to support the child and their families.
- There were no joint meetings between the neonatologists and general paediatricians.
- Discharge information was communicated to the child's GP as well as to their health visitor or school nurse.
- Parents told us the community paediatric service provided an excellent multidisciplinary and multi-agency service to their children. The senior lead director told us it was essential to the success of the Child Development Centre and the Children's Community Nursing Service to have excellent multidisciplinary working across all children's services. We observed care planning meetings with parents and representatives from the multidisciplinary team in a school to support the care of a child with a long term medical condition where there had been attendance issues and further support was required from the Children's Community Nursing Service.
- We observed good working relationships with other health professionals for example speech and language therapists, community nurses and other specialist nurses. We saw examples of multidisciplinary specialist assessment and intervention that supported individual children to stay healthy while living with a range of long term conditions. These included children living with neuro disability, ASD and Down's syndrome. A child with Down's syndrome and other clinical complications had been referred to the paediatric community service as they had required frequent admissions to hospital. The Child Development Centre was supporting the child and their family by providing multidisciplinary support from the following services: community paediatrician, specialist paediatric consultants in renal medicine and urology, physiotherapy services the LD nurse, the audiology, and ophthalmology and orthotics services. The family had also received help from the Early Years Education and Portage Services in Plymouth City Council.
- We saw evidence of how the Child Development Centre were working with the acute trust to deliver effective transition services to help young people to move through adolescence and into adulthood in a planned and timely way. The lead nurse for the Children's Community Nursing Service and the LD nurse were leading on the Commissioning for Quality and Innovation (CQUIN)) for transition services and had helped to develop a transition policy which was awaiting ratification.

Seven-day services

- There were seven-day services within the paediatric wards and units, with the exception of day surgery and outpatient clinics. Play specialists were currently available five days a week.
- General theatres were available out of hours for paediatric emergencies not covered by the paediatric specific emergency list.
- Consultants reviewed their patients daily on the ward rounds, during the week and were available out of hours via on-call arrangements.
- Physiotherapy, paediatric pharmacy and imaging services were available out of hours.
- The Child Development Centre was open five days a week and there were no plans to develop seven day services. Appointments were offered in the evenings to young people to enable them to attend after school.

Play Therapy

- The play specialist team of five supported children and young people during particularly difficult times. The team supported children through play therapy five days a week.
- The play specialist team was able to provide their personnel to all wards and units across the paediatric departments and adult settings where children may visit such as dermatology or fracture clinic, and a central play room. The play team was informed of planned admissions and involved in multidisciplinary ward rounds as necessary.
- The play team held a bleep to respond if any child needed immediate support for example with unplanned blood tests.
- The hospital play specialist team was trained to use play therapy with children and young people. Staff across the wards and departments told us how important this was due to some children being anxious about particular procedures. The play team was able to work with the children and family to overcome those fears through play. The play specialist team was highly regarded by children, parents and staff.

Access to information

- We saw 'patient passports' had recently being introduced. They were designed to provide up to date communication between the patient, parents/carers, community teams and hospitals without having to be asked the same questions by each individual practitioner.
- The Child Development Centre co-ordinated the provision of clinical reports which were copied to parents who then took the responsibility for sharing the reports with other professionals.

Consent

- We were told that consent was obtained for all children who were admitted for surgery, for a procedure at the pre admission clinic, chemotherapy involving an anaesthetic and prior to surgery itself. The consent forms included details of the specific procedure and the potential risks and complications of surgery.
- It was clear during discussions with staff that they used the principles of the Gillick competencies (used to help assess whether a child has the maturity to make their own decisions and to understand the implications) when making decisions about people's ability to consent to procedures, especially with adolescent patients.
- Consent was obtained from parents or carers for each child or young person. Staff were aware of the appropriate procedures in obtaining consent. We saw staff talking to and explaining procedures to children in a way they could understand.
- We saw examples of how staff on each ward/unit involved children and young people in their care and treatment and would seek the child's consent prior to doing anything, for example, taking a pulse.
- We observed staff in the Child Development Centre and the Children's Community Nursing Service obtained consent from children (verbal or implied) whenever it was possible to do so. When it was impossible to gain consent from a child due to their age or clinical condition, consent was sought from the parent in line with legislation and guidance including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004.
- When seeking consent we observed the community children's nurses spending time with each child or young person and using terminology the child or young person could understand when explaining what they were going to do
- We were told when young people aged 16 and over lacked the mental capacity to make a decision, "best interest "decisions were made in accordance with legislation. Young people were supported to make decisions and follow up clinics were held at times to best suit them and protect their confidentiality. Follow up appointments and advice and support were often communicated using text message which had been requested by the young person.

Are services for children and young people caring?

Outstanding ☆

In the community paediatric services we observed children and their families were cared for by staff that were kind and compassionate and ensured their privacy and dignity needs were being met. We observed children were involved with the planning of their care whenever possible. Parents were closely involved throughout the assessment, planning and delivery of their child's care and were kept informed of changes and developments by members of the multidisciplinary team. Children were truly respected and valued as individuals and encouraged to self-care and were supported to achieve their full potential within the limitations of their clinical condition. Feedback from children who use the service, parents and stakeholders was continually positive about the way staff treated people. Parents said that staff went the extra mile and the care they received exceeded their expectations.

In the paediatric services in the acute hospital we observed children and their families were cared for by staff that were kind and compassionate and ensured their privacy and dignity needs were being met. We observed children were involved with the planning of their care whenever possible. Parents were closely involved throughout the assessment, planning and delivery of their child's care and were kept informed of changes and developments by members of the multidisciplinary team. Children were encouraged to self-care and were supported to achieve their full potential within the limitations of their clinical condition.

Compassionate care

Services for children and young people

- The NHS Friends and Family Test was not carried out in acute paediatric services at the time of our inspection, but was to be rolled out in line with the national programme.
- During our visit we saw very good interactions between staff, children and young people and their parents. The interactions were compassionate and very caring. Staff were skilled in communicating with children and young people; we observed this on every ward and department we visited. Children and young people and their relatives told us they were very happy with their care throughout the paediatric departments. They said that staff were very caring, one relative said they "Always felt fully informed".
- Written feedback from paediatric theatres included "Staff that met with and dealt with my daughter took time to explain, reassure and answer all her questions in a way that she could understand". We also saw 'thank you' cards on the ward and units from parents and children expressing their thanks for the care provided.
- We saw the parent's accommodation on the NICU which provided an area where parents could sleep, make something to eat or drink and have a shower. There were separate bedrooms which provided some private space for parents to use, maintaining their need for privacy and dignity.
- During conversations with NICU staff it was clear they were very sensitive to parents' needs and supportive when helping them come to terms with their current situation.
- We observed some very compassionate care to a family who had been through a very bad time and were still using the paediatric services. Staff demonstrated real understanding of their situation and were supportive, discreet and very caring.
- During observation of a multidisciplinary meeting of the children's cancer service we heard about an incident where the local pharmacy was unable to dispense a particular medicine. The paediatric nurse prescriber was able to prescribe the medication got the medication from the hospital pharmacy and delivered it to the patient's home. This helped to reduce the anxiety of the family concerned.
- We observed staff interactions with children and their families as being friendly and welcoming. Staff went out of their way to be child centred and we observed many examples of where staff had established a trusting relationship with the child and their family. People spoke in glowing terms about the staff at the Child Development Centre and in the Children's Community Nursing Service. One parent said "The staff will always go the extra mile and nothing is ever too much trouble. If I have a problem I will ring the Child Development Centre and whoever I speak to I know they will always be able to help me".
- A parent whose child was regularly visited by the Children's Community Nursing Service said "I cannot thank the children's community nurse and the health visitor (HV) enough for all the support and reassurance they have given me which has been invaluable and I am just so full of praise for the service" (faltering growth pathway).
- We observed a children's community nurse supporting a child with a long term clinical condition who was confined to bed and unable to mobilise independently and required two people to turn them. The child was very anxious as their clinical condition had worsened and the child was concerned about the administrative route (feeding tube) for their medication which had become blocked in the past. The children's community nurse spent time reassuring the child and explained a number of alternative treatments that could be used to ensure the medication was administered safely and did not cause the child any further anxiety. Communication throughout the care episode was conducted with the child and the parent being present and was undertaken in a calm and reassuring manner. We observed by the end of the visit, the child and their parent had been reassured by the care given and had received guidance on how to seek support if it was required before the next visit by the children's community nurse.
- The community paediatric service implemented the Friends and Family test in March 2015 and we observed parents completing the questionnaires in the waiting areas of the Child Development Centre. 36 positive comments and 17 negative comments were received. The themes around the positive comments were communication, staff attitude, quality of care and praise and thanks about the service. For example "all the staff we encountered were friendly and made us feel comfortable" and "the Child Development Centre was very clean and nicely decorated for children" and "I can't ask for a better place for my child" and "have been fantastic with my child and helped me to understand more about their ongoing needs".

- Themes around the negative comments were access and waiting and car parking. For example "there were long waits for appointments" and "a long wait for follow up appointments". The service line manager at the Child Development Centre told us they had reviewed all the questionnaires and had addressed the concerns at the earliest opportunity and we saw evidence of this in the paediatric governance minutes.

Understanding and involvement of patients and those close to them

- We saw how staff explained things to parents and children and young people. For example, we saw a play therapist explaining a procedure to a child. We saw how this reassured both the child and their parent. Parents told us that staff listened to what they had to say and involved them and their children where possible, in the care and treatment of their baby/child. All parents said that they were kept well-informed by staff.
- We observed a clinical intervention on a child. We saw good preparation of the parent and child and age appropriate communication and praise.
- Children and young people told us how staff involved them in their own care.
- A range of information on particular procedures and conditions was available for parents on all the wards and departments. These added to the verbal explanations children and their parents had been given. We saw that staff allowed time for questions from parents or the children themselves and checked understanding when having procedures explained to them. We saw that information had been written in a way that children and young people could understand.
- On each ward and unit it was clear which doctor and nurse was looking after each particular patient. The children and young people we spoke with all knew who was looking after them.
- Anaesthetists visited all children on the ward prior to surgery to check consent and pre-admission details and to explain the anaesthetic procedure to the parent and the child (where appropriate).We were told that parents were given time to ask questions to ensure they understood the procedures.
- We saw evidence that parents were encouraged to be involved in the care of their child as much as they wanted to be. We heard staff engaging with children and young people of all ages with age appropriate conversations.
- We spoke to a young person who told us how they had been involved with planning their care and support as they had a long term clinical condition. The young person said "I have a whole heath team around me who have worked with me and my family over many years. I have always felt involved in my care and the children's community nurse is excellent and I would like to nominate them for a trust WOW award". The young person told us the family were not getting enough support to manage their ongoing care and the children's community nurse was doing their best to address the situation with the lead nurse of the service.

Emotional support

- The chaplaincy service was available throughout the paediatric departments to support parents, children and young people with their emotional and spiritual needs. A multi-faith prayer room was available to support people's spiritual needs. Staff told us pastoral support was readily available regardless of faith.
- We were told the bereavement team followed parents who had had a bereavement on NICU for as long as necessary, which in some cases may be years and/or until there is another pregnancy.
- In the NICU information booklet there was information about pastoral and spiritual care that said baptisms, naming ceremonies or blessings could be arranged. It added support could be provided "to everyone, regardless of their faith".
- Staff were able to build relationships very quickly with parents, children and young people. We saw evidence of this in every ward and department we visited for example during observation of a pre surgery assessment where staff were able to support the child and parent and ensured they understood about the forthcoming procedure.
- Children and young people who needed surgery were able to be accompanied by their parents to the anaesthetic room and stay with them until they were asleep. This ensured that parents were able to continue to provide emotional support for their children. Parents were able to see their child in the recovery area as soon as they were awake to provide reassurance and support.
- We saw there were psychologists on site who worked with children and young people with a variety of issues. They worked across all the paediatric specialities.
- We spoke to a parent whose child was attending the continence service at the Child Development Centre.

The parent told us they had been at their wits end around trying to manage their child's soiling problems on their own. The emotional support they had received from the lead nurse of the Children's Community Nursing Service had been wonderful and had included supporting the parent at multidisciplinary Common Assessment Framework (CAF) meetings.

- The parent said "I can always get hold of the lead nurse and they have been a constant support to me and they also talk through my son's anxieties with him". The parent said they were seeing the lead nurse weekly which was a great support to the family.
- Another parent told us the Children's Community Nursing Service had made sure the family had all the children's community nurses telephone numbers and those of the relevant consultants and secretaries is case they were anxious about anything. The parent said "I do have a lot of care and support for my child but their needs are changing and sometimes I just need to share this with the care team and it is never a problem to be able to talk to someone".

Are services for children and young people responsive?

Good

We observed general and community paediatric services were providing a highly responsive service to babies, children and families who required specialist intervention and support either as an inpatient, outpatient, day case or in their own home or appropriate community setting. We saw evidence that children and their families were listened to and were involved in the plans for their short and long term care.

Data performance showed there had been a significant reduction in follow up backlog at the Children's Development Centre (CDC) which had reduced from 501 in August 2014 to 66 in April 2015. All overdue follow ups were clinically validated to ensure there were no risks to patients.

A learning disability nurse specialist was available in the trust to support children with a learning disability. They also provided advice and support to staff to help them meet children's needs. The learning disability specialist nurse was available during theatre lists that were specifically for children and young people with learning difficulties for example a dental list.

Trends and themes from complaints and concerns were discussed at ward level, specialty level and care group level. Good practice advice and required learning was identified and actions taken. Information was then disseminated to staff.

Community paediatrics was providing a highly responsive service to children and families who required specialist intervention and support as an alternative to their admission or prolonged stay in hospital. Children and their families were listened to and were involved in the plans for their long term care.

Service planning and delivery to meet the needs of local people

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- Most outpatient appointments were in dedicated paediatric facilities. Some children accessed the fracture clinic where they waited with adults. There was a box of toys and access to a play specialist if required.
- Plym Unit provided dedicated paediatric surgical services. Emergency surgery may take place in adult theatres when the paediatric theatres were closed but a paediatric team including an anaesthetist, operating department practitioner and a paediatric nurse were on call. Recovery following emergency surgery would not be in a paediatric dedicated recovery area.
- Each ward/ unit and department had escalation plans for when there was lack of capacity and demand for their services. A 24-hour clinical site team had an overall view of capacity and emergencies within the hospital.
- The NICU was a level 3 tertiary unit and part of the South West Neonatal Operational Delivery Network (ODN) that included two other tertiary units.
- Good working and transport arrangements were in place with neonatal intensive care and high dependency units across neighbouring counties as part of the regional transfer network.
- If there were male and female adolescents needing inpatient care on Wildgoose Ward, designated single rooms as well as bays could be used. There were separate male and female toilet and bathroom facilities.

A parent on Wildgoose Ward commented that they and their child were not used to seeing and hearing young people with mental health issues attempting to self-harm. They said it was upsetting and disruptive.

- There was a teenage lounge. We saw this being used several times during our inspection visit. The upgrade for the lounge had been funded by the "Children's Happy Hospital Fund". A registered charity that aimed to help children, young people and their families both in the hospital and at home by improving the environments by contributing to the costs, providing and maintaining hi tech medical equipment and purchasing new toys and quality play equipment.
- We heard that the trust had recognised the cancer care facilities on haematology, Wildgoose Ward and children's and young people's outpatient department were were not appropriate for older adolescents 16-19 years. A project was underway, with young people involved, to renovate areas of facilities on Brent Ward (oncology and haematology ward) and Bracken Ward (clinical haematology) to make then suitable for cancer care of adolescents.
- Long term sickness in medical staff and maternity leave followed by Psychology staff leaving the service had impacted adversely on the delivery of the outpatient services at the Child Development Centre.. There had been a significant reduction in a backlog of follow up appointments which have reduced from 501 in August 2014 to 66 in April 2015. Plans were in place to move patients who required a medical appointment to the Choose and Book service. This would improve patient choice and provide a more efficient service for children and their families. This would be undertaken when the current medical waiting list had been addressed.

Access and flow

- For planned surgery, pre assessment clinics were held a few weeks before the surgery. During this appointment, all the relevant information was taken from the parents and the child or young person. The procedure was explained to the parents and the child and consent was taken from the parents (and the young person, where appropriate). Parents were asked to phone the ward on the day of admission to check for bed availability. Planned admissions were occasionally cancelled if emergency admissions had filled the available beds.
- Children were discharged home directly from the wards. If there was any delay in their discharge, there were play specialists on hand to involve the child and their parent in activities while they were waiting.
- There was a single cubicle that had been configured for high dependency care on the children's assessment unit. It was staffed by the children's high dependency unit. If a child required isolation and high dependency care, this could be provided but could mean a bed was closed in the main children's high dependency unit..
- The Child Development Centre had implemented an improvement plan in August 2014 which had taken into account the different needs of children and ensured they had timely access to initial assessment, diagnosis and / or urgent treatment through outpatient services. In April 2015 there were 194 new patients waiting to be seen of which 140 patients had yet to receive an appointment. The waiting times in April 2015 were : 10 weeks for a medical appointment, 13 weeks for a psychology appointment and 12 weeks for non-consultant appointments (physiotherapy and occupational therapy).
- 18 new medical patients were being seen each week as this was the service with the longest waiting time. The target waiting time was six weeks which had decreased from 2014 when it had reached nearly 18 weeks. Where ever possible the Child Development Centre coordinated appointments to minimise travel and child care issues for families.
- Registrar's allocated to the Child Development Centre for six month training placement, were part of the on call rota for the trust which affected their availability to support the medical team. Their varying levels of experience and expertise also dictated how much support the registrars were able to give to the medical team at the Child Development Centre which had impacted adversely on the responsiveness of the outpatient service. Increases in referrals had also occurred in relation to the media and public awareness and the expectation of other agencies. For example we were told changes in the national adoption framework had increased the number of referrals for children's assessments in the Child Development Centre.
- The total follow up caseload for community paediatrics was 4, 529. The senior team at the Child Development Centre had validated the waiting list to ensure there were no clinical risks involved in the delays. 73 appointments had been identified as being "Time

Critical". We were told by the senior team this would ensure this group of children would not exceed their see by date. A further validation was being undertaken of all medical follow up patients of which 50% have already been completed.

- We were told that a PIFU model had been successful for some long term condition patients who were well known to the service. A protocol was in place to ensure a consistent service was being delivered. The LD nurse was undertaking nonmedical prescribing training to enhance their role in the ASD/ADHD assessment pathways for pre and school age children.

Meeting people's individual needs

- We saw there were support mechanisms for parents of babies in the NICU and ongoing support for them and their babies when they went home via the outreach team. We saw lots of 'thank you' cards and letters, on wards and departments visited, showing families' appreciation for the support offered.
- A learning disability nurse specialist was available in the trust to support children with a learning disability. They also provided advice and support to staff to help them meet children's needs. We were told the learning disability specialist nurse was available during theatre lists that were specifically for children and young people with learning difficulties for example a dental list.
- There was access to age appropriate TVs, games machines, DVDs and toys.
- Some of the staff on Wildgoose Ward told us they did not feel confident in looking after the number of children and young people admitted with mental health problems. We were told there had been a registered mental health nurse on the wards but that had not worked out and other avenues were being explored around how best to employ a member of staff with mental health nursing experience. During a recent safeguarding incident the internal security team although present were not able to assist in restraining a young person who was trying to leave the unit. The matron was involved in ongoing negotiations with the internal security team around how to manage these incidents in the future.
- Each ward and department catered to the needs of children. This included ensuring that there was enough space by each bed for a parent to stay and providing play and school rooms.
- There was no outside play space available for children. Staff told us they were able to take some children out for a walk in the grounds where there was a small nature reserve and seating.
- There was a sensory room that contained a range of equipment for children to use. The play specialists were able to spend time with children in the room or take some of the equipment to the cot/bedside.
- There was a dedicated recovery area for children following their surgery. There was space for parents to join their children as soon after their surgery as possible.
- There was a school service providing education to relevant children on the paediatric inpatient wards. Where the child was able to, they could attend the school/play room to make sure they did not fall too far behind in their learning. The service liaised with the child's usual school and could support young people in taking exams if necessary.
- We were told there was access to translation and interpretation services, usually via a telephone. Staff said the system worked well. We saw leaflets were printed in English but stated they were available in large print, other formats and languages and had a contact number for the ward/unit manager.
- The transitional care ward (TCW) provided care and support to mums and babies with a mix of post natal staff from the maternity services to care for mum and neonatal staff who provided care to babies and advice and support to mums. TCW cared for babies who may have been admitted straight from the delivery suite or from the NICU when they no longer required close monitoring, so Mums could get to know their baby and establish feeding routines before going home
- The matron told us feedback about meals, especially from older children had not always been good. She said she intended to ask the children what they would like to have on the menu and then discuss with housekeeping services about how the changes could be achieved.
- In discussion with the matron and nurses on the wards and departments we heard that children with complex needs were cared for by the most appropriate team of specialists and in conjunction with the Children's Development Centre (CDC) to ensure their long term needs were managed effectively.
- There were occasions when children were seen in adult outpatient settings, for example ear, nose and throat

(ENT). We were told these departments had good communications with the paediatric team and that, with planning, a paediatric nurse or play specialist could attend the clinic to help with distraction if required.

During our inspection, we did not observe any outliers (that is, children on wards other than paediatrics due to capacity issues). We were told occasionally a teenager may be admitted to the trauma ward as that may be more appropriate. Staff added a teenager would be given the choice of an adult or paediatric ward. We were also told girls aged between 14 and 16 who were having a termination of pregnancy would be admitted to the Freedom Unit (specialist day surgery unit).

- The play therapy team held a caseload of children to work with and also carried a bleep so they could respond the requests to assist with and distract children who were having non planned interventions.
- We saw a wide range of leaflets and booklets that explained to children and their families about the services offered in the various departments across the paediatric services and about resources in the wider community.
- Community paediatrics facilitated a highly responsive multidisciplinary response to meeting the individual needs of children and their families. For example: A two month old child was diagnosed with a syndrome while living abroad. Following communication from the family and clinicians a community paediatrician appointment was arranged following their immediate return to the UK. The community paediatrician, the children's community nurse, the speech and language therapist (SALT) met with the family to ensure a robust plan of support and intervention was put in place immediately for the child and their family.
- An immediate swallowing assessment was undertaken by the SALT team. A home visit was undertaken by the children's community nurse and an open access arrangement was put in place for the family to access acute paediatric services at the trust. Further appointments were made with other relevant clinical professionals for example a paediatric dietician, occupational therapist and a Health Visitor to undertake weekly visits. The response of the community paediatric team demonstrated how care for a complex child in vulnerable circumstances who had recently moved into the geographical area had been met in a responsive and timely manner.
- Services at the Child Development Centre took into account the needs of different people including those in vulnerable circumstances. The implementation of the assessment pathways for ASD and Downs Syndrome included monthly drop in sessions which enabled parents to ensure their children were able to access the range of clinical professionals engaged in the assessment pathways in a timely manner.
- The pathway for the preschool assessment group followed a three week model which had been running since September 2014. The model (had been six weeks) was being audited for the effectiveness of assessment, right diagnosis and number of children completing the pathway.
- The implementation of the school age pathway was led by the LD nurse who provided an integrated learning disability (LD) service for children across the trust and was based at the Child Development Centre. The LD nurse held clinics and undertook assessments in schools where practical strategies were deployed to enable children to better manage their condition. The LD nurse was a point of contact for families and there had been close liaison with Plymouth City Council to provide additional educational psychologists and enhanced SALT services to the assessment team. Additional clinical staff were undergoing assessment training to enable a prompter diagnosis to be achieved and to provide a more responsive service to children and their families.
- Community paediatrics provided a wide range of leaflets signposting families to services and resources for children with special needs. Follow up information describing the roles and responsibilities of the multidisciplinary team members were given to parents when they first attended the Child Development Centre and the Children's Community Nursing Service. Appointments and advice and support were often communicated using text messages which had been requested by the young person using the service.
- There were strong multi-agency links with commissioners, Devon, Cornwall and Plymouth Children's and Adolescents Mental health Services) CAMHS teams and Plymouth City Council. The Child Development Centre was able to access social services for children through a single point of access and the Central Children's Disability Team were able to undertake assessments and act as a resource panel for the funding of Children's Integrated Disability Service.

This ensured services were planned and took into account the needs of different children for example on the grounds of age, disability, gender, race religion or belief and sexual orientation.

Learning from complaints and concerns

- Information was displayed in all wards and departments explaining how parents, children and young people could raise their concerns or complaints.
- Staff we spoke with were all aware of the complaints process. Staff told us that they would always try to resolve any issues immediately. If issues could not be resolved, the family was directed to the complaints process. Staff were aware of any complaints that had been made about their own ward or department and any learning that had resulted from them. Complaints received by the Children's and Young People's Outpatient Department (CYPOD) were mostly related to waiting times. We spoke with staff who said they were committed to trying to improve waiting times and felt their ideas for improvements were listened to. For people that had to wait for any length of time staff tried to make the environment and décor suitable for all ages of children and young people and play therapists were made available if a child was upset at being in the department.
- Trends and themes from complaints and concerns were discussed at ward level, specialty level and care group level. Good practice advice and required learning was identified and actions taken. Information was then disseminated to staff. The matron for paediatrics told us the issues would be discussed at ward/unit and department meetings to ensure staff were aware of how to implement the changes and why. We saw the practice educator had introduced training into the block week training schedule as a result of past concerns or complaints.
- The level of complaints for the community paediatric service was low which demonstrated children and their families were satisfied with the level of service they received. Two complaints had been received in 2014. We saw how they had been managed and the lessons learnt were clearly documented. We saw in the clinical governance minutes how learning from complaints was shared across the wider paediatric service.
- We were told about the trust complaints policy and procedures and staff were able to tell us how they would advise people using the service to make a complaint. Parents were encouraged to report delays of greater than 20 minutes to the reception team at the Child Development Centre.
- Staff in the diabetes team told us they received complaints from their patients when they had been an inpatient on the acute wards as staff were not always familiar with their equipment. The diabetic nurses had trained staff on the acute wards in 2014 but a small number of complaints were still being received. Ongoing issues were raised at the paediatric governance group. The lead children's community nurse for diabetes had advised the diabetic team to ask patients to put their concerns in writing.

Are services for children and young people well-led?

Good

We observed that paediatric services offered at the Plymouth Hospital site, the Children's Development Centre (CDC) and Children's Community Nursing Services (CCNS) were well-led. The service line managers and line managers provided clear and visible leadership across all the paediatric services.

Outcomes of audits and governance meetings were shared with staff across the paediatric services.

There were effective systems in place to ensure staff were trained, supported and appraised and were able to give feedback to their team leaders and line managers. It was evident that staff were supported by the wider organisation and staff were aware of the wider vision of the trust.

The community paediatric service comprising of the Child Development Centre and the Children's Community Nursing Service were well-led. The service lead director, the lead nurse and the service line manager for both services provided clear and visible leadership across the service and had robust links with the Women and Children's Care Group (WCCG). The WCCG General Manger visited the Child Development Centre weekly. There were effective systems in place to ensure staff were trained, supported and appraised and were able to give feedback to their team

leaders and line managers. It was evident the lead managers of the community paediatric service were supported by the wider organisation and staff were aware of the wider vision of the trust.

Vision and strategy for this service

- We saw the trust values displayed in a number of areas we visited. All grades of staff knew about the values and some were able to talk about them in detail.
- Staff said they knew about the trust's vision for the future and strategies by way of trust newsletters and felt they could influence the future via the board.
- We were told of plans for a dedicated Children's Hospital on the Derriford site in the future. There were no firm commitments to expected dates for this to happen. As a result staff were committed to ensuring the current facilities were the best they could be in the confines of the current layout. The paediatric services had therefore launched the "Gold Dust Appeal" that aimed to raise money to create a bright and welcoming environment on Level 12 where the paediatric wards and outpatients department was situated. The Plymouth Hospitals Trust website states "the project aims to introduce colour, texture and interactive spaces which will incorporate all patients' needs, every age group and ability".
- Child Development Centre and the Children's Community Nursing Service staff told us about the trust's vision and purpose (The Plymouth Way) and the sessions they had attended to inform them about the trust's vision and values. Staff were aware of the trust's daily email and trust newsletter which were circulated weekly across the trust. There was a clear vision in place for the service which was owned by the staff in the Child Development Centre and the Children's Community Nursing Service. Staff told us they were proud to work in community paediatrics and believed the care and support they gave to children and their families was of a high standard.

Governance, risk management and quality measurement

- Issues on the risk register were discussed at the appropriate meetings for example the Children and Young Peoples Clinical Governance meeting. We saw the minutes for the April 2015 meeting which included updates on safeguarding clinics and the two consultant's posts that had been approved to help support the clinics. The meeting also discussed the introduction of supportive handling training. This was being introduced due to the increase of young people with mental health needs being admitted to Wildgoose Ward and the associated difficulties with accessing the Devon, Cornwall and Plymouth Children's and Adolescent Mental Health Services (CAMHS) teams at a weekend.
- The perinatal governance meetings, held monthly, also discussed items on the risk register and the NICU dashboard.
- The paediatric services produced a monthly dashboard for paediatrics, neonates and community paediatrics. They showed statistics for a variety of indicators, including staffing levels, staff sickness rates, mandatory training and referral to treatment waiting times. The results of the dashboard were discussed with staff at their team meetings.
- NICU medical staff attended perinatal governance meetings arranged by the obstetric governance and/ risk lead. We saw minutes from March and April 2015 perinatal governance meetings and saw items discussed included quarterly incidents and complaints, NICU dashboard and the risk register. There have been no deaths in NICU from July 2014 until January 2015.
- There was not a non-executive director (NED) on the board with a special responsibility for paediatrics. We were told this was a trust decision and that all NED's were collectively responsible for an oversight of all the care groups. Staff we spoke with told us they felt that paediatric issues did get the attention of the board and their concerns were always heard.
- We spoke with staff who were involved in local and national audits. We found staff to be engaged with the audit process and they were able to show examples of where audit results had been shown to improve and inform practice for example with the introduction of a medicines management system on NICU that had decreased the numbers of minor medication administration errors.
- A consultant paediatrician from the Child Development Centre was the nominated governance lead for community paediatrics and attended monthly governance steering group meetings for paediatric services at the trust. We reviewed five sets of governance minutes and noted that governance issues

relating to the Child Development Centre were documented. For example, the management of incidents through the incident reporting system, signage, audits and complaints.
- The service leads used a number of tools to gather data needed to meet the trust's governance arrangements. Incidents, accidents and near misses were recorded and investigated using the trust incident reporting system. Community paediatric staff were aware of the incident reporting system and were using it effectively.

Leadership of service

- The staff we spoke with were all aware of who their immediate managers were. Staff described the matron as being supportive, approachable and visible.
- Staff at all levels told us they felt they could approach the care group manager, director of nursing or the chief executive if necessary. Staff told us the care group manager, director of nursing and chief executive were very visible around the hospital and had visited paediatric departments and units as part of their regular walk arounds.
- The community paediatric service was well-led locally. Staff spoke highly of the service lead managers and told us they were always approachable and would listen to issues and concerns raised by staff, patients and families. The service lead managers told us they were part of the wider paediatric team in the trust and frequently liaised with other specialist leads in relation to safeguarding and transition services Staff were supported in their roles and were able to access a wide range of training courses.

Culture within the service

- On all the wards and units we visited we saw friendly and open engagement between all groups of staff. The theatre suite staff, although managed by the surgical care group, told us of good working relationships with the paediatric departments. Theatre staff carried out surgical procedures in the children's and young people's outpatient department (CYPOD) and play specialists worked in the theatre suite during pre-assessment clinics. The ethos of the NICU included "prioritise patients and patient care always and in all ways". The matron of the paediatric services was clear that care for the child and young person was at the centre of what staff did every day.
- Staff we spoke with were very proud of the care they provided and of their ward or unit. Staff told us they thought their voice was heard at board level.
- Staff told us the culture of the paediatric departments had improved since the current matron began in post nine months ago. They felt she understood their concerns about staffing levels and caring for young people with mental health problems and was continuing to take those issues forward.
- The staff described a culture in which they were encouraged to report incidents, concerns and complaints to their manager or to the matron. They added they received feedback or support as required as a result of reporting/discussing their concerns.
- There was a culture of openness, support and good team working across the community paediatric service. All staff told us about the importance of the multidisciplinary approach to the care and support of children and their families and we observed many examples of this throughout our visit. A staff member said "Our greatest strength is the staff at the Child Development Centre. Staff really do work together to ensure the best care and support for children and their families and this gives us a much bigger picture of a child's overall needs and how they can be met".
- Staff understood their individual roles and responsibilities and felt supported within their individual teams. Parents of children who used the service told us they felt well informed and stated that staff were friendly, professional and put children's best interest at the heart of everything they did.

Public and staff engagement

- A young people's group met regularly and were currently involved in a project to provide age appropriate facilities on the haematology wards. They told us they were also working with the Teenage Cancer Trust to get ideas about improving the local facilities.
- Comment/feedback cards were available in all wards and departments. Themes of feedback was discussed at the ward meetings and disseminated through the appropriate newsletters.
- Staff told us that they currently felt included in changes and developments planned for the paediatric departments and units that included a dedicated Children's Hospital within the Derriford site.
- Staff received regular feedback via the trust newsletter and at team meetings.

- The paediatric oncology team and Wildgoose Ward had been nominated, by a 17 year old patient, for a Staff Celebration Award. The team were to find out in June 2015 if they had won.
- There was a parent's support group that had started a year ago and met monthly. The group was funded by a local charity. There was also a teenage support group. Other support systems in place have included a Mummy pamper day, an annual Daddy day that had included go carting and an annual families day for families of children undergoing long term treatments.
- We were told there had been a number of service user group initiatives over the years at the Child Development Centre but many of the users had now left the service. The senior team at the Child Development Centre recognised the need for wider engagement with service users and a variety of options were being explored including an interactive web site for young people.
- Therapy services told us a survey had been undertaken by children attending the physiotherapy service. The feedback had been positive but there were no immediate plans to repeat the survey. Staff told us how much they valued the lone worker policy arrangements and how supported they felt when they were out on lone visits. Staff told us they were able to meet their annual training requirements and praised the allocated week of mandatory training (block week training) the trust provided each year.

Innovation, improvement and sustainability

- At the time of the inspection the paediatric theatre team were starting a three month trial (starting May 2015) providing an evening list for paediatric emergencies. They had to be "off the table" and to the ward by 8.30 pm. This was to try to avoid cancelling elective lists when there was a spike in emergencies. Cancelling children's operations has led to some complaints.
- In the waiting room prior to theatre there were two pedal cars that small children could use to get themselves to the theatre. We were told this helped to relieve anxiety for some children.
- A review of staffing levels was underway to ensure the skills mix and number of staff met the needs of the babies, children and young people the trust cared for.
- We were told meetings were held regularly with the local Devon, Cornwall and Plymouth CAMHS teams to ensure adolescents with mental health problems are placed in the most appropriate settings and looked after by appropriately trained staff when requiring hospital admission.
- We saw a briefing document written to the Trust Management Executive (TME) and the Care Group Director and Manager from the neonatal Service Line.
- Staff told us they were encouraged to share ideas about service improvements and spoke positively about how they were actively involved in service planning. For example, meeting twice a year to share the outcomes of audits with the acute paediatric service. The Child Development Centre was part of the quality improvement plan for the Women's and Child crew group group.
- We saw examples of outstanding practice which had been recognised by the senior team particularly around multidisciplinary working and delivery of patient care. A doctor told us "The benefit of working at the Child Development Centre is the opportunity to be able to share concerns or obtain a professional opinion from a wide range of clinical professionals who are all based in the same building. This really helps you to look creatively at the care of a child and enable them to be treated much more quickly and appropriately".

End of life care

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

Information about the service

End of life care at Derriford Hospital sits within the oncology directorate and is accessed across the hospital with care being provided by ward and department staff. The hospital did not have specified acute oncology beds but have an acute oncology team. St Luke's Hospital Specialist Palliative Care Team (SPCT) provides support and advice for those patients who have complex care needs and/or complex symptom management. Support is also provided to relatives and/or representatives of patients at the end of their lives. Referrals are accepted for any patient with a life threatening condition who has complex physical, psychological, social or spiritual needs. The Specialist Palliative Care Team leads the palliative care provision at the hospital and is contracted from St Luke's Hospice.

The SPCT provide a Monday to Friday 9am to 5pm specialist palliative care service with out of hour's advice provided by St Luke's Hospice. There is an Oncology Registrar on-call at all times. Most have some palliative care experience and would be able to offer advice around end of life care if required. The SPCT remains part of an integrated service with St Luke's Hospice and St Luke's Community Specialist Palliative Care Team. Urgent referrals are seen within 24 hours and at weekends within 2 days. Between April 2013 and March 2014 the hospital team received 986 new referrals including 196 re-referrals, they provided over 4,277 face to face contacts between staff and patients.

The team consisted of 2 part time Consultants in Palliative Medicine, 2 part time Associate Specialists in palliative medicine, four clinical nurse specialists, an End of Life Care Facilitator and 2 team administrators.

We visited 13 wards and specialist departments. We met nine patients, spoke with four relatives and reviewed five Last Days of Life care plans (LDOL). In total we reviewed 58 patient records looking at end of life care but also specifically at Treatment Escalation Plan (TEP) records. We talked to 56 staff about end of life care. These included the specialist palliative care team, ward nurses and doctors, allied health professionals, porters, psychologists, the chaplaincy team and bereavement and mortuary staff. We observed care being provided to patients and relatives. Before and during our inspection we reviewed the trust's performance information for end of life care.

End of life care

Summary of findings

End of life care was provided safely throughout the trust which protected patients from avoidable harm and abuse. The Specialist Palliative Care Team provided consistent, safe care and advice for patients, relatives and staff throughout the trust. The Specialist Palliative Care Team worked closely with the Acute Oncology Service to support safe patient pathways through the hospital.

The effectiveness of some aspects of end of life care required improvement. While some aspects were good, including multidisciplinary working, several areas required further improvement. These included the Treatment Escalation Plans (TEP) used to identify decisions around resuscitation and ceilings of care agreed with the patients which were not consistently completed to ensure patient choice was being identified. The ceilings of care were an indication of when a patient wanted treatment to stop or what treatment they did or did not want.

The facilities for multi faith prayer were not large enough to enable Friday prayers for men and women separately. The arrangements for ritual ablutions also required improvement. The arrangements for discreet use of lifts when transporting the deceased required improvement.

Some patient outcomes were being developed to achieve effectiveness. Seven day working was not yet in placed but was planned to be.

The compassionate and sensitive end of life care provided to patients on wards by medical and nursing staff and by the Specialist Palliative Care Team was seen to be outstanding.

Patients and relatives told us they felt included and involved in decisions about care and treatment and that they had been treated as individuals with their choices listened to and respected. We saw that the responsiveness to patients' individual care needs was outstanding. The Specialist Palliative Care Team was responsive to requests to support patients with complex end of life symptoms and care needs. Close working relationships with the Acute Oncology Service improved the patient's pathway through the hospital.

The involvement with community services in patient care was integral and as a result discharges were seen to be managed quickly to meet patients' needs. Fast track discharges were seen to be managed in the patient's best interest, with a proactive approach taken to ensure the support and safety of vulnerable patients.

We found leadership of the end of life service to be good. Leadership of end of life services by the Specialist Palliative Care Team was clear to staff throughout the trust. The Specialist Palliative Care Team promoted a culture of sharing knowledge and developing the skills of others. The trust's vision for the end of life service was shared by all staff.

The culture was seen to be that end of life care is 'everybody's business' and all staff shared a priority to ensure the care provided was right for the patient. The trust recognised the need for ongoing development of the service to include further access to the SPCT.

End of life care

Are end of life care services safe?

Good

End of life care was provided safely throughout the hospital which protected patients from avoidable harm and abuse. The Specialist Palliative Care Team provided consistent, safe care and advice for patients, relatives and staff throughout the trust. Nursing and Medical staff were contracted to provide specialist palliative care and provide support and training for trust staff. The SPCT team and staff demonstrated how they learned from incidents and shared learning with others.

Medicines were planned for patients near the end of their life in anticipation of symptoms. This was undertaken to ensure patient comfort. Records were accessible in three formats and enabled information to be accessed to support patients' welfare.

The Specialist Palliative Care Team worked closely with the Acute Oncology Service to support safe patient pathways through the hospital. Staff told us the SPCT was an 'excellent service'. The SPCT identified that staff capacity limited attendance at all MDT meetings and the service they were able to provide.

Incidents

- Openness and transparency about safety was encouraged. Staff understood their responsibilities to raise concerns and report incidents; they told us they were supported when they did so. Staff told us they had seen a change in reporting culture since the current Chief Executive had been appointed with a more open culture being encouraged.
- No incidents relating to end of life care had been reported in the last year until the week before our inspection. This incident had been recorded on the Datix system and immediate action had been taken. The incident was currently being investigated.

Duty of Candour

- Most staff spoke with some understanding about their duty of candour, they understood their responsibly to be open and transparent. They gave us an example of when they had used the duty of candour to explain treatment options and outcomes to patients when they had not been as expected

Medicines

- Patients identified as requiring end of life care were prescribed anticipatory medicines. These 'when required' medicines were prescribed in advance to manage promptly any changes in patients' pain or symptoms. We spoke with junior medical staff who confirmed they had been taught how to set up a syringe driver and how to prescribe anticipatory medicines. A training session had run the week before our inspection. As part of the Last Days of Life care plan, suggested doses of anticipatory medicines were available and a junior doctor confirmed they were guided by this
- Clear guidance by the SPCT on medicines was provided for doctors and nurses to assess manage and review a range of end of life symptoms which included pain management. One family told us that pain had previously been a problem but their relative was now comfortable since the start of a syringe driver for continuous delivery of medication.
- Records showed that those patients who were referred to the SPCT had their medicines reviewed regularly. This was done in consultation with other medical staff involved with the patient's care. Two of the SPCT nurses were qualified to undertake prescribing as needed if patients needed them to.

Records

- Specific end of life care plans were in place in the form of 'Last Days of Life Nursing Care Plan' and 'Medical Care Plan' which were two separate documents designed to record all aspects of end of life care. These care plans had been developed at Derriford Hospital and were reviewed by the End of Life Committee. Annual audits of compliance with the Last Days of Life care plans had been recently coordinated by the SPCT but the results were not yet available.
- The medical care plan included identification of the consultant with overall responsibility for the patient and recorded detail that identified that the patient was dying and included patient preferences and advance decisions. There was also guidance for symptom management, a record of all sensitive communication with patients and their relatives and subsequent

changes in the personalised plan of care. We spoke with a junior doctor who explained that the medical plan was helpful particularly if the doctor was on call and had been asked to see a patient they didn't know.

- The nursing care plan detailed care of the patient and relatives, pastoral and spiritual care. There were also sections for symptom management and a record of all reviews undertaken. When these care plans were in place, they appeared well completed and used. Nursing staff told us they found them to be clear and informative. They also told us that any questions they had about using the forms were answered by the SPCT.
- We saw instances when the patient would stabilise and the doctors were considering stopping the LDOL care plan until it was needed again. Training had been provided for all staff to use the LDOL care plans but due to the change in documentation not all patients near the end of their life were using these care plans and the SPCT were encouraging ward staff to use them more. The SPCT told us they were seeing them being used more as staff got used to them
- Staff recognised and responded appropriately to changes in risk to patients using the service. Risk assessments were seen for the environment, falls and infection control. The assessments were seen to be fully completed and updated when changes occurred.

Safeguarding

- Staff in all areas of the hospital wards which provided end of life care were knowledgeable about their role and responsibilities to safeguard vulnerable adults from abuse and they understood what processes to follow. We saw records of a safeguarding alert for a patient who was near the end of their life, which demonstrated staff understood the risks to vulnerable patients approaching end of life.
- The SPCT undertook safeguarding training as part of their mandatory training programme.

Mandatory training

- Specialist training for the SPCT was undertaken at the hospice. However, mandatory training for the SPCT was undertaken through the trust.
- Some shortfalls on trust-wide mandatory training were evident. The trust aim was to ensure that 95% of all staff were up to date with mandatory training. The mandatory training rates for February for Basic life support, manual handling and trust update were all below target. The shortfalls were identified as due to low attendance rates which were caused by staffing pressures.
- All staff training in Treatment Escalation Planning (TEP) was included in the annual mandatory update for basic life support. Current mandatory resuscitation training as of January 2015 was 75.6%.
- The 2015 the trust Quality Assurance Committee report recorded the risk when staff did not attend the training; this was currently 10% of the trust's clinical workforce and had been escalated to executive level via the Risk Register. There was noted to be no further capacity by the Resuscitation Team to provide more training and further measures were needed to ensure staff attendance.
- Mandatory training for all staff in respect of the required topics for end of life care was monitored on line by the trust's e-learning account system. Training for the SPCT was monitored by the hospice Learning Management System.

Assessing and responding to patient risk

- Advice and support from the SPCT regarding deteriorating patients was available on all wards by telephone or visit request. Staff on wards and departments were clear that the SPCT would respond quickly to requests for advice and support.
- We looked at records which documented the regular visits on the wards to patients near the end of their life, this included ongoing assessment and records of changes to manage risk and symptom control.

Nursing staffing

The Specialist Palliative Care Team consisted of five trained nurses:

- One Band 8A whole time equivalent (WTE) Clinical Nurse Specialist (CNS)
- One Band 7 WTE CNS
- 2.2 WTE Band 6 CNS
- One Band 6, 0.8 WTE End of Life Care Facilitator
- Two full time team administrators

- The SPCT were provided as a contractual agreement from St Luke's Hospice. This was via a Service Level Agreement which had been in place for the previous five years. Currently attendance by the SPCT at Multi-Disciplinary Team meetings (MDT's) was limited

due to a lack of staff capacity. Cancer peer review mandates SPCT attendance as core members at six cancer MDT's and associate members at five cancer MDT's each week. This is one of the cancer standards. Currently the SPCT only had resources to attend two MDT's in addition to their own. This may impact on patients as staff did not have the capacity to attend meetings and provide input as part of a multi-disciplinary team.

- The medical and nursing staff had identified that expansion of the SPCT would benefit patients. Currently the team were mostly involved in fast track discharges and clinical care. Staff told us that with an expanded staff, further education and research could be undertaken.

Medical staffing

- The team consisted of two part time consultants in palliative medicine delivering 11 sessions a week in total, with each session lasting four hours. There were two part time associate specialists in palliative medicine delivering11 sessions in total.
- Access to the SPCT consultant was currently available five days a week with access to telephone support available out of hours from the hospice. Access to an oncology registrar was available at the weekends.
- One of the consultants for the SPCT divided their working week between the hospital and the hospice. This enabled a link between the two services and provided 'joined up care' between the hospital and the community.

Major incident awareness and training

- Mortuary staff had additional facilities available in the event of a major event and if the mortuary became full. Mortuary staff also confirmed some training was provided should a major incident take place.
- The chaplaincy services were on call for any major incidents in the local area.

Are end of life care services effective?

Requires improvement

The effectiveness of some aspects of end of life care required improvement.

Patients identified as having end of life care needs had their needs assessed and reviewed and had symptoms managed effectively. Staff recognised that end of life care related to a range of conditions and had training and resources to respond appropriately to patients' individual needs. Multidisciplinary working was in place to support patients to have all symptoms managed effectively.

The Treatment Escalation Plans (TEP) used to identify decisions around resuscitation and ceilings of care agreed with patients were not consistently completed to ensure patient choice was being identified. The ceilings of care were an indication of when a patient wanted treatment to stop or what treatment they did or did not want

Staff training was in place for nursing and medical staff to ensure competency. Some patient outcomes were being developed to achieve effectiveness. Seven day working was not yet in placed but planned to be.

Evidence-based care and treatment

- The SPCT had written the Standard Operating Procedure (SOP) for end of life care (updated 2015). This drew on recommendations from the National Institute of Clinical Excellence (NICE) QS103, End of Life Care for Adults (2011) strategy and the five priorities of care. There are 16 quality statements set out and the SPCT provided evidence of how each one was being met.
- The Priorities of Care for the Dying Person were published in June 2014 by the Leadership Alliance for the Care of Dying People. Taking the five priorities to recognise, communicate, involve, support, plan and do, the SPCT had developed a personalised care plan for each patient in the last days of life with guidance for staff of how to best meet the five priorities of care. The implementation of the Last Days of Life Care Plans (LDOL) provided the means to address the recommendations of the National Care of the Dying Audit and fulfil the requirements set out by the National Leadership Alliance for the care of Dying people. This SOP also included guidance on Advance Care Planning.
- An implementation plan for end of life care against National Quality Markers was in place. This was RAG rated and we saw that no red areas were identified and those requiring amber status had an action plan in place.
- The trust had been undertaking an ongoing audit of the Last Days of Life care plan. A baseline audit was

undertaken prior to implementation of the LDOL care plan and a post implementation audit was currently taking place. No outcomes to that audit were available to us.

Pain relief

- Pain management was well assessed and recorded. Within the Last days of Life Care Plan there were sections relating to pain management including the need to observe patients for non-verbal cues and the concerns of family members around pain. Symptom control included pain scores and directed staff to complete any separate records for syringe drivers in use.
- Palliative medicines (which can alleviate the pain and symptoms associated with end of life) were available at all times. Staff told us that they had access to an adequate supply of syringe drivers and appropriately trained staff to set up this equipment.
- Medication for pain relief was reviewed by the SPCT at each of their visits to review patients. Staff told us that should they find pain control complex or ineffective, they would have no hesitation in contacting the SPCT for advice and support. They said the SPCT were 'excellent' in their support and advice about pain management.
- We spoke with patients who told us the staff checked with them about pain control, offered analgesia and monitored its success. They told us that when they had pain, staff responded quickly and any complex pain control decisions included the support and expertise of the SPCT.
- Patients and relatives were offered support with emotional and psychological pain through the SPCT, the chaplaincy service and ward staff. We saw this support was documented within care records.

Facilities

- Portering staff underwent annual training on the dignity and care of patients being transferred to the mortuary. They felt that wards could sometimes be better prepared for the patient transfer by having the patient ready for collection, especially at night time to avoid them waiting and disturbing other patients.
- Areas of the mortuary accessed by staff were covered by CCTV to enable footage recall if needed.
- We saw some wards did not have access to a room where patients and their relatives could be spoken to about sensitive news. This meant that patients' privacy may be compromised. We were told of a recent instance when the discussion took place at the patient's bedside, which afforded less privacy than a room. Some wards used side rooms if available and other wards had plans to develop a quiet space.
- We saw that the emergency Department did not have viewing facilities for relatives to see their loved ones and a side room would be used if available. Should a side room not be available a procedure was in place to escort relatives to the viewing facilities within the mortuary. Staff told us this system was more dignified and respectful.

Nutrition and hydration

- We saw that patients had been assessed using a Malnutrition Universal Screening Tool (MUST), which identified nutritional risks. Records showed that, following MUST, appropriate nutrition and hydration monitoring tools had been used by staff. These included monitoring charts for food and drink taken. Specialist dietician support was available on all wards and we saw records of their involvement.
- Nutrition and hydration was included in the Last Days of Life care plan and in all end of life care provided. We observed patients had drinks available within easy reach. Patients told us that staff supported them to access snacks and drinks they wanted and that family members could bring them items in to eat and fridge facilities were available.
- We observed staff taking time to support those patients who could not access drinks or food independently. In some cases a food record chart for those patients identified as being of medium or high risk of insufficient nutrition were used and these were seen to be well completed to monitor sufficient food and drink was taken.
- Staff told us that those patients identified as being in the last hours or days of life had their nutrition and hydration needs evaluated and appropriate actions followed.

Patient outcomes

- The hospital participated in the National Care of the Dying Audit 2013/2014. The hospital produced a report which detailed the outcomes and presented recommendations for improvement of end of life care and in particular the care needed in the last days of life.

End of life care

There were seven key recommendations and evidence had been provided to CQC of how these were to be or had already been met. The areas of recommendation are included below.

- The results for the trust were varied with some positive areas which included :
  - Good access to Specialist Palliative Care Services/ advice – although this is only face-to-face for five days per week. The need for a seven day face to face service had been identified in NICE guidance (2004) and by Derriford Hospital. This was currently being addressed and pending a final agreement of when this would commence.
  - End of life training was included in the Trust Induction training and Mandatory Training programme (three year rolling programme); other training re communications skills and supporting patients/families was available.
  - 95% of cases had recorded discussions of end of life care with families. Patients received regular reviews/ assessments of pain control and other symptoms.

There were some areas where the trust scores less well, these included,

- Decision that the patient was in the last days/hours of life made by multi-disciplinary team, led by senior doctor was only recorded for 22% of case files this was in comparison to a national average of 59%). Recognition of the dying phase was only recorded in 41% of cases (national average 59%).The LDOL care plan recommends sign off by the relevant consultant within 24 hours.
- Discussions regarding end of life care were only recorded for 25% of patients (national 46%). We saw records which detailed sensitive discussions and how decisions had been made and agreed for those patients receiving end of life care.
- Only 49% of patients were prescribed medication which anticipated the symptom control required (National 81%). The trust noted this was probably due to the fact that very few patients were on the last days of Life care plan at time of the audit.
- Only 2% of patients received clinically assisted nutrition (national 29%). The assessment of need for clinically assisted hydration was undertaken for 42% of patients (national 59%); 11% had clinically assisted hydration in place (national 29%). These now form part of the suggestions for discussion in the LDOL care plan.
- Records of support from Pastoral & Spiritual care team were only made for 4% of patients. We saw that within the LDOL care plan this area was recognised and fully completed.
- An action plan had been formulated to address the areas of shortfall noted by the National Care of the Dying audit and the hospitals Quality Assurance Committee was asked to comment on the audit results and recommendations proposed. The End of Life Committee was to develop and monitor the action plan to meet the recommendations.
- Advance Care Planning was seen to be used at Plymouth Hospital NHS Trust (PHNHST). This enabled patients to plan their future care and an Advance Care Plan would be available to patients on the wards. Patient information leaflets were available which explained that the advance care plan was an opportunity to discuss in advance and record specific requests.
- Staff worked together to support the patient after death. Policies were available for porters to inform their practice when transporting patients. Training was provided to ensure porter staff understood infection control measures and protected themselves and others from the risk of infection. Ward staff communicated any such risks to porters.
- Policies and training were in place for mortuary staff to ensure staff and visitor safety. Mortuary staff were clear that they would do all they could to meet individual families' needs. Training was provided to ensure the mortuary staff were conversant and fully compliant with the hospitals procedures for viewing and managing infection control risks.

Competent staff

- A programme of training was in place by the SPCT for all nursing and medical staff who provided end of life care. At the end of 2013 new guidance was introduced regarding management of last days of life care. The trust undertook a programme of education by the SPCT and developed a presentation which was delivered to all clinical teams and all wards. This programme was in addition to the regular education commitments.
- Hospital medical staff received training specifically in palliative care. Oncology junior doctors spent two weeks with the SPCT at the hospice and two weeks with the

SPCT at the hospital. This practice was in place to embed end of life care in the practice of junior medical staff. Further mentoring was available at consultant level, led by the oncology clinical lead.

- Training records for TEP and end of life training for 2014-2015 showed a diverse range of training available. Some aspects of the training were well attended, these included clinical and medical e- learning which were attended by 792 staff in total. Areas of end of life training included communication skills, symptom management and end of life conversations. The numbers for those training sessions appeared low with ten members of staff completing End of Life Conversation training and one member of staff completing Initiating Conversations about end of life care. The TEP training included training in Dementia called 'Dementia Friends'. This had been completed by 354 trust staff overall. The total number of staff having received some aspect TEP training trust-wide was 6739 members of staff.
- Informal 1-1 teaching was provided by the SPCT to nursing staff on a daily basis. Bespoke sessions were also held for wards alongside clinical education teams from other specialist areas.
- End of life facilitator sessions for the hospital nursing teams and link nurses for end of life care and care after death were provided. The SPCT also had involvement in the roll out and education of the Last Days of Life care plan across the trust and also participation in regional advanced communication skills training to all health care professionals in the Peninsula. The SPCT also provided formal nurse teaching for preceptorship nurses, foreign nurses and health care professionals.
- The SPCT used the local hospice professional development review paperwork for annual appraisal and six monthly reviews. Supervision took the form of daily team meetings each morning as an opportunity to discuss any clinical or other issues. Clinical nurse specialists also attended six weekly individual clinical supervision sessions with an independent counselling service. Specialist trainees undertook/received regular supervision with clinical and education supervisors and all staff received regular one to one meetings with their managers.
- The SPCT contributed to regular junior doctor education programme. The SPCT delivered training to medical students around the importance of timely verification and certification of death.
- The SPCT provided an introductory session every 4 months to the new junior doctors on Brent ward and informal 1-1 teaching when junior doctors were on rotation with palliative care.
- End of life conversation workshops were run quarterly for senior clinicians and nursing staff. Teaching sessions were also including the use of an actor and a DVD made by Derriford staff was used for induction and training.
- During term time, between 2-3 medical students will take part in 2 ward rounds a week and a feedback session with the medical team. Workshops were in place for 4th year medical students completing a medical humanities/ethics module.
- Medical staff including Consultants and Associate Specialist engaged in annual appraisals within the trust and re-validation process with the responsible medical officer. All doctors undertake a revalidation process every five years to maintain their registration. Doctors also attended six weekly individual clinical supervision sessions with an independent counselling service.

Multidisciplinary working

- Close working relationships were maintained at the hospital between the SPCT who provided their services across the hospital and the Acute Oncology services. We were advised by staff that due to the good level of communication between the two specialities this had reduced the waiting time to access the Oncology ward (Brent Ward) and over the last 12 to 18 months had reduced the risk of these patients being inappropriately placed on general medical or surgical wards. Patients placed on such wards were known as outliers. We saw two patients who were currently end of life on outlier wards.
- Weekly multi-disciplinary meeting were held. These meetings included all members of the SPCT, occupational therapists, physiotherapists, discharge coordinators, chaplaincy, MDT co-ordinator and on occasion consultants from other specialities.
- We attended a multidisciplinary meeting and saw that discussion took place for all patients receiving palliative and end of life care. As part of this discussion discharge and links with the community services were discussed to enable the best outcome for specific patients. We saw that a fast track discharge had been organised for one patient and the TEP form discussed to include the patients choices of ceilings of care. We saw that spiritual

as well as healthcare needs were discussed. Where an Advanced Care Plan was in place, this was recorded in the patient's notes and staff were made aware. This was also included in the LDOL care plan.

- Weekly community MDT meetings also took place at the hospice, with a lead member of staff from the hospital SPCT attending the meeting. This provided a facility for follow up information and review of care.
- The SPCT facilitated a rapid discharge from hospital to the patients preferred place of care and accessed equipment, care packages and medicines urgently. Links with the Hospice at Home team had, according to staff on the wards and in the emergency department, reduced admissions for patients at end of life. The hospital based SPCT enabled quick access for referral to the community SPCT and referral to the hospice for admission.
- Two outpatients clinics took place for patients receiving palliative care and a pain clinic took place at the hospice which the hospital SPCT could refer patients to. The hospital outpatient clinics were accessible in urgent cases if needed. In addition to this, the consultants said that they were sometimes called about a patient being seen in an oncology clinic and would do all they could to go to the clinic rapidly themselves to help as required with symptom management or even hospice admission if required. Patients could also be referred to 'The Mustard Tree'. This was a day care facility for patients receiving care and treatment from the oncology and palliative care teams. Referral from the Mustard Tree to the SPCT also took place for patients to be seen quickly.

Seven-day services

- The SPCT provided a Monday to Friday 9am to 5pm specialist palliative care service, out of hour's advice was provided by St Luke's Hospice by telephone. The SPCT had a current business plan submitted to increase five day working to seven day working. This plan was pending approval /action from the trust board.

Access to information

- Patients told us they could access their medical records should they want to. They told us they had been included in decisions about their care and staff had confirmed decisions about their care with them.
- When patients were discharged, a letter was sent to the patients GP; this would be done either by mail or by email. Staff told us this was done within 24 hours. The electronic recording system was also available to GP out of hour's service to enable information access if needed.
- There was in place an Electronic Palliative Care Coordination system called 'Cross Care'. This enabled all palliative care staff involved in the patients care access to all the information available. The SPCT, community team and hospice all used this joint database which ensured communication between healthcare professionals and patients was consistent across the hospital and community. This system ensured patients individual choices were recorded and recognised both in hospital and the wider community.
- Due to the 'Cross Care' electronic recording system, should advice be sought out of hours from the hospice staff, they could access those records to ensure patient safety.
- Another electronic system called Electronic Palliative, Care System (EPACS) was used by the hospital and the out of hour's doctor service to access information about patients. An End of Life link nurse was available on most wards. These link nurses could access and upload information on the EPACS for patients receiving care on each ward. The exception to this was on some surgical wards that did not have many patients with end of life care needs. However, they did not hesitate when asked to show us the information accessible to them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had replaced the Do Not Attempt Resuscitation (DNAR) form with the Treatment Escalation Plan (TEP) documentation which had been in place since 2012.The TEP form was a Devon wide document and recorded important clinical decisions regarding resuscitation and other ceilings of care. The Resuscitation Chairperson for the trust confirmed the trust policy was that all adult patients should have a TEP form in place. These forms were only completed by medical staff.
- Guidance provided to staff for completing TEP and resuscitation decisions included the process in place for making best interest decisions in serious medical decisions for all patients over 18 years. A flow chart had been provided to ensure the correct process was followed to ensure the patient's best interests were

served. Further information had been provided to staff from the Chair of the Trust Resuscitation Committee in 2014 to medical staff to clarify the process involved around resuscitation decisions. Despite the training and guidance available the completion and review of these forms varied from ward to ward.

- Twelve out of the 53 forms we saw were fully completed and included varying levels of discussions with the patient and their relatives. For the completed forms we saw recording was also within the patients notes regarding the content of the discussion and the names of doctors involved.
- We saw that the majority of forms were not fully completed. We also saw that some patients did not have any TEP form in place. We spoke with the lead for teaching of staff and the medical TEP Champion about the use of TEP forms who accepted that completion was an issue. The last audit undertaken was in February 2015 and wards were identified where issues had been identified.
- We saw that for 34 of the 53 forms we looked at, the question relating to the patients mental capacity was not completed. When the assessment of patient capacity was needed, the completion of the next page to assess capacity was not consistently completed.
- Some of the gaps in completion regarding the rationale and discussion detail related to the decision to resuscitate or not. The gaps in information included who had been involved and what qualifications level the doctor was signing the form. Some TEP forms had none or very limited information around the reason for not attempting resuscitation. Others had a lack of detail with words such as 'frailty', 'futility' or 'patient's wishes' being used without explanation.
- We saw a person whose change of status for resuscitation was delayed due to further discussion needed; this change of status was only made at the latest stage of the person's illness and could potentially have been made earlier.
- We saw that one patient had in place a previous outdated version of the TEP; we revisited the patient the next day and saw that staff had updated and transferred to the updated version to ensure the patient was receiving the current practice.
- For those patients who were not for resuscitation and for whom ceilings of care have been defined and agreed, the completed TEP form was sent home with the patient at discharge. This ensured up to date and accurate information was provided to the receiving team.
- There was an Emergency Calls Retrospective TEP Audit carried out between October to December 2014, which showed that during this time period there was an increase in TEP forms not in place from 18% to 29%. There were TEP follow up visits to 22 wards in February 2015 with four wards showing major concerns about TEP completion. We visited these wards and nine others and saw a variation in how the forms were completed, with some well completed and some incomplete.

Are end of life care services caring?

Outstanding ☆

Compassionate and person centred end of life care was provided to patients on wards by medical and nursing staff and by the Specialist Palliative Care Team (SPCT). Feedback from all patients and relatives was extremely complementary about the care they had received and the staff who had delivered the care. Patients told us there was nothing more they thought that staff could do to support them and that staff always went above and beyond their expectations

There was a strong and visible person centred approach to end of life care. The development of the Last Days of Life Care plan identified a person centred approach which reflected the caring culture for end of life care seen throughout the hospital. For patients identified as having end of life needs on admission to the Emergency Department, they would be immediately transferred to a bed for their comfort as opposed to a trolley. On wards the most suitable space was found and patients and relatives told us they had been considered, included and treated with dignity and respect at all times.

Patients and relatives input to care needs were valued. Patients and relatives told us they felt included and involved in decisions about care and treatment and that they had been treated as individuals with their choices listened to and respected. Staff told us about how the patient's whole care both in and out of hospital was considered as part of end of life care.

End of life care

A range of services to support the emotional needs of patients and relatives was available throughout the trust. The results of the Bereavement Survey January 2015 noted eight different wards and all comments seen were very positive and confirmed that relatives considered care provided to have been excellent.

Compassionate care

- Feedback from patients using the service and their relatives was continually positive about the way staff had treated patients. We spoke with patients and families about the care they had all received from ward staff and the SPCT. One family said they had received "First rate care", and they had seen many "caring moments with other patients". A family told us that they found cleaning staff to be "polite and sensitive". They said they had experienced "joined up communication" from medical and nursing staff and that the staff offered "excellent management and quality care".
- Another family told us "Every box was ticked" indicating that staff had done everything they could to help. They also described "amazing care" and "good support from ward staff and the Specialist Palliative Care Team". Patients told us that they had easy access to the SPCT and their doctor to discuss any concerns or thoughts they had on how they wanted their care to be delivered.
- There was a strong and visible person centred approach to end of life care. For end of life patients identified on admission to the Emergency Department, they would be immediately transferred to a bed for their comfort as opposed to a trolley.
- Ward staff told us that any patients identified as being near the end of their life would be preferably placed in a side room, for privacy and dignity. This would enable family members to stay overnight and have open visiting access throughout the day. A family confirmed they had open access visiting and that a camp bed was available for them to stay overnight. They told us parking was free and they appreciated this as one less thing to worry about. Staff also told us that the only time a patient at the end of life would be moved at night would be to access a side room if one became available and this would always be their choice. The MAU department had taken a slightly different but compassionate approach. Side rooms on that unit were principally used to manage infection control. To place a dying patient there, to then have to move them was not considered compassionate and so if the patient could not be transferred to a more suitable ward, a window bay was used and curtains drawn. A staff member explained that even under pressure staff would endeavour to support the privacy and dignity of patients at the end of their lives
- The patient's bereavement survey was last undertaken between January 2015 and April 2015.This audit was to assess the patient experience of the SPCT. The results noted eight different wards and all comments seen were very positive and confirmed that relatives considered care provided to have been excellent. It was identified that patients felt able to influence the decisions made about them and that relatives felt included in treatment decisions. The comments also identified that over periods of time of multiple admissions and discharges relatives continued to have the same experience of satisfaction and appreciation of the support and care provided. This was also reflected by discussions with current in patients.
- Porters and mortuary staff were clear that respect and dignity were an essential part of their job and they would honour the cultural and spiritual wishes of the deceased. The staff member in the bereavement office was understanding of peoples cultural preferences and would undertake to ensure they were met. She ensured she met with families and escorted them to viewings and supported any preferences they may have.

Understanding and involvement of patients and those close to them

- Staff were committed to working in partnership with patients. We spoke with patients who were, without exception positive about the care they had received. Patients confirmed that the priorities for their care had been discussed with them and when appropriate the preferred place of death discussed. They told us this had been handled sensitively. Patients told us there was nothing more they thought that staff could do to support them and that staff always went above and beyond their expectations.
- Two patients told us that because of the sensitive but frank discussions about their care they were able to discuss their choices with their families and make informed decisions about their futures. A family told us

that they were happy with the discussion they had with medical and nursing staff. They understood what was happening and the decisions made had been agreed with them.

- The Learning Disability lead nurse had planned a presentation for the End of Life Committee about end of life care planning for patients with a learning disability. The support needed by patients and carers with a learning disability was identified in all areas of the hospital and staff spoke about the consideration needed to ensure that learning disability specific needs were met and how they had done this in their day to day work.
- Staff empowered people who used the service to make decisions. We saw an occasion when the patient had a ward preference outside of where they would normally be admitted. As a result the patient was supported to remain where they wanted to be and the oncologist and SPCT visited the person there. We looked at the ward electronic system which identified where the patient was and that they had been seen by the appropriate medical staff.

Emotional support

- A patient told us that the time spent with them and their family by the consultant and staff was welcomed and they appreciated the extended time spent explaining their condition and treatment options. They felt this had helped them make better decisions and appreciated family members being afforded the time to ask the consultant questions. They were grateful not to have to duplicate the same conversation to their family and particularly appreciated how the meeting was set up at the convenience of the patients and family members.
- The Chaplaincy provided pastoral care – described as a listening ear to anybody in need of this. They also offered spiritual care, for patients trying to make sense of their situation and religious care for faith support for the major religions. Ward staff described the input of the Chaplaincy service as 'valuable, accessible and supportive'.
- Patients emotional and social needs were included in their care and treatment. The Last Days of Life care plan included a spiritual assessment to inform staff of the patients choices and needs. Chaplaincy services were available to access different faiths through the Chaplaincy service. There was an on-call rota to enable access to this service at any time. A team of 200 Chaplaincy volunteers including 35 ward visitors ensured spiritual support was available. A representative Chaplain sat on the End of Life Committee and the hospital Patient Experience Committee and were considered as integral to the end of life service provided.
- Staff were supportive of patients but also of each other. We observed a junior nurse who was upset after the death of a patient. The senior nurse was very supportive and took time to be compassionate to junior staff.

Are end of life care services responsive?

Good

Patients' individual needs were responded to by ward and SPCT staff and patients individual needs were central to the planning and delivery of their care. As a result of the good working relationship with the SPCT and Acute Oncology Service, patients were being seen in the Emergency Department and referrals to the SPCT picked up sooner. Fast track applications were being facilitated by the SPCT and enabled patients to be looked after in their preferred place of care. Access to outpatient clinics for end of life or palliative care was facilitated through the hospital and in the wider community to suit patients' needs.

The involvement with community services in patient care was integral and as a result discharges were seen to be managed quickly to meet patients' needs. We heard and saw instances of how the SPCT within the hospital worked with the local hospice and Hospice at Home team within the community to improve patient support. Fast track discharges were seen to be managed efficiently and in the patients best interest and a proactive approach was taken to ensuring the support and safety of vulnerable patients. Follow up in the community was enabled by multidisciplinary meetings between hospital and community staff which also facilitated learning and development of the service provided.

The SPCT was responsive to requests to support patients with complex end of life symptoms and care needs. Close working relationships with the Acute Oncology service improved the patient's pathway through the hospital. Patients were supported to access services in a way that suited them. Admissions avoiding the Emergency

End of life care

Department for those patients known to the Oncology or Palliative care teams were managed with patients being admitted to the MAU or directly to the ward undertaking their care.

The facilities for multi faith prayer were not large enough to enable separate Friday prayers for both men and women. The arrangements for ritual ablutions also required improvement.

The arrangements for discreet use of lifts when transporting the deceased required improvement.

Learning was taken from involvement in complaints and fed back to staff. Complaints and learning were reviewed at the End of Life Committee meetings to oversee changes identified.

Service planning and delivery to meet the needs of local people

- People's individual needs and preferences were central to the planning and delivery of services. The service was flexible, provided choice and ensured continuity of care in the wider community. The involvement of other organisations and the local community was seen to be integral to how patient care was planned and ensured the service met people's needs. We heard and saw instances of how the SPCT within the hospital worked with the local hospice and Hospice at Home team within the community to improve patient support. These included rapid discharges, access to packages of care and equipment at short notice and provision of anxiety support on discharge.
- Staff told us that patients individual needs and preferences were central to their accessing services. Between January – December 2014 the SPCT completed 169 fast track applications to enable patients to be looked after in their preferred place of care. Between April 2014 – January 2015 – 86 patients were referred to and cared for at St Luke's Hospice. Access to outpatient clinics was between three and four clinics each week held at St Luke's at Pearn, Derriford (Oncology OPD) and St Luke's Hospice. The SPCT advised that The outpatient clinics for end of life or palliative care at Derriford hospital were run in a way that enabled access to other specialist teams and should advice from the SPCT consultants be needed they could be facilitated by a phone call and the consultant if possible would attend. Should a hospice bed be needed, depending on availability the longest a patient would have to wait was three days.
- As a result of the good working relationship with the SPCT and Acute Oncology Service, patients were being seen in the Emergency Department and referrals to the SPCT picked up sooner. This pathway enabled end of life care issues to be identified earlier and acted upon more promptly. This also supported the transfer of patients known to the specialties through the hospital and direct to the correct specialty ward when appropriate. We saw this happened during our inspection and the patient confirmed that this had been less stressful for them.
- There were daily assessments by the SPCT of patients on their caseload. Referrals were accepted for any patients with a life threatening condition who had complex physical, psychological, social or spiritual needs. There was a daily handover of caseload information, which we attended and saw that all patients receiving both palliative and end of life care were discussed and reviewed and allocated to a member of the SPCT.
- 23% of patients referred to the SPCT were from a non-malignant cause. When such a diagnosis was confirmed the patient would be seen in the Emergency Department and a referral made to request SPCT support. The SPCT told us that they had a good working relationship with the Emergency Department team and this system of referral was responsive to patients' needs.
- The hospital had recently commenced using a 'Six steps Model' for recognising patients in the last six to twelve months of life. Education of nurses in this model was due to commence with the education team of the local hospice championing this approach.
- The arrangements for porters to transfer deceased patients to the mortuary did not consistently ensure the patients' privacy and dignity. We saw in one area of the hospital porters had access to lifts which did not enter public areas and so avoided the issue of lift doors opening to waiting public while transferring deceased patients. These were the main theatre lifts and porters would have to wait for them to be available. The main lifts used by the public would sometimes be used and an override swipe card was available to prevent the doors opening to the public on each floor. Access to this swipe card was not available as a matter of course but a

card was accessible in the porter's office. Some porters were not aware of this or the code needed. Public lifts in the Terrence Lewis building did not have this facility, a key was needed which was not available to portering staff and so the lift would open in public areas. Other than the lift issue, porters felt the transfer process to the mortuary was dignified.

- As part of the Chaplaincy service a multi faith prayer room was available for patients, relatives and staff. We saw that this lacked capacity to enable both Muslim men and women to pray on a Friday. We observed that space would be divided for men and women to pray separately. The space available was insufficient and that as a result we saw that women left without praying. The Chaplain explained that a reconfiguration plan was ongoing to consider the facilities for ablutions and prayers but no outcome was currently agreed.
- The space provided for ritual ablutions was also not appropriate and was being considered for improvement in the configuration of space.

Meeting people's individual needs

- There was a proactive approach to understanding the needs of different groups of people and to delivering care in a way that met those needs. This included people who were in vulnerable circumstances or who had complex needs.
- We saw that complex care needs included medication complexities and anxiety. These needs were both for patients with malignant and non-malignant illness.
- We spoke with the staff member who attended the End of Life link meeting with community services. This enabled the trust to get feedback on patients who had been discharged home or to the hospice. This was used to develop the trust service and identified any areas for development of practice to support patients' needs.
- Translation services were available for patients who needed support to ensure a full understanding of the care being agreed. A sign language service was also available. Staff told us they would contact the switchboard and they would organise a translator. Staff confirmed that this system was accessible and appropriate and generally response to requests was very quick.
- We spoke with staff on the wards about the support available for patients with a learning disability or who had a long term carer. They explained that when possible a side room was used to enable the carer to remain with the patient and reduce any anxiety associated with admission and treatment. We saw that some wards had 'put up beds' available for carers or relatives to stay overnight. They also explained that accommodation facilities were available in the grounds of the hospital but there was a cost included in using those facilities.
- We saw patients receiving end of life care who also had a level of encroaching dementia. We saw that when possible they were nursed in a side room. However when this was not possible, they were cared for on the ward and staff tried to support their extended needs. We saw staff being caring and supportive to these patients and in one case the patient was rapidly discharged within 24 hours to a nursing home which was a more suitable environment.
- We visited the bereavement office and spoke with staff there. The office was open Monday to Friday 9-5 with an answer machine out of hours. The office was currently run by one staff member who met with families to organise death certificates. They booked viewings and escorted relatives to viewings in the mortuary. They also dealt with the coroner and ensured relatives received patients' belongings and valuables. They explained that some delays were encountered because doctors were not trained to complete death certificates and sometimes did not understand the importance of timeliness to bereaved relatives.
- Should a deceased person be homeless or without next of kin this staff member would register the death and organise the funeral. The staff member was clear about how to access translation services and the administrative processes involved in complex cases where finances were involved.
- This staff member was calm and efficient but had not been provided with any training for this role to hold difficult conversations and provide support to bereaved people. They did not receive any supervision or clinical support to prepare them for the challenges their role presented.
- We visited the mortuary which appeared organised and it was evident that the dignity of the deceased was an ongoing important consideration. The environment for viewing was clean and facilities were available for relatives to spend time with their loved ones. Facilities were available for bariatric patients and systems were in place to ensure their ongoing dignity.

- Should any issues arise in the mortuary, such as cross infection risks or patients with no identification wrist bands, a datex report was completed and information fed back to the ward to improve practice.

Access and flow

- Response rates for referrals were seen to be within 24 to 48 hours of referral. The exception to this would be over the weekend and bank holiday periods. This was planned to change with the implementation of seven day working. Not all patients received support from the SPCT or were seen by a consultant in specialist palliative care. This would depend on the needs identified and they would be supported by the consultant treating any other identified illness. Referral to the SPCT could be made at any time to provide support with the speciality consultant remaining the named lead for that persons care.
- Staff on the wards told us the SPCT were accessible and responded promptly to referrals and requests for support. Delays caused to patients by lack of SPCT at the weekends and bank holidays had been identified by staff as a problem.
- We saw that flow of end of life patients was dependant on the admission and discharge process. This was seen in both cases to be efficient and patient centred. On admission through the Emergency Department, initial holistic needs assessments were carried out by the Acute Oncology Specialist Nurse and if any specialist needs were identified then a referral was made to the hospital SPCT. The Emergency Department had a direct number to access the Acute Oncology Specialist Nurses to alert if a known patient was admitted via the Emergency Department.
- A recent incident had demonstrated the responsiveness of the service to staff who told us about a patient admitted to the Emergency Department. The accessible information from a recent episode of treatment informed the decision making process. As a result treatment was provided in the Emergency Department, the patient was seen by a consultant from the SPCT and discharge took place within three hours of arrival thus avoiding admission to hospital. Support in the community was arranged with the Hospice at Home team. Links with the community services would enable follow up of the patient through community MDT meetings.
- The Acute Oncology Service was a five day service managed by an on-call consultant and two specialist oncology nurses. We were advised that the majority of referrals to the Acute Oncology Team were from the Emergency Department who were efficient at ensuring assessments and appropriate referrals were made. The Acute Oncology Team visited the Medical Assessment Unit (MAU) every weekday at 11am and reviewed any patients for their care who had been recently admitted. An oncology registrar was available on call at the weekends. Both Oncology and Palliative care staff told us of the close working relationship and how this benefitted patients in their care.
- Admissions avoiding the Emergency Department for those patients known to the Oncology or Palliative care teams were managed with patients being admitted to the MAU or directly to the ward undertaking their care. We spoke with a patient who confirmed they had been admitted directly from home to the ward. They had rung the Oncology Ward and been directly admitted. They told us they felt able to ring at any time.
- A weekly multi-disciplinary meeting took place and a joint community/trust multidisciplinary (MDT) meeting took place weekly. The joint MDT meeting with the hospice and community services was in place to ensure patients transferred out to the community were supported to have a smooth discharge. The electronic recording systems linked the SPCT to the Hospice and Hospice at Home care service in the community to ensure that patient's information remained accessible during transfer and any potential readmission.
- Staff told us that when a patient was identified for rapid discharge, the SPCT would organise the discharge in conjunction with the patient, their family, the ward, and the community services involved. Because of the close links with the hospice and Hospice at Home team, staff confirmed discharge was improved.
- Every ward staff member we spoke with confirmed in glowing terms the support of the SPCT. They told us they were "Brilliant and always supportive". They told us they saw improvements in the timeliness of discharges because of the community links and that the SPCT supported ward staff to provide end of life care to meet patients' individual needs. One staff member from a ward explained that the previous week a patient had needed an urgent discharge to the hospice to meet that patient's choice. This had been coordinated and achieved within 24 hours.

- We spoke with a patient who wanted to go home. This patient was vulnerable with fluctuating capacity to understand their care needs. Considerable work was being undertaken to ensure the discharge being organised was in the patient's best interest, safe and included the patient's choices. The discharge was being facilitated by the SPCT and the ward staff. The ward staff told us that they had received support and guidance from the SPCT for this patient's discharge and others, and that due to the close links with the community palliative care services the discharges undertaken were efficient and successful in supporting patient choice.

Learning from complaints and concerns

- There was an ongoing review of complaints by the SPCT lead and how they were responded to. Improvements were made as a result. We saw that there had been seven complaints relating in some part to end of life care within the last year. While there was no specific theme to the complaints, learning was noted to be taken and fed back to the staff via the multidisciplinary teams. The SPCT confirmed that this took place and that they received feedback and updates from any complaint about end of life care.
- While the SPCT were employed by the hospice, any complaints which related to them were managed by the trust. Further review of complaints were also undertaken by the End of Life Committee to review any changes identified as a result of complaints.

Are end of life care services well-led?

Good

Leadership of end of life services by the specialist palliative care team was clear to staff throughout the trust. All staff valued the expertise and responsiveness of the team. The specialist palliative care team promoted a culture of sharing knowledge and developing the skills of others. The trust's vision for the end of life service was shared by all staff.

There were governance processes in place to monitor the quality of end of life care throughout the trust.

The culture was seen to be that End of Life care is 'everybody's business' and all staff shared a priority to ensure the care provided was right for the patient.

The trust recognised the need for ongoing development of the service.

Vision and strategy for this service

- Plymouth Hospitals NHS Trust 'End of Life Care in Hospital' Standard Operating Procedure March 2015 set out the trust vision for end of life care from the point of diagnosis of to the last days of life and care after death. The vision was for end of life care to support both patients and their carers, offering services where appropriate to both, to meet their physical, psychological, spiritual, and social needs during end of life care and in bereavement. The End of Life strategic Plan 2009-2015 also highlighted the trust's vision for end of life care. All staff we spoke with were clear about the importance of end of life care and the need for it to be recognised, planned for and delivered to meet the patient's needs.
- The SPCT told us that they felt supported by the trust board. They regularly saw the 'Director for the Day' and they saw the Chief Executive regularly on the wards. The 'Director of the Day' was in place to enable staff access to the trust board members at ward level. The SPCT identified areas which were in need of development and felt that they were supported to effect those changes when possible, this had included access to seven day working.
- The trust had in place an End of Life Strategic Plan 2009-2015. This identified the quality markers and metrics used for end of life care which included end of life performance targets and current performance reviews. This document continued to make reference to the Liverpool Care Pathway which is now obsolete and had been replaced by the trust. The strategy was clear that end of life care nurses were named and available to support patients and relatives.
- Derriford End of Life Committee led the implementation across the trust of the national End of Life strategy and other nationally driven end of life care initiatives.

Governance, risk management and quality measurement

- The End of Life (EoL) committee provided the trust Board and Senior Management Team with assurance against end of life care quality markers and national standards. The committee reported to the Quality Assurance Committee and also annually to the trust board. The EOL committee met every two months to

receive feedback and discuss future plans for the end of life service provided. The chair person was the Oncology Clinical lead and minutes noted the attendance of representatives from the learning disability team, cancer services, chaplaincy, palliative consultants and nursing staff, medical staff, resuscitation and discharge lead staff. The SPCT told us that through the End of Life committee they felt they had a voice.

- Notes of the meeting reflected the inclusion of community teams to provide a wider end of life service. There were also records of discussions about development of patient information booklets to improve them. We saw audits of TEP forms were discussed and issues related to them were being monitored as part of the End of Life Committee agenda.
- There was also a patient experience Committee who were included in viewing the Cardiopulmonary resuscitation (CPR) Patient Information leaflet.

Leadership of service

- One ward staff member told us 'The new CEO was a breath of fresh air'. Staff we spoke with regularly made reference to an improved leadership since the current CEO took up the position.
- Leadership of end of life services by the specialist palliative care team was clear to staff throughout the trust. All staff we spoke with on the wards and in departments valued the expertise and responsiveness of the Specialist Palliative Care Team.
- There was a lead role on the executive board for end of life. The executive lead was the Director of Nursing and there was also a non-executive lead for end of life care who sits on the trust board. These roles did not attend the EOL committee but the EOL committee provided information to the trust Executive Board, where they both attended. The End of Life lead told us this was a conscious decision not to attend the EOL committee and to delegate to the lead roles to feed back to the Quality Assurance Committee and then to the Board. The Non-Executive lead for End of Life care also attended the Patients Experience Committee and was considered a 'critical friend' to the SPCT and end of life care generally.
- The Specialist Palliative Care Team led the palliative care provision at the hospital and was contracted from St Luke's Hospice. While the team remained responsible to the executive lead for the trust, the ultimate responsibility for the SPCT sits with the CEO of St Luke's Hospice. We were told that the joint working was well established and cohesive to provide a responsive service. The Head of Nursing (Cancer) had recently also became the Lead for End of Life and this would enable the transition of information from both services to the EOL committee.
- We were made aware that the Service Level Agreement with St Luke's hospice for the provision of the SPCT had expired in March 2015. The trust board provided assurance that the new service level agreement was underway.

Culture within the service

- Staff told us that End of Life care is 'everybody's business'. Because it took place across the hospital, staff training and involvement was essential. Staff on wards and departments spoke passionately about the end of life care provided.
- The specialist palliative care team promoted a culture of sharing knowledge and developing the skills of others.

Public and staff engagement

- Patient and relatives views were gathered as part of the bereavement survey and the results shared with staff. Promotion was used to develop awareness including a planned 'Dying Matters week', planned for May 2015.
- Patient and relative engagement was seen on a day to day basis by their active inclusion in the decisions about treatment and care.
- The specialist palliative care team have presented information to the public trust board meeting and are also active within the Schwartz rounds. These were in place for staff to share successes and challenges.

Innovation, improvement and sustainability

- There were plans to open an assessment unit which would be open between the hours of 9-5 on the oncology ward (Brent Ward). This would provide one bed and would be audited to identify if this would reduce admissions as it had been identified that some patients only require a one night admission. The aim of the unit would be to reduce the need for those admissions.
- While the trust recognised the improvement in completion of TEPs following training over the previous two years, they have identified that this will be a continued focus for further training and audit for 2015-2016.

Outpatients and diagnostic imaging

Safe	Inadequate
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Inadequate
Well-led	Inadequate
Overall	Inadequate

Information about the service

Plymouth Hospitals NHS Trust outpatient services were provided at Derriford hospital with a small portion at satellite centres. At Derriford Hospital there was a dedicated 23 clinic room outpatient department, and 19 specialist clinic areas around the hospital and in the Royal Eye Infirmary. Outpatient services were split into a number of service lines (broken down into specialities) which sat within one of four care groups. The diagnostic imaging service provided inpatient and outpatient services for plain X-ray, non-obstetric ultrasound, computed tomography (CT), magnetic resonance imaging (MRI), nuclear medicine and breast imaging. During 2013-2014 the outpatient services provided 580,000 appointments and the diagnostic imaging department provided 168,000 appointments.

During our inspection we visited: the main outpatients department; the ear, nose and throat clinic, trauma and orthopaedics, rheumatology, ophthalmology, urology, haematology, audiology, and oncology outpatients departments. We also visited the therapies department (including physiotherapy, speech and language therapy (SALT), dietetics and occupational therapy). We visited all modalities (such as CT or MRI) in the diagnostic imaging department.

We spoke with 44 patients and 20 carers and relatives. We also spoke with 58 members of staff including managers, clinical (doctors, nurses, allied health professionals and health care assistants) and non-clinical staff.

Summary of findings

Plymouth Hospitals NHS Trust outpatient and diagnostic services were overall rated as inadequate.

We rated safety as inadequate. We found the level of staffing did not match the establishment in many service lines, increasing the risk of harm to patients waiting for an outpatient appointment by delaying diagnosis and treatment causing unacceptable levels of serious incidents. We found multiple incidents of harm to patients as a result of delayed appointments and diagnosis of scans. Examples of this included: patients having deteriorating sight, and patients having had delays in the diagnosis of cancer. We also found that the safe use of medicines was inconsistent, as responsibilities for dispensing medications and the responsibility of keys were not following trust policy. We also found that fridges in outpatients, used for the storage of medications, were not being monitored appropriately.

We did not rate effectiveness. We found that staff followed competency frameworks based on standard operating procedures for all processes. We found that patient outcomes were monitored and benchmarked in the therapies department and that dose audits were regularly conducted in diagnostic imaging. Good multidisciplinary working was evident for one-stop clinics which were reflected by positive comments from patients. However, we found that staff understanding of the mental capacity act was limited.

Outpatients and diagnostic imaging

We rated caring to be good. Patients told us that they received compassionate care from staff and we observed that patients were being spoken to appropriately, kindly and politely. Patients told us they were included in the decision making process. However, we were told that due to delays in clinics the emotional support that patients expected was not always evident.

We rated responsiveness as inadequate. We found that due to the scale of the backlog in the follow up of patients, image reporting backlog and restrictions in the capacity of clinics, people were frequently and consistently not able to access services in a timely way for an initial assessment, diagnosis or treatment. People experienced unacceptable waits for some services. Large numbers of patients were in breach of their see-by date for follow up, many of which had not received appointments. We found that the waiting areas in some service lines were not appropriate, as these areas were crowded and obstructed with equipment and some areas such as nuclear medicine did not have a waiting room at all.

We rated the leadership of the service as inadequate. Strategy was not underpinned by realistic objectives and plans and did not reflect the health economy in which the service worked. Action plans did not match the urgency required to manage the risks to patients, and improvements to services were slow. In diagnostic imaging action plans to reduce the backlog were described as 'work in progress' and the urgency had not been identified. We also found that there was little understanding of risks to outpatients at a trust and service line level.

Are outpatient and diagnostic imaging services safe?

Inadequate

We rated safety in the outpatients and diagnostic imaging service as inadequate.

The levels of medical staffing were having a severe impact on the backlog of follow up appointments and the backlog of unreported diagnostic imaging scans. Delays in patients being seen in outpatients or having their scanning reports delayed increased risk to the patient of delayed diagnostic, treatment and surgery causing unacceptable levels of serious incidents. We found multiple examples of where harm had been caused to patients as a result of delays.

We found inconsistency in the safe management of medicines in outpatients. In main outpatients we found that arrangements for the safe keeping of the keys to medication stores/cupboards were not secure, and in ophthalmology we found that patient group directions were not being followed appropriately.

Generally incidents were managed well with action plans in place, although there were concerns in diagnostic imaging regarding the effectiveness of a 'pause check' system in computed tomography.

We found that the design, maintenance and use of facilities and premises used to keep people safe was inconsistent throughout the hospital as design flaws and lack of space were having a negative impact on patients' wellbeing and privacy.

Incidents

- Between September and December of 2014 there were 45 reported incidents in outpatients. Of these incidents 28 were not categorised, 11 were categorised as 'minor' and 2 were 'moderate'. Other incidents were recorded under their related service line and speciality rather than in main outpatients therefore incidents may have occurred in the main outpatients department but were not recorded as such.
- Between September and December of 2014 there were 219 reported incidents in the diagnostic imaging department. Of these incidents 92 were categorised as no harm, 109 were 'minor', 15 were 'moderate' and 3

were 'severe'. One 'severe' incident was as a result of delays in reporting, leading to a patient having surgery based on an older scan. A second was on a paediatric patient who had a delay in having a scan which led to a temporary postponement to their cancer treatment. The third was in interventional radiography where the required equipment for a procedure was not available resulting in delays to the patient's diagnosis.

- Staff we spoke with were confident to record incidents through the computer system and could give recent examples of when they had used it. Senior staff were confident to investigate and analyse cause of incidents through this system also.
- Incidents were discussed at diagnostic imaging meetings and appeared as a regular discussion point although this was less consistent in other service lines. Staff in outpatients said that incidents were discussed at team meetings.
- We saw evidence that lessons were being learnt as a result of incidents. In minutes of a general diagnostic imaging meeting, learning from a marker placement near miss had been discussed and we saw evidence of actions to prevent future occurrences. It is a requirement for certain radiology incidents to be reported to the Care Quality Commission and we saw in the radiology department that such incidents were reported appropriately. In a four month period there were 5 reportable incidents all of which were managed appropriately.
- In March 2014 there was an ophthalmology never event where an eye injection was administered into the incorrect eye. This was investigated by the department's matron and an action plan was created as a result. The root cause analysis of this incident showed that it occurred due to staff pressures. At the point of the incident clinics were treating 20 patients per session which has been reduced to between 12 and 14 patients per session. Additional nurses had been trained to reduce the number of injections one nurse has to administer. Extra sessions have also been added to meet the demand of one-stop and walk in patients requiring this injection whereas previously this would have resulted in the over booking of clinics. There has also been improved use and understanding of the World Health Organisation surgical checklist and improved patient safety checking processes.
- Staff in ophthalmology were able to describe the incident and had a good understanding of learning from it. We observed that 'stop checks' were being used before eye injections as recommended from the investigation. A 'stop check' ensures that staff double check the eye the procedure is to be carried out in with the patient as well as a second practitioner.
- The sister in main outpatients said that most incidents recorded in their department were managed by their individual service lines. Little feedback was received by the main outpatients department as a result, which staff felt limited learning opportunities. When feedback was given managers discussed with individuals involved before sharing learning with the wider team in staff meetings.
- In diagnostic imaging there was a good understanding of incident reporting. Managers ensured that learning from incidents and outcomes were also included on Datix forms. Radiographers were being trained to do this effectively through a programme which was being rolled out to improve the quality of information provided on an incident record.
- All radiation incidents were discussed at a radiation protection committee and information disseminated to staff through meetings, notices on walls (if considered necessary), changes to local rules and competencies implemented.
- All lead radiographers have a one-to-one meeting with the general manager when incidents occur to discuss the reporting of these incidents. The clinical governance board and care group managers received monthly updates on any incidents.
- In diagnostic imaging there were a high number of incidents in the Computed Tomography (CT) unit. The introduction of a 'pause check' has helped but senior radiographer's felt that the level of incidents was not going down. We were told by one manager that they did not feel confident that learning and involvement of action plans was occurring. This issue has been identified and is being managed by the general manager.
- Clinical staff in both outpatients and diagnostic imaging were not aware of what the duty of candour was. However they told us that the culture of their department was open and honest and apologised to patients when required. They had not received training in duty of candour.

- We were assured by senior managers that at a trust level there was a good understanding of duty of candour and a culture of openness and transparency.

Cleanliness, infection control and hygiene

- During our inspection we found the hospital and all areas we visited to be clean and tidy with 'I am clean' labels on the majority of equipment. Patients said the hospital looked clean and tidy.
- Hospital policy states that infection prevention and control link practitioners should perform monthly hand hygiene audits and a qualitative 'Globox' audit should be performed at least every 12 months. The use of a 'Globox' assessed the quality of an individual's hand washing technique. In the outpatients departments we saw evidence of regular auditing and a positive culture towards hand hygiene.
- Services provided by diagnostic imaging were not maintaining 95% compliance in hand hygiene audits. In diagnostic imaging plain film X-ray and Magnetic Resonance Imaging (MRI) there was only 65% compliance. This was mostly due to results of local audits not being collected in time to be reflected in reports. If this did occur the last score was reported.
- We observed hand washing practices being implemented before and after patient interaction. All staff we observed were bare below the elbow following the trust's infection prevention and control and uniform policy.
- In all clinics we observed treatment rooms had cleaning logs. These were up to date and complete. This meant that regular cleaning had taken place reducing the risk of infection.
- Monthly environment and quality safety audits were carried out. This showed that the environment in diagnostic imaging was mainly clean however it was recorded that high level surfaces were not free from dust.
- We were told that all patients were screened for Methicillin-Resistant Staphylococcus Aureus (MRSA) during their first appointment with further monitoring if found positive.

Environment and equipment

- We observed that the main outpatients department was hot during the inspection. When asked, the sister of outpatients said that this was a regular occurrence due to the lack of air conditioning. We were told that patients were often affected by this and could at times become dehydrated. This was raised with managers and water was offered to patients waiting for an outpatient appointment and fans were placed to reduce the temperature.
- Staff in oncology felt that the department was cramped and that confidentiality could be breached due to the patients being in such close proximity to each other. They said that patients could over hear private conversations and confidential discussions with clinicians. We were not told if this had been raised with managers or if anything had been done to address the issues.
- We found that in oncology the outpatients department and waiting areas were crowded and cluttered with blood pressure equipment, medical gas cylinders and linen trolleys.
- In ophthalmology and in the chestnut centre we found the environments fit for purpose as they had recently been renovated, improving the effectiveness of the department. For example in the chestnut centre walls had been removed to allow reception staff to have oversight of the waiting room improving patient safety. Staff in these areas said that the estates team were effective and reliable and that any issues were quick to be addressed with minimal impact to the patient.
- We observed that resuscitation trollies were available throughout the hospital and that staff were confident to locate them. They were checked both daily and weekly. However we did find on one trolley that the defibrillator was beyond its service date. This was immediately raised with the nurse in charge and corrective action was taken.
- In diagnostic imaging the department was fragmented into several locations around the hospital. Staff said that the service worked less effectively as a result of having to move around. We were also told that as a result of the department's infrastructure patients were being asked to sign consent forms in a corridor which was not appropriate. We were not informed of any actions done as a result of this.
- In diagnostic imaging there was an equipment replacement programme. However, at least ten pieces of equipment have gone beyond replacement date. Although regular monitoring was in place this could cause an impact to the patient as equipment is more

likely to break down and delay scanning. We were told that two plain X-ray machines needed urgently replacing as were 20 years old and if they broke down replacement parts would not be available.

- We were told about various issues with imaging equipment. Warning lights remained on with some of the imaging equipment and discussions were ongoing with the manufacturer. Risk assessments had been made and the risks identified. All radiographers had been made aware and we were told that if the issue was not resolved an amendment will be made to the standard operating procedures for these machines.
- We were also told that the X-ray tube output for newer imaging equipment were set too high meaning that patients may have been overexposed to radiation. All staff have been made aware of this and the manufacturer had been contacted. Medical physics were rectifying this by reducing exposure factors.
- Environmental audits were regularly carried out in the outpatients and diagnostic imaging service. We found that they were compliant based against a 95% benchmark. However, it was noted that in diagnostic imaging sharps bins were not always dated correctly, they were overfull and that the temporary lids were not utilised increasing the risk of needle stick injury to both patients and staff.

Medicines

- Patient Group Directions (PGD) were written directions that allowed the supply and / or administration of a specific medicine by a named authorised health professional to a well-defined group of patients for a specific condition. In outpatients we found that the list of staff authorised to supply and administer medicines under PGD was unavailable. A new list was produced on the last day of the inspection. However the original list was not recovered.
- We saw PGDs in use that lacked authorised signatures (trust sign off) and therefore did not comply with trust policy.
- The trust policy states that the keys for medicines cupboards should remain with a designated registered nurse. On inspection we found the keys to be in the top draw of a supplies trolley and were accessible by all health care assistants and nurses. On the last day of the inspection we observed that keys were with the responsible nurse and that all staff had been made aware of this change in practice.
- Some medicines required refrigeration. In main outpatients we found that staff were not following the correct procedure for the checking of fridge temperatures. We observed that temperatures were being recorded as less than 1o which is outside the threshold for safe storage. After investigation it was found that the temperatures were recorded incorrectly due to the misplacement of a decimal point and that the medicines in the fridge were safe to use. This highlighted that staff were not alerting pharmacy in accordance with trust policy. This was immediately raised with the sister of the outpatients department who alerted all staff at a staff meeting the next morning and created a clearer document for recording temperatures.
- Trust standard operating procedures stated that 'Any stock balance identified as incorrect must be reported through Datix and fully investigated'. We saw an incident report stating that one ampoule of Fentanyl, a controlled drug, went missing in the outpatients department. The incident was investigated. However there was little detail as to the actions taken as a result. The drug was never recovered.
- In the outpatients department we found that FP10 (prescription documents) were stored securely. NHS fraud audits, Clinical Commissioning Group audits and internal audits were all good.
- The nuclear medicine department ensured that the medicines (administration of radioactive substances) regulations 1978 were being followed. The department was secured by swipe access cards and all materials were signed in and out with the hospital and the manufacturer. Daily contamination audits were carried out and all equipment was regularly tested but the increasing workload made it difficult for medical physics to be able to close the rooms to do required testing. The environmental agency regularly inspects the nuclear medicine department and had raised no concerns around the disposal of radioactive waste.
- We were told that the capacity of the waste room in medical physics was satisfactory but discussions were being had with managers to increase size to match future demand.

Records

- In the outpatients departments medical records were stored securely in trollies with keypad locks. All sets of records we looked at were in good condition and were legible.

Outpatients and diagnostic imaging

- The hospital had 918,000 medical records in active use (1.2 million records in total) at the time of the inspection most of which were stored off-site at Bush Park. This site was 2.4 miles away from the main hospital and we were told that medical records could be transferred from Bush Park to the main hospital site within thirty minutes by courier.
- Staff said that the service provided by medical records was good and that rarely notes were missing. We were told that they found the requesting system easy to use and received notes in a timely way once requested. However, in main outpatients we were told that medical records were mostly available for outpatient appointments. However a small numbers of notes were frequently unavailable. This was not reflected in all clinics as some staff said they always get a full set of notes for clinics, even when they were booked late.
- Managers described the use of medical records as a "mixed economy" where different service lines were managing and storing notes in different ways. We were told that prior to 2014 no one took overall responsibility for medical records. Since this point a central management system had been implemented with specific roles created for the management of certain projects based on identified themes improving the quality of the management of patient records.
- We received conflicting information about how many medical notes were missing. Several managers stated that there were 60,000 sets medical notes (5% of all medical notes) missing in the hospital. However, we were also told that only 6784 notes were missing matching the number of temporary notes created in the hospital. Since our inspection we were told that other than the number of temporary records any figures would be based on speculation as there was no reliable way to determine the quantity of notes missing.
- Temporary notes were managed by a project officer who was responsible for reducing the number of temporary notes in circulation. An action plan had been created and a monthly report of progress was reported to the trust's governance and Caldicott committees. In the previous 14 months there had been a 26 per cent decrease in the numbers of temporary medical notes and it was estimated to be less than 100 sets of temporary notes by August 2015.
- Some doctors allowed temporary sets of medical records to be created based on the information they had, whereas other doctors refused to see the patients without the full records. There is an increased risk for patients seen with a temporary set of medical notes as decisions may be made about their care without a complete history.
- It was identified that the highest risk for the medical records department was the numbers of medical records being incorrectly traced as it was believed that most missing notes were being stored in clinics and not at Bush Park due to people not following trust protocol.
- We observed in some clinics that processes for the storage and tracing of notes were not being followed and that local organisation systems were in use instead. In ophthalmology we found that there were several cupboards with a large quantity of temporary notes in which were stored in an office. We were told that they were kept there for 6 months before being sent to Bush Park in case the patient re-attended. In physiotherapy we found that there was a cupboard with a large number of physiotherapy records in. This was reported on the therapies risk register. Since our inspection we were told that these should be transferred to the main medical notes however this was not achievable.
- Areas for greatest improvement had been identified and further training was being developed by the medical records team. Individual practitioners who regularly fail to trace properly were being held to account and additional training was given.
- Staff in the ENT clinic were concerned about the security of medical records overnight. The department was locked although the domestic staff had access to the department.
- Patients were able to check in to their appointment when they arrived to hospital either by talking to a receptionist or by using a self-service check in counter. These counters were touch screen computers where patients inputted their details to check into an appointment. Patient information at the self-service check in counters was visible from all angles. This means that confidentiality is compromised when people were waiting or walking past these counters.

Safeguarding

- The trust had a safeguarding steering group who ensured appropriate processes, procedures and culture exits to adequately safeguard those people at risk of abuse, neglect or exploitation. This group directly reported to the hospital board.

Outpatients and diagnostic imaging

- Staff understanding of safeguarding roles and responsibilities was inconsistent throughout the hospital. Staff in main outpatients and ophthalmology were able to clearly demonstrate understanding of safeguarding and said that they would escalate issues to their manager for further guidance. However, in the Chestnut Centre two members of staff were unable to demonstrate an adequate understanding of their responsibilities of safeguarding. One of them said it was the process of reporting incidents when a patient had a fall.
- There was a mixed understanding by reception staff of their duties and responsibilities under safeguarding. One receptionist gave examples of where they had previously raised a safeguarding alert and received feedback from their line manager about the outcome.
- All outpatient and diagnostic imaging staff undergo either level 1 or level 2 child protection training.
- In ophthalmology and rheumatology a new safeguarding lead had recently been appointed who was currently attending additional training. Staff felt confident to approach them and liaise with consultants if they felt an issue arose.
- There was an increased risk to the patient receiving multiple scans and being exposed to unintended dose due to multiple request cards being received. We were told that digital requesting will reduce this issue which was due to be implemented in October 2015. This was on the risk register and a pause check system was introduced to encourage radiographers to check patient information. Service lines were receiving Datix incident reports to raise awareness.
- In diagnostic imaging issues were raised with us about the evaluation of imaging outside of radiology (clinicians making decisions on unreported scans) and reports on these images being written in the patient notes. This practice could result in misinterpretation of scans and unsafe care. The responsibility of the image lies with the radiologist unless deferred to clinicians. During a Care Quality Commission IR (ME) R inspection in 2010 at the trust this had been raised as only 50% of scans had written reports. The medical director had discussions with the audit team and we were told that this was being added to the audit programme later this year as other issues took priority.

Mandatory training

The trust's target for compliance in mandatory training at any one time was 95%. In outpatients and diagnostic imaging basic life support, manual handling and safeguarding were all compliant with the trust's target. However level 2 and level 3 child protection training was not

- We were told that training in safeguarding of children was being reviewed as non-compliance with training had been identified as a risk by the sister in outpatients.
- Staff in outpatients were able to describe where to find policies and procedure notes and felt confident to ask line managers questions if they were unsure.
- As part of the "trust update" all staff must complete e-learning prior to each appraisal. Included in this e-learning was infection prevention and control, and manual handling. Basic life support training was always completed in a classroom environment.
- Staff felt that mandatory training was of an adequate level to ensure safety to patients. One member of staff said they 'like that it is kept simple'.
- In outpatients staff were reminded when they need to complete mandatory training 3 months before they were due to. If the staff member is struggling time is made for them to complete it and if they still cannot do it the manager invites them for a formal discussion.

Assessing and responding to patient risk

- Reception staff we spoke to were unclear what to do if a patient collapsed in the waiting room and were unclear as to the emergency telephone numbers. All reception staff we spoke with said they would shout for nursing help. The resuscitation council recommended that all staff, including non-clinical, should be trained in basic life support.
- All Staff we spoke to were able to identify where the nearest resuscitation equipment trolley was.
- In one clinic we were told that patients who were feeling unwell were transferred to accident and emergency for assessment and an incident form completed.

Staffing

- The levels of staffing were having an impact on the size of the backlog of follow up patients which was increasing the risk to patients delaying diagnosis and treatment.
- In ophthalmology the service line managers stated that they were managing demand however this began to slip

with four vacancies and two nurse practitioners trained in eye injections leaving to work elsewhere in the hospital, therefore reducing the capacity of the clinic. More nurse practitioners were to be trained to replace them. We were told that a scoping exercise was being undertaken to make eye injections part of the job role for all nurses in ophthalmology. A competence framework was also being developed to allow greater flexibility in staffing minimising the impact on capacity.

- Staff in ophthalmology said that a shortage in staff had not had a significant impact on their workload but were aware that this was increasing the backlog of patients waiting for appointments. This made the staff members feel that they were not overworked, able to work safely, and at an appropriate pace to ensure good care of patients.
- Numbers of administration staff in some service lines was down by as much as 50 per cent increasing workload. Staff felt that they were not supported and that issues which had been voiced has not been acted upon by managers. They were finding the job stressful due to a backlog of paperwork, such as patient outcome forms, which was increasing delaying bookings of subsequent appointments.
- In diagnostic imaging an on-call rota had been implemented to manage staffing during the evenings and at weekends. This increased the risk to the patients as the availability of staff fluctuated and the required skill mix was not guaranteed. Managers agreed that if a rota system was implemented for 7 day working the staffing structure would be more robust with less reliance on overtime and reduce the risk to patients. This was based on staff volunteering and working beyond their contracted 37.5 hours. Radiographers were working 16 hour shifts during weekends. A manager said that the staff were used to this system of working, however they felt that patient safety could be compromised due to the long working hours.
- We were told that in order to implement a 7 day working system an increase in 20 radiographers would be required. A senior radiographer in diagnostic imaging said that the workforce structure had been neglected.
- In diagnostic imaging some staff said if there were more staff it would allow them to manage the demand better. One member of staff said that the process between appointing and the individual starting was too long.
- staff were concerned that the level of goodwill by staff was not recognised and that claiming hours back for extra hours worked was difficult. The arrangements for compensatory rest were inconsistent and there was little direction from HR about staff entitlement.
- In the therapies department we were told there were sufficient staff to meet the demand and staffing establishment was reviewed on a yearly basis.
- Staff said that their teams were dynamic and helped each other out to cover sickness or vacancies. This had a positive impact on how supported they felt by their peers.
- The trust was trying to recruit staff from outside of the United Kingdom but no managers could provide evidence of incentives to encourage staff to work at Plymouth. New job roles were being explored for nurses and medical staff and the introduction of telemedicine for certain low risk patients was being scoped to increase capacity.
- Managers in several service lines told us that some staff were approaching retirement age, and that their intention is to produce a succession plan however none had done this yet. One manager said that this needs seriously addressing.

Medical staffing

- The levels of medical staffing were having a severe impact on the backlog of follow up appointments and the backlog of unreported diagnostic imaging scans. Delays in patients being seen in outpatients or having their scanning reports delayed increased risk to the patient.
- Between the period of January 2013 and September 2014 the Clinical Commissioning Group's (CCG's) recognised, in meeting minutes, that there had been 21 incidents which "may have been attributed to by delays in patients having inappropriately timed appointments following an initial consultation with a clinician". These were reported as SIRI's which meant that they resulted in either an unexpected or avoidable death, permanent harm to a patient, a threat to the trusts ability to deliver services, or adverse media coverage.
- At the time of inspection a further three patients were identified through analysis of incident reports. One patient who should have received an urgent follow up appointment after a CT scan showed probable cancer did not receive an appointment until three months later. Another patient who was diabetic required an urgent

appointment and did not receive one for six months. Finally a patient diagnosed with skin cancer who should have had an appointment every three months did not receive an appointment for eleven months. It was reported that this patient's cancer had spread elsewhere in the body.

- At the time of the inspection there were six medical staff vacancies in ophthalmology which reduced the capacity of the service. The shortage was being covered through the use of locum doctors and the goodwill of staff.
- There was a staffing issue in radiology which was having a direct impact on the capacity of reporting scans and X-rays. At the time of the inspection 9 of the 36 radiologists (32%) had either left or were on long term sick. There were 30 registrars with varying levels of training however at the time of the inspection many of them had left to complete their university examinations. This reduces the amount of scans which can be reported upon delaying diagnosis and treatment.
- Exit interviews help services to understand any issues and help to target recruitment in the future. In diagnostic imaging exit interviews were not conducted for medical staff as they were not compulsory.
- Medical staff we spoke too felt well supported by their peers and mentors. They also feel they have a good working relationship with the nurses and supportive staff.

Major incident awareness and training

- Staff we spoke with had completed major incident training but felt they would need to re-read policies to be confident in their application. All staff knew where to find the policy.
- The sister of outpatients was a manager trained in the management of major incidents and could explain the processes involved. We were told that in outpatients drills were not undertaken as their responsibility is to help wards and other areas rather than have a specific role.
- We were told that staff in the outpatients department worked well during a major incident last year when 50 people were brought to hospital due to a coach crash.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The effectiveness of outpatients will not be rated due to insufficient data being available to rate outpatients effectiveness nationally at present.

The use of best practice was evident throughout the outpatients and diagnostic imaging services with service lines taking responsibility for this. Staff felt that their training was adequate and robust frameworks were in place to ensure competence.

Multidisciplinary working was in place to ensure an efficient patient pathway. All outpatient clinics had access to therapies support and one stop clinics were available for certain conditions.

We found that seven day services were offered to patients but they were inconsistent and were staffed on a voluntary basis.

Evidence-based care and treatment

- In March 2014 it was recognised by the Imaging Service Accreditation Scheme (who perform external audits) that diagnostic reference levels (the factors to identify the amount of dose required to perform an optimised X-ray) had not been fully implemented in the department. We were told that dose optimisation was recognised by the trust board several years ago but was actioned six months prior to the inspection. An action plan was created and a programme of auditing was implemented by September 2014 ensuring compliance. New standard operating procedures have been written and have been approved by the trust's governance committee.
- Dose audits were done to monitor the dose a patient is receiving. These were monitored by medical physics based on radiographer dose data inputted into a computer system. However it was commented that accuracy of this was 'hit and miss' due to radiographers not filling in the spreadsheets accurately. This issue has been raised with managers and was being addressed.
- In diagnostic imaging audits were regularly conducted by staff at all levels and results of these were shared at staff meetings. Audits included bone scan audits, positioning audits, lung scan audits, and personal contamination checks in nuclear medicine.

Outpatients and diagnostic imaging

Patient outcomes

- In the therapies department patient outcomes were recorded using an online tool. These were monitored as a performance tool to establish the effectiveness of the treatments they were giving. The department also benchmarked against other services as part of the NHS benchmarking network.

Competent staff

- Staff said they felt comfortable to discuss further training with their direct line and service line managers and said they found their appraisal a useful forum.
- In outpatients all staff must read standard operating procedures and be assessed as competent before using equipment. Staff in main outpatients were able to easily access the operating procedures and we saw records of competency assessments were stored.
- In diagnostic imaging standard operating procedures were available in all imaging rooms and stored digitally for all staff to access. Staff attend a continual professional development session once a month to develop their skills.
- In nuclear medicine a succession plan was produced. However, the training schemes to implement this effectively had been withdrawn. This had the potential to leave the workforce without the correct skills mix in this department to provide safe care.
- In some clinics such as the fracture clinic band 2 staff were being trained in the removal of casts relieving nursing staff to perform other duties in clinics.
- In ophthalmology we saw a training folder with a list of staff competencies, information about competencies, and reflective practice. One new member of staff felt they were pressured to finish their competencies quickly. This was voiced and has been addressed for future staff.
- In diagnostic imaging all radiation protection supervisors attended regular training to maintain their practice. Certificates were distributed to evidence their continual professional development.

Multidisciplinary working

- The outpatients services have access to a range of therapies such as physiotherapy, occupational therapy, dieticians, and speech and language therapists and also offer services for rehabilitation and hydrotherapy. The outpatients department can urgently refer for therapies and can get a patient seen either on the same day or the next day.
- One stop clinics were utilised in several departments, where patients had their tests and diagnostic examinations and consultations in a four hour period. Patients were told about this in advance so they can be prepared to spend a long time at the hospital.
- Regular team briefs were held in outpatients which a range of staff attended including from the royal eye infirmary, to share information and discuss incidents.
- A Healthwatch report quoted a patient who had received good multidisciplinary care. They said: “I have 5 different Outpatient appointments today and the bookings department have synced them all to be today so that is convenient for me! I am very pleased!”

Seven-day services

- We found that seven day working had not been introduced in all outpatients services. Services provided at weekends were being arranged as part of a waiting list initiative to reduce the number of patients waiting in the backlog. However, these were being staffed by staff volunteering to do overtime. If staff were not willing to do overtime these clinics would not be staffed sufficiently with the correct skill mix increasing risk to patients.
- Seven day services were implemented for outpatients in the CT department and a plan had been developed to provide seven day services in MRI also.

Access to information

- Signage in the hospital was good and used symbols and colours to differentiate between areas. For example we found that all signage to and in the royal eye infirmary was backed with yellow to improve readability for visually impaired patients
- Information was available either in patient notes or through various computer systems on the intranet. Imaging and reports, blood reports, and pathology were available.
- In oncology we found that information governance and personal information security was compromised as medical record information was stored on a shared computer drive using word documents before being

printed and placed in the medical notes. These records could be accessed by people who did not have permission to do so, and therefore there was a risk they could be amended.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- In many outpatient and diagnostic imaging procedures assumed and verbal consent was gained omitting the use of a consent form.
- Some staff in the Chestnut centre and in Ophthalmology were unable to confidently describe their responsibilities under the Mental Capacity Act (MCA) and felt that they would need to read the policy again before acting on any concerns.
- Staff felt that training around this was poor which reflected their understanding.
- Staff said they felt confident to challenge doctors over consenting issues. For example, one nurse from the learning disabilities team questioned a junior doctor who signed inappropriately on behalf on the patient on a consent form and advised the doctor that the patient had capacity. This responsive care prevented a patient from receiving a treatment without proper consent. As a result of this the consent form was filled in again appropriately and the doctor was challenged on his practice.
- If patients required more information when consenting for diagnostic scans a DVD was available explaining the process visually.

Are outpatient and diagnostic imaging services caring?

Good

Patients we spoke with were positive about the care provided in the outpatients and diagnostic imaging services. Patients described staff as friendly, brilliant and welcoming. Healthwatch Plymouth had undertaken a consultation on the outpatients services at Derriford in November 2014 and the majority of feedback received about care was good.

We observed compassionate care and that patients were spoken too appropriately, kindly and politely.

Friends and family questionnaires were regularly collected however the results from these had not been analysed at the time of the inspection. In oncology we found that 55% of patients would not recommend the service to friends and family due to long waits for appointments.

We observed good practice where relatives and carers were included in patients' decision making, however some patients felt that the nurses were too busy to spend time to talk with them.

Compassionate care

- We observed that staff in both outpatient and diagnostic imaging waiting areas spoke appropriately, kindly, and politely to patients and communicated at their level by bending down to make eye contact with the patient. We observed that staff were able to relieve anxieties of patients who had been waiting for long periods of time and were able to put them at ease. One patient said that staff were "friendly, brilliant and lovely".
- Healthwatch Plymouth undertook a consultation in November of the outpatient services and received 565 feedback comments on the services. Of these 305 were positive with the standard of treatment and care generally being reported as good and that staff attitudes (dignity & respect, honesty, support) were also good.
- Of the remaining comments, 162 were negative and 98 were mixed. The major themes identified from negative and mixed comments were about poor communication and waiting times in clinics. It was also noted that staff attitudes at clinic reception point could be improved. The trust had developed an action plan in response to the report.
- Patients said that even though it could be difficult to get an appointment and a long wait the staff were kind and friendly. They said that they had no complaints about the service.
- Another patient said that "everyone was amazing" and that they were very happy with the care received within the service.
- Patients gave good examples of compassionate care. Patients told us how caring staff were and that they were polite and efficient. One patient said that "although I am over half an hour late staff seem very friendly and caring". Another said that the staff were "very welcoming and top class".

Outpatients and diagnostic imaging

- There was permanently a volunteer by the self-service check-in machines to help patients and direct them to their clinic appointment alongside two receptionists managing queries.
- One patient in ophthalmology stated that he had received excellent treatment and that the nurses were very caring.
- In oncology we found results from friends and family tests. They showed that out of 59 responses 55 per cent would not recommend the service to friends and family. The main cause of this was long waits for appointments. The friends and family test results showed that staff were friendly and provided a good level of support to patients.

Understanding and involvement of patients and those close to them

- Patients we spoke to said that they were included in the decision making processes and were explained all options available to them prior to having treatment.
- The hospital has a carer's policy which was based on the national strategy for carers. This had helped staff ensure that carers of all ages were well informed and involved in the decision making process. We saw examples of where this was implemented were through our observations of carers being included in conversations with patients.
- We observed an incident of poor care in a clinic where a patient was feeling slightly unwell. The receptionist tried to explain the situation to a health care assistant who did not listen to the full story and quickly moved him into a room when he said he was ok, without listening to the patients concerns or understanding their needs.

Emotional support

- One patient felt that emotional support was not evident for all staff she had interactions with. They described how during one appointment the specialist said "now tell us about your problem". They felt that the specialist should have had the information available and was concerned they had to repeat their response.
- Several patients told us they felt stressed sat in the waiting rooms because staff had not informed them of delays; they felt that this was not very caring to their needs. While they recognised the pressure staff were under they would like them to taken the time to inform them of the delays.
- In oncology patients were given telephone numbers of key contacts if they had any questions or issues they wanted answering. However, this was not the case in other specialities.

Are outpatient and diagnostic imaging services responsive?

Inadequate 

We rated the responsiveness of the outpatients and diagnostic imaging service as inadequate.

We found that due to the scale the backlog in follow up of patients, image reporting backlog and restrictions in the capacity of clinics, people were frequently and consistently not able to access services in a timely way for an initial assessment, diagnosis or treatment and people experienced unacceptable waits for some services.

At the time of the inspection 36,724 patients were in breach of their follow up see-by date. Over 26,000 of these patients had not received an appointment. Over 7,500 patients were identified as high risk of harm as a result of long waits. In diagnostic imaging there was a reporting backlog of over 7000 scans.

Only 87.8% of new patients were seen within the 18 week referral to treatment target. This meant that each week 2900 patients were breeching this target. Within the last year10, 788 patients had not had their diagnostic imaging scans within four weeks.

Environments were not always appropriate for the patient needs. Waiting areas were crowded and we were given examples where people had to wait in corridors and sit on floors.

Although the number of complaints received concerning outpatients and diagnostic imaging services to be high we found that they were mostly managed effectively, and learning was taken away from them. Staff welcomed being made aware of concerns and saw them as opportunity to learn.

Service planning and delivery to meet the needs of local people

- In oncology, ophthalmology and in the fracture clinic the waiting environments were not always meeting

people's needs. We found that waiting areas were overcrowded with patients having to stand up due to lack of appropriate seating. Staff told us that patients regularly had to sit on the floor as there were not enough seats.

- In ophthalmology we observed that there was no dedicated space for patients in wheelchairs. We observed that because of this the corridors were obstructed and access for patients was restricted.
- We were told that when the waiting room in ophthalmology was full the corridors were used as an 'overflow' waiting area, which patients considered to be windy and cold. This also increased the risk to patients where they were not being observed by a member of staff.
- A Healthwatch consultation in November of 799. Of these patients 369 stated that were not offered any choice in location or time of appointment. Although numbers of patients was not stated another theme stated that patients were also not aware they could have a choice in where their treatment was carried out. However, it was noted that patients were accepting of the dates, times and locations given.
- The report stated that 526 of 799 patients had received their first appointment within 6 weeks with 141 being seen within 18 weeks and 54 waiting greater than 18 weeks. Patients said that they seemed to be lost in the booking system and that there was continual cancellation of appointments.
- Out of 799 patients only 64 had problems when booking their first appointment, with the main themes being about inconsistent communication between departments, lateness of transport and lateness in receiving clinic letters.
- In diagnostic imaging we found that some areas, such as nuclear medicine, did not have a dedicated waiting room meaning that patients were waiting in the corridor.
- We observed that patients were rarely told when a clinic was delayed and did not know how long they would be waiting for their appointment.
- In ophthalmology and some patients with young children were not told where the children's area was. We found that in ophthalmology there was a children's waiting area. However, this was only for younger children and teenagers would need to wait in the adults waiting area. This meant that patients were unable to sit in the most appropriate place for their child's needs.
- Information was being displayed around the outpatients department concerning issues with car parking in the hospital. It stated that car parking had been made easier for patients and that disabled spaces were available closer to the outpatients department, moving from car park C to A. We observed of the four disabled parking spaces closest to the outpatients department, two were occupied by non-blue badge holders.
- One patient said there were frequently no spaces available in the car park. One patient we spoke with in the waiting room said they did not get a disabled space and had to park elsewhere, even though they were wheelchair bound. One patient we spoke to was asked to move their car by a car park attendant to a blue badge space on the other side of the hospital which upset them.
- An outpatient management centre was being rolled out to make booking high risk and time critical patients easier and centralised. Several services were using the new system. Previously the central booking team organised clinics for doctors. The new system gives the clinicians oversight over who they see and when allowing them to prioritise high risk or time critical patients.
- This system of booking was to ensure continuity of bookings across service lines. However, it was more successful in some clinics than others. For example, the system was used in urology which was successful but in neurology it was unsuccessful and had to be pulled.
- In the therapies department referral to treatment was within 6-8 weeks with do not attend (DNA) averages at 4% which was better than the national average. The manager of therapies said they managed to keep DNA rates low due to efficient appointment management systems and reminders for patients either by text message, email, or by telephone appointment. Patients were given the choice as to where and when they attended their appointment.
- In therapies additional slots were left free during the day to be used as slots for urgent patients minimising disruption to their scheduled patients.
- Over the last 12 months the average waiting time for a post clinic letter to be typed was 9.56 days and the average signing delay being 9.16 days. Meaning that it takes an average of 18.6 days for a patient letter to be sent. However in December 2014 with the introduction of digital dictation, the time between clinic appointment

and a letter being sent was an average of 4 days. An improvement of 10 days. There are some service lines which still required improvement, for example neurosurgery which had a delay of 19 days. The trust was working with this service line to reduce this.

Access and flow

- In April 2015 there was a total of 110,657 patients on a follow-up waiting list with 36,724 (33%) of these patients in breach of their see-by date. A total of 1961 patients had their outcomes missing and no see by date (meaning that the hospital did not know when a follow up appointment was required). Out of the patients in breach of their see-by date over 26,000 (71%) did not have appointments.
- In April 2015 there a total of 7,555 patients had been identified at risk of harm as a result of delays. The departments with the highest risk to patients were ophthalmology (with 2,375 at risk patients), Gastroenterology (with 774 at risk patients), and colorectal surgery (with 758 at risk patients).
- The numbers of at risk patients had not reduced for certain service lines. For example in gastroenterology there were 774 patients at increased risk and this number has been identified to increase until September 2015 due to reduced clinic capacity and the need to meet two week waiting time targets.
- In October 2014 a validation exercise was started to identify and prioritise patients who may be at high risk of harm as a result of long waiting times. Because of this a 'time critical' flagging system was introduced for prospective patients on digital record systems. There were a total of 4,703 'time critical' patients identified at the time of the inspection. However, progress with the validation exercise varied between service lines as not all service lines had begun the validation exercise.
- Prior to the validation exercise patents were not identified as 'time critical' so the trust was working to examine 39,000 patients still on a separate waiting list. As of March 2015, 10,215 patients had been examined with 3,220 of them being identified as 'time critical'. We were told that the remaining patients would be examined by June 2015 with service lines providing trajectories to the board to monitor performance.
- For those patients identified as 'time critical' the service lines had worked to identify which patients were at risk and in some services this number had increased.
- In ophthalmology there were 2,800 high risk patients. We were told that although there was a better understanding of the backlog due to the validation process many of these patients would require multiple appointments to manage their care. This meant that more than 10,000 appointments would be required to reduce the risk.
- Until the validation exercise is completed it is unknown how many of the patients in the backlog may not require further follow up appointments and could be discharged from the hospital. Managers said that it was impossible to identify the impact the backlog has made to patients until they present at an outpatient appointment or their general practitioner with symptoms. There was a risk that treatment could be started later or be less effective or a patient's condition may have deteriorated as a result of the long delays. All of these could have an impact on patient outcomes.
- We were told that because capacity is close to the limit small changes can have large consequences. For example when a doctor leaves there were significant changes to activity which take a long time to recover from. This increased both the scale of the backlog and the risk to patients.
- Patients we spoke with were negative about the timeliness of receiving their appointments. One patient said they only received an appointment after telephoning the hospital several times. The same patient had to wait a long time to get to an outpatients appointment due to the specialist being on holiday and delays incurred as a result. One patient said that they regularly had to get their GP to contact the hospital to receive an appointment which was inconvenient for both the patient and the GP.
- In September 2014 there were a total of 12,693 unreported diagnostic imaging scans. An action plan was implemented consisting of:
  - prioritisation of urgent scans;
  - general practice chest X-ray's taking ultimate priority;
  - a waiting list initiative to prioritise patients at risk.
- This was managed by radiologists and radiographers volunteering to report on these scans as well as close monitoring of reporting capacity. As a result of this unreported scans dropped to 4,750 in March 2015. However, since then, in the time leading up to the inspection this had increased to approximately 7,000.
- Of the 7,000 diagnostic imaging scans 1000 of them were in CT. This was identified as a high risk as 40% of

these CT scans were for cancer diagnosis so should take priority over other patients. In response to this two weeks prior to our inspection a hotline was set up for GPs and a pathway set up for patients who were considered high risk. As this was a new service at the time of the inspection the impact had not been identified.

- Currently there was a 2000 report deficit between the number of images taken and the capacity to report them each month increasing the scale of the backlog.
- It was discovered by the radiology department that the productivity of their consultants and registrars was not as high as originally expected. Job plans for radiologists had recently been changed to increase the number of reporting sessions for resident radiologists.
- We found that not all patients were seen within the 18 week referral to treatment target. At the time of the inspection 393 patients were in breach of this target. With 4 of these in Oncology.
- Only 87.8% of patients were being seen within the 18 week referral to treatment target. This meant that in one week 2900 patients were breaching this target.
- Within the year April 2014 – March 2015 10,788 patients had not had their diagnostic imaging scans within 4 weeks. In MRI 31% of activity was outside of 4 week wait, 40% of ultrasound activity was outside of 4 week wait and 16% of CT activity was outside of 4 week wait.
- In ultrasound sonographers were being paid per scan completed as an incentive to work overtime and assist in clearing the waiting list of patients. At the time of the inspection the average waiting time for an ultrasound was six weeks.
- In the MRI unit all patients were seen within six weeks. A business case had been written for the purchase of two additional machines which was to be discussed at the next equipment meeting. The largest challenge in MRI was the management of children who require anaesthetic as they take the most time.
- We saw that staff informed patients of delays in some clinics although this was not consistent throughout the hospital. Patients we spoke with discussed having long waits once they arrived in the department and felt frustrated that they were not updated frequently. One patient said: “no one tells you what is happening and if you go and get a drink you might miss your appointment”. Another patient who attended hospital every two weeks said that “normally there were delays every time I attend” and told us: “I have to put extra money in the parking machine as I know I will be late”.
- Patients commented on the effect long waits was having on staff. One patient said that because the staff were stretched they do not have time to talk with patients about waits. We were also told by patients that doctors were often called away to manage other issues throughout the hospital creating delays. A patient commented that “they make do with the capacity they have” and that “waits between an hour and two hours” were common place. We were also told of an instance where two doctors were called to outpatients to manage a long waiting time.
- One patient said that he did not receive the same level of care at Derriford outpatients as he has received elsewhere. He told us he felt like just a number and that the communication between himself and staff in the hospital was not good. He had never received copies of letters concerning outpatient appointments and had been on a waiting list for a neurology appointment for 18 months.
- In outpatients staff told us that there was constant pressure to put more patients into a clinic slot so overbooking was common. We were told that doctors were often late and were held to account by the sister of outpatients where this happened on a regular basis.
- We saw during one morning session in main outpatients that two clinics were cancelled at short notice and doctors arrived late to two other clinics creating significant delays.
- In main outpatients staff said that delays were common. This was partly due to inappropriate time slots for patients. For example doctors were given 10 minute slots and sometimes need to deliver bad news to patients which may take longer. A nurse practitioner is always available during these clinic slots to offer support to patients in a private room.

Meeting people’s individual needs

- There was a hospital wide learning disabilities team available to all patients in the outpatients department and staff informed the learning disabilities team when patients at risk were attending and were able to attend the clinic appointment for support.
- However there was little promotion of the service offered reducing awareness of this service. In

outpatients patients and visitors have access to a health care assistant who is trained to manage people with learning difficulties. They were then able to manage their care and refer to other services if necessary. Support was also provided by a community health care assistant who helped patients and carers outside of the hospital setting.

- All staff, including non-clinical staff had received dementia awareness training. There were two dementia champions to promote good practice around dementia care.
- Some GPs will make a note of dementia on a patient's referral so staff were able to 'flag up' at risk patients, although this wasn't standard practice. Risk assessments were conducted at the patients first outpatient appointment by the learning disability team who managed their care.
- We were shown memory boxes placed in the waiting rooms of outpatient clinics. Within these were pictures of old film stars which would be used to encourage patients living with dementia to remember positive aspects of their life. Questions were attached to these photographs asking "Who is this?" and "Do you remember these?" as a prompt to reminisce about these memories.
- Wi-Fi was available for patients and visitors to allow them to use the internet on their tablets or smartphones.
- We found that several clinics had facilities available for breast feeding and baby changing. We were told that the sliding doors to access disabled toilets saved space and were safer than swinging doors which could be heavy for the patients.
- We observed interactions between a nurse and a patient through the use of an interpreter. We were told that translation services were available through the trust contract with an external agency.
- Wheelchairs were available for patients who required them. Volunteers were seen wheeling patients from the main entrance to their outpatient appointment. However, we saw on several occasions that patients who were struggling to walk with walking frames or walking sticks were not always approached for assistance.
- Information leaflets for charity support groups, internal support groups and services were available in all outpatient areas. Additional information about the patient advice and liaison service (PALS), making a complaint, friends and family test questionnaires and transport were displayed on television screen in the outpatients department. We were told that patients will eventually be called to their appointment by a messaging service on the television screen but this has not yet been implemented.
- Information was also available for external advocacy companies in the main reception. However, this was not displayed in the outpatients departments.
- There were information posters about friends and family tests but results of these were only displayed in oncology. We were told that results had recently been collected and were being analysed by the trust.
- In ophthalmology all patients were given a friends and family test questionnaire however results from this had not yet been received.
- In ophthalmology we found that notice boards and leaflets were all in small print making it difficult for visually impaired patients and visitors to read.

Learning from complaints and concerns

- The outpatients department had received 159 complaints in the previous 12 months. Out of these 67 concerned delayed access and extended waiting times. All of which had a letter of apology sent along with an explanation of investigation findings. Generally most complaints were managed in a timely way with patients receiving correspondence quickly.
- One complaint was considered to be 'serious' where a relative raised concerns that her husband had not received appropriately timed follow up appointments after a diagnosis of malignant melanoma. We found that this was investigated and the patient received an apology.
- The diagnostic imaging department had received 27 complaints in the previous twelve months. Out of these five concerned incorrect diagnosis resulting in patients not being given the correct information, or being misdiagnosed for fractures and cancer. Of the complaints 11 concerned access and extended waiting times. We were told that all complaints received in diagnostic imaging were managed by the service line manager personally and were responded to in seven days. All complaints received through the Patient Advice and Liaison Service (PALS) service were responded to on the same day.
- Complaints and concerns were managed by individual service lines and were escalated to the care group

managers, and trust board if considered significant. Staff told us they welcomed feedback from complaints and concerns and described an open and no blame culture. Staff saw complaints and concerns as an opportunity to learn and develop. One member of staff said that "learning from such incidents is key to progression".

- The PALS leaflet provided good information for the service user and gave the contact details for the chief executive's office and external advocacy. The leaflet was available in different formats through patient services.
- We observed good practice in the outpatients department where a patient wished to complain about extended waiting times. The nurse listened to the complainant's situation, apologised, and escalated to the sister in charge who directed him to the PALS.
- When compared to national data on NHS Hospitals and Community Health Services we found that the outpatients department received 12% more complaints concerning outpatients and 11% more complaints concerning delays and cancellations in outpatients than the national average.

Are outpatient and diagnostic imaging services well-led?

Inadequate

We rated the leadership in the outpatients and diagnostic imaging service as inadequate.

Although it was identified that the backlog of follow up patients was a major issue and steps were being put in place to address this, the urgency and pace of improvement was not sufficient to demonstrate an impact was being made and clear actions were in place. In diagnostic imaging risks to patients as a result of a backlog was not identified appropriately and action plans were weak.

The strategy of outpatient and diagnostic imaging services were not underpinned by realistic objectives and plans and did not reflect the health economy in which the service worked. Service plans were reliant on either increased staffing, which was described as a scarce commodity, on an increase in capital to manage the risks to patients. It was agreed with the CCG that arrangements for 'planned failures' to 18 week referral to treatment targets were implemented.

Understanding of risks was variable in service lines and with senior management, and staff could not identify who had oversight of the follow up backlog.

Vision and strategy for this service

- The values of the hospital were to put patients first, take ownership, respect others, be positive and to listen, learn, and improve. However, not all staff were aware of the vision and could not identify the core values. Many staff in multiple clinics when asked about vision and strategy discussed the backlog in outpatients as the main focus of the organisation. Staff were aware of a backlog in outpatients but did not appear to know the scale of the problem or their role in reducing it.
- The diagnostic imaging strategy stated that capacity is currently at its maximum particularly in CT and MRI. It had been identified that investment was required to meet the targets and to ensure a responsive service. An increase in workforce has also been identified as a requirement to meet future demands.
- In outpatients the vision and values of the organisation were used to evidence behaviours of staff. If staff did not follow these behaviours the departmental sister spent time with the staff member to understand problems and issues.
- We were told by the general manager of diagnostic imaging of their vision to bring together the diagnostic leads from different centres nationally to share experience and skills which was currently not happening.
- A senior manager stated that service plans were too focused and reliant on staffing which is a scarce resource in Plymouth. Medical vacancies across the hospital have been advertised on multiple occasions without success. Risks concerning staffing were identified in the service line risk registers with staffing levels a high risk particularly in diagnostic imaging, dermatology, ophthalmology and gastroenterology.

Governance, risk management and quality measurement

- There was no overall risk register for outpatients as all risks sat in the care group risk registers. On the

trust-wide risk register the failure to reduce the backlog of waiting list follow-ups was identified as serious risk. Actions were identified by introducing the time critical appointments however it was unclear as to how the backlog was being addressed despite patients being prioritised.

- Diagnostic imaging had its own risk register with two items from diagnostic imaging appearing on the trust-wide risk register. Firstly the number of patients waiting over six weeks for diagnosis and inappropriate radiation protection for staff and patients, both of which had agreed actions attached to them and showed improvement.
- Knowledge and understanding of the risk register was inconsistent among management and staff. For example a senior manager could not tell us items on the trust risk register for outpatients and a service-level manager could not identify any risks to their service. This means that risks may not have been managed appropriately.
- A senior manager said that prior to the validation exercise responsibility for the backlog was held at service level and believed that if this had been better managed prior to this time the backlog would probably be reduced. However, now responsibility was held by the care groups, and the finance department, they were confident that risks were being identified.
- A senior manager said that an agreement had been made with the Trust Development Authority allow 2014/2015 to be a 'planned failure' for the 18 week referral to treatment times. This is to allow the trust to treat the patients which have been waiting the longest who were at highest risk. This agreement was set to be renewed for the next financial year also. He said that there was little ability to divert work into the community, especially with an increasing service line workload.
- The CCG had expressed concern about the backlog issues at Plymouth hospitals NHS Trust and a contract query notice had been issued regarding this. The CCG and Plymouth hospitals NHS Trust were meeting monthly to discuss the reduction of the follow up back-log. Meeting minutes from the CCG state that even though the remedial action plan is comprehensive there has been slippage in its delivery.
- We were told that commissioning for quality and innovation (CEQUIN) documents were being drafted once the full scale of the backlog and at risk patients had been identified through the validation exercise. The validation exercise was due to be completed by June 2015. With this a review of capacity and demand would be established to see if patient pathways were efficient. If the efficiency of pathways could be improved capacity would increase. A senior manager stated that if this exercise wasn't successful they will need to work with the CCG to acquire capital to build extra clinic space and staff the new clinic space.
- Service lines including gastroenterology, dermatology and ophthalmology were identified as high risk and processes were put in place to improve the situation. Gastroenterology had an increased demand in two week waits therefore a nurse-led follow up service model was being defined. In dermatology a number of patients had been discharged into community care and in ophthalmology a risk stratification exercise was being implemented to identify patients at highest risk.
- Monthly reports were being produced from service lines identifying how many patients needed to be seen and how many were actually being seen. The reports found that due to an increase in emergency admissions and an increase in cancer referrals many of these service lines failed to meet demand as doctors were deployed elsewhere in the hospital. Service lines within the medical and surgical care groups were mostly affected by this issue.
- The diagnostic imaging reporting backlog was being monitored and an action plan was in place. However the rate of improvements was slow and not proportionate to the risk posed to patients. The managers saw this action plan for managing the backlog as a 'work in progress'. They explained that all radiology departments have a backlog of reporting as most reports are provided retrospectively but are aware that the figure of 7000 scans is too high. They said that they are working hard on this but do not have a target date to complete this.
- The backlog was identified on the risk register for diagnostic imaging with the causality due to staffing rather than infrastructure. The risk register did not include any action plan descriptions, due date or responsible risk manager.
- As a result of conversations with inspectors we were informed that an extraordinary meeting with the radiologists was held. We were told that despite the action plan being implemented and changes being made a more urgent plan was required. The intention of the action plan was to reduce the backlog by 95 per cent in five weeks.

Outpatients and diagnostic imaging

- During an unannounced inspection two weeks after the initial inspection we were told that the action plan had not yet been approved by the trust board however progress had been made, particularly in CT where 40% of the backlog had been reduced. We were also told that scoping to outsource further reporting was being considered.
- We looked at various risk assessments in both the outpatient and diagnostic imaging services. They were all completed to a high standard with descriptions of the risk, mitigating actions and responsibilities.

Leadership of service

- There was no overarching leadership of outpatients as service lines reported into their care groups. This led to a lack of clarity as to who was responsible and who had knowledge of capacity and demand. We were told by service line managers that responsibility and accountability lay with the performance team however senior managers said that it was with the service lines.
- One manager in diagnostic imaging raised concerns that they have been firefighting. Those in leadership roles cannot perform their job roles (as having to perform clinical duties) therefore cannot manage effectively. A senior radiographer in diagnostic imaging said that "they do not have enough time to do the job" and that concerns are "not heard above us".
- Management in service lines had a clear understanding of the issues of capacity in their speciality. One manager described that in the last couple of years there had been a 20per cent increase in demand and that this has resulted in patients being discharged into the community setting.
- Staff said that they felt well supported by their direct line and service managers and that they could approach them with any issues or problems.
- Staff in the ENT clinic felt included in the agenda items for staff meetings and clinics were booked to allow all staff on duty to attend.
- In diagnostic imaging monthly newsletters are sent from management with hard copies placed in the staff room. The general manager reports to the care group manager on a monthly basis and has a good relationship with the chief executive.
- Admin staff in diagnostic imaging said they felt all management were approachable.

Culture within the service

- 'The Plymouth way' was a programme which all staff needed to attend. The session explained further about the values of the trust. We were told staff must attend before an appraisal can be completed.
- Senior managers described the outpatients service as "the unsung hero" of the hospital and that "they don't hear anything when things go right". They also thought that there was a mixed culture in outpatients as the service lines all work independently from each other. We were told that this improved ownership of a service and makes staff feel they are part of a team.
- Staff in ophthalmology were proud to work in a new hospital and found the clinic rooms good to work in.
- Staff in ophthalmology were aware of the staff survey results and actions as a result. They felt well supported and were listened too.
- There were posters on walls of clinics which described various achievements of the trust such as "you said we did" and "reasons to be proud".
- Sickness rates were low (3.5% in December 2014) compared to the national average. 1.5% of staff were on long term sickness and 2.1% were on short term sickness.
- In main outpatients the sister said that there was a positive culture in the hospital as "everyone gets to know each other and all staff are supportive of each other".
- The managers in diagnostic imaging said that they are proud they completed ISAS and praised the dedication of the staff through a difficult time.
- The general manager for diagnostic imaging said that they were slowly changing the culture to be proactive around incidents and governance rather than reactive.

Public and staff engagement

- Staff spoke positively about the blog updates and newsletters received by managers. They said that this allowed them to have a better understanding of the hospital and its leadership.

Innovation, improvement and sustainability

- Staff in ophthalmology were encouraged to attend a journal club to discuss recent literature and how learning from other hospitals can be implemented at Plymouth.

Outpatients and diagnostic imaging

- In main outpatients we were told that the sister had a good relationship with representatives from companies who provided medicines and equipment. She would ensure information was available to improve the staff's understanding of what they are using.

Outstanding practice and areas for improvement

Outstanding practice

- The care and support provided to patients at the end of their lives was outstanding. Patients and relatives told us that they felt included and involved in decisions about care and treatment, and that they had been treated as individuals, with their choices listened to and respected. Feedback from all patients and relatives was extremely complimentary about the care they had received and the staff who had delivered the care.
- The SPCT was responsive to requests to support patients with complex end of life symptoms and care needs. Close working relationships with the Acute Oncology service improved the patient's pathway through the hospital. The involvement with community services in patient care was integral. As a result discharges were seen to be managed quickly to meet patients' needs. We heard and saw instances of how the specialist palliative care team (SPCT) within the hospital worked with the local hospice and Hospice at Home team within the community to improve patient support. The tea with matron initiative helped patients to feedback their views about the service they received.
- The procurement team were working with the clinical staff in theatre to review the use of some equipment and to help reduce their capital spend.
- The use of the Enhanced Recovery After Surgery (ERAS) pathway, which has been converted into a mobile phone app, provided evidence-based protocols to ensure patient recovery was maximised.
- The acute care team within critical care providing an outstanding service in terms of outreach and responding to deteriorating patients in the hospital. This was recognised by other staff, in particularly the surgical and medical wards. We were told the team were quick to respond, were highly experienced and knowledgeable, and staff could ask their advice and support on any matter. Staff said the acute care team had encouraged and enabled them to ask for advice or a review of any patient where, although the patient might not be triggering a risk level, the nurse or doctor had doubts or, as was described by one of the staff, "something that didn't feel quite right, or a gut instinct."
- The consultant intensivist clinical lead provided an outstanding example of compassion and support to a past patient who came to the unit during our inspection. This patient had effectively become "lost within the healthcare system" for a number of reasons linked to other events in their life. The patient was not judged for perceived or accepted failings in their life so far, but was offered compassion, advice, support, understanding and encouragement to move forward.
- Staff on the delivery suite, Argyll ward (maternity) and Norfolk ward (gynaecology) provided outstanding care to patients. The culture was focused and embedded on the provision of person-centred care and treatment to meet individual patient needs. Patient feedback was overwhelmingly positive, which was also reflected in monthly Friends and Family tests. Patients said that the reassurance and care given had increased their own confidence. Staff of all professions and grades demonstrated kindness, compassion, dignity and respect. Patients were fully involved with their care and treatment and were actively encouraged to ask questions. Specialist professional counselling was available from midwives and a clinical psychologist supported women with difficult or complex decisions, care or treatment.
- The neonatal intensive care unit (NICU) clinical director was an advanced neonatal nurse practitioner (ANNP). NICU benefitted from a neonatal technician service, which staff found invaluable. The clinical educator for general paediatrics offered bespoke training and had performed a comprehensive training needs analysis to ensure staff were able to access training to meet their needs.
- The paediatric services benefitted from dedicated pain assessment services and dedicated pain nursing staff.
- We found staff to be very caring and supportive of the children, young people and their families that the paediatric services looked after – both in the acute and community settings. We heard many positive comments about staff going beyond the call of duty to provide care and support. Children were truly respected and valued as individuals and encouraged to self-care and were supported to achieve their full potential within the limitations of their clinical

Outstanding practice and areas for improvement

condition. Feedback from children who used the paediatric community services, parents and stakeholders was continually positive about the way staff treated people. Parents said staff went the extra mile and the care they received exceeded their expectations.

Areas for improvement

Action the hospital MUST take to improve

The trust must ensure:

- All staff are aware of their role in incident reporting and there are systems and process in place to monitor not only individual incidents but trends and themes.
- Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be are deployed to provide adequate levels of nursing and medical staff to ensure the safety of patients at all times. This applies to the emergency department, children's services, outpatients and diagnostics, maternity services, surgery and medical services.
- Patients in the emergency department that are awaiting x-rays in the corridor and the reception area away from staff vision are suitably monitored.
- Systems for booking theatre slots are robust and coordinated across the trust so that theatre time is utilised to provide a timely and consistent service.
- Ensure there are systems in place so that the impact of system escalation does not delay patients who are cancelled at short notice and that they are re booked for their surgery within the 28 day requirement.
- The safety and security of staff and patients in the CDU by providing a means of calling for assistance in an emergency.
- The reception and waiting area in the emergency department complies with the Disability Discrimination Act.
- Staff are administering medicines in line with the NMC standards for medicines management.
- The checking systems for ensuring medication is fit for use, is consistently followed by staff. Intravenous fluids should be stored securely so that they are not accessible by patients and visitors to wards and departments.
- Medicines and controlled drugs are kept in locked in cabinets in the obstetric theatre and anaesthetic rooms when not in use.
- Medications are managed appropriately in the outpatients departments and trust processes and policies are followed.
- Patients receive appropriate and ongoing risk assessments such as mental health risk assessments and complexity scoring, to determine the appropriate place for them to be cared for and monitored.
- All staff have sufficient knowledge of and implement the Mental Capacity Act so that patients' mental capacity is confirmed and to identify patients who lack capacity to make decisions, so that patients' best interests were being served.
- Patients are protected from risk through improvement of systems and performance in relation to the time patients spend in the emergency department.
- Treatment Escalation Plans (TEPS) are fully completed to ensure patients' choices and preferences and ceilings of care are identified.
- It improves the premises for patients who are using Interventional Radiology, to make sure there is a suitable environment for patients to recover post procedure.
- Patients' records are stored securely at all times to prevent unauthorised access to them.
- It improves the experience of patients by addressing the high numbers of elective operations that have been cancelled.
- The critical care service improves the experience of patients by addressing the significantly high levels of discharge from the unit that are either delayed for more than four hours or happen at night.
- It provides a suitable environment for patients awaiting x-ray that will provide privacy and the ability to call for assistance if required.
- The environment and equipment on the delivery suite is fit for purpose and is able to be effectively cleaned and decontaminated to prevent the risk of cross

infection. The delivery suite did not comply with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.
- Care and treatment is provided in a safe way for patients by ensuring premises are safe to use for their intended purpose, that is cleaning materials and sharps materials are stored securely in areas that are not accessible to patients or visitors.
- There are sufficient resources to ensure the cleaning of blood and body fluid spillages does not pose a risk that clinical staff are unable to meet the clinical needs of patients in preference to cleaning
- The ratio of supervisor of midwives to midwives is at the recommended level of 1:15 (Midwifery Rules and Standards, rule 12, Nursing and Midwifery Council, 2014).
- Staff working in gynaecology are supported to have annual appraisals.
- Rooms used for recovery of children following procedures under general anaesthetic on the children's Outpatients Department meets laid down recommendations.
- The safety of adolescents with mental health issues when using any of the paediatric services at all times.
- All children using the acute or community paediatric services have a care plan in place that is updated at regular intervals or when changes occur to the child or young person.
- Systems and process are in place to manage the backlog of follow-up appointments and the backlog of imaging reporting, to mitigate the risks to patients of delayed diagnosis and treatment.
- Action plans are realistic and focused on the areas of concern in relation to the backlog of unreported scans in diagnostic imaging.

Action the hospital SHOULD take to improve

- Ensure adequate infection control processes are in place in the emergency department while alternate entry doors are in use.
- Ensure the safe storage of medical gases at all times.
- Review privacy arrangements for patients arriving in the emergency department, either through reception or via ambulance, awaiting investigations such as x rays and while in the 'corridor' area.
- Review the provision of translation services in the emergency department to ensure they can be provided in a timely manner.
- Review bereavement and viewing facilities within the department.
- Review the governance systems to improve the function, monitoring and learning from incidents, complaints and risks.
- Review nursing leadership within the CDU.
- Review the provision of a play specialist for the paediatric emergency department area.
- Ensure that the facilities for multi-faith prayer are large enough to enable Friday prayers for men and women and ensure the arrangements for ritual ablutions are appropriate.
- Ensure that patients' dignity and respect are considered in the arrangements for discreet use of lifts when transporting the deceased.
- Within critical care, review the nursing presence in case review and other relevant meetings. This is to ensure communication and learning from risk meetings is cascaded to the nursing team.
- Prioritise pressure area care within critical care to reduce the incidence of pressure ulcers. The target levels for patient harm from falls or pressure ulcers being considered as 'acceptable' at levels above zero should also be reviewed and reflected on. Data on venous thromboembolism (VTE) or urinary tract infection (UTIs) should also be captured in dashboard reports and incident data.
- Ensure the emergency equipment trolleys within critical care are of a type to make them easily differentiated from other trolleys in use. They should be sealed to prevent tampering, or show when equipment had been used but the trolley not replenished and resealed.
- Review the level of physiotherapy provided to general and neurosurgical critical care patients, as it did not meet recommended levels of the Faculty of Intensive Care Medicine for therapeutic treatments.
- Review the level of pharmacy support provided to general and neurosurgical critical care patients, as it did not meet recommended levels of the Faculty of Intensive Care Medicine.
- Review the professional development of the nursing team within critical care and ensure over 50% have a post-registration award in critical care nursing, as recommended for safe care by the Faculty of Intensive

Outstanding practice and areas for improvement

Care Medicine. Appraisal rates should be improved to trust levels and continuous professional development should be funded and included in this review, to ensure staff skills and rates of retention are continually improving.

- Produce a clear local audit calendar within critical care to meet the recommendations of the Faculty of Intensive Care Medicine, to ensure it analyses care effectiveness and outcomes and can identify where this is sub-optimal or of particular success.
- Decisions around consent, mental capacity assessments and the use of any deprivation of liberty or restraint should be improved in the critical care medical notes.
- Review the provision of mental health support given to patients and their families who are or have been patients in the critical care unit.
- Ensure all patient records on the delivery suite are stored securely and have accessible monthly midwife to birth ratio figures in order to be able to confidently audit and monitor safe staffing levels.
- Ensure the process for learning from incidents is embedded in practice at ward level.
- Ensure access to mental health services for women using the maternity service
- Ensure the information collated for the regional maternity dashboard can be displayed in a way which provides context and clarity. For example; the midwife to birth ratio figures for the trust were not easy to identify or to track any changes. This meant it was difficult to assess the how governance and quality standards had been monitored.
- Ensure a visible birth pool cleaning schedule is available, to show that it is clean and ready to use at any time, and ensure there is a an audit trail that this has been completed .
- Ensure staff have adequate guidance and equipment available at all times to enable the controlled removal of body fluid spillages to prevent risk of cross infection.
- Have a baby abduction policy, and review the policy and procedure for discharge of patients from the maternity unit.
- Patients and the public should have access to the ward patient safety information.
- Ensure that the dissemination of information from investigations following incident reporting should be communicated more thoroughly to support learning across the trust.
- Ensure that service specific mortality and morbidity meeting minutes are recorded in sufficient detail to enable any trends or issues to be identified, in order to take action or learning from the minutes.
- Ensure staff consistently complete infection control training and that patients with communicable infections requiring isolation are cared for in isolation.
- Ensure that there is evidence that up-to-date servicing and maintenance of equipment has taken place.
- Ensure that patients' personal and confidential information on computers and electronic systems is kept securely.
- Ensure risk assessments and care documentation for individual patients are consistently and appropriately completed by staff.
- Ensure that all staff are knowledgeable about the sepsis identification and management system in operation within the trust.
- Ensure that the system for advising staff of the medical cover for medical outliers is disseminated efficiently and to all staff.
- Ensure that the PALS department is able to respond promptly and efficiently to patients and visitors to the hospital.
- Ensure the milk kitchen is kept locked so it is not indiscriminately accessible to patients or visitors on Woodcock Ward.
- Review the caseloads of the diabetes service in the children's community nursing service in line with national guidance (RCN 2013).
- Review the standard operating procedures for Patient Group Directions used in Outpatients to ensure these comply with the legislation and best practice.
- Ensure that staff in outpatients have an adequate understanding of safeguarding to ensure that incidents are identified appropriately.
- Ensure that there is adequate and suitable seating available for patients waiting for an outpatient appointment and that these seating areas are not obstructed.
- Review the processes for the referral to diagnostic imaging scans, particularly in computed tomography to reduce the risks of patients receiving multiple scans.

Ensure that staff understand their role in relation to the responsibility, management and oversight of the risk registers throughout all levels of the organisation related to outpatients and diagnostic imaging.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 Good Governance 17(2) (a) There must be systems and process in place to monitor and improve the quality of and safety of services. Action plans to manage the backlog need to be focused and realistic in achieving what is required. Staff must be aware of their role in incident reporting and there must be systems to ensure trends and themes are monitored Systems to improve the quality and experience of patients must improve to address the high numbers of elective operations cancelled. 17 (2) (b) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; The processes and systems in place to identify and assess risks to the health and safety of people who use the service were not effective or timely. The numbers of patients at risk of harm due to the backlog of new and follow up appointments and delays in reporting of diagnostics was not fully understood by the provider. This placed patients at risk of harm due to delays in treatment and assessment. The processes and systems in place to identify and assess risks to the health and safety of people who use the service were not effective. The system used for booking operations failed to identify when mistakes were made resulting in patients being cancelled. This placed patients at risk of harm due to delays in their treatment. Patients were being cancelled for surgery and not being rebooked within the 28 day required timescale. Ensure

Requirement notices

there are systems in place so that the impact of system escalation does not delay patients who are cancelled at short notice and that they are re booked for their surgery within the 28 day requirement.

17(2)(c) must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Records must be stored securely at all times to prevent unauthorised access.

17(20(d) End of life decisions were not consistently recorded. We saw evidence of end of life decisions having been made without documentation of, or discussion with, patients. The Treatment Escalation Plans (TEP's) that included do not attempt cardio-pulmonary resuscitation (DNA CPR) decisions were not consistently being completed appropriately. Mental capacity assessments were not consistently undertaken to identify patients who lacked capacity to make decisions and so ensuring patients best interests were being served.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Person-centred care 9 (1) (a) and (b) The care and treatment of service users must – (a) be appropriate; and (b) meet their needs. Patients in the critical care service were not discharged from the unit onto wards when they were ready to leave. In the most recent data provided (the last quarter of the year 2014) around 70% of patients were delayed more than four hours. Patients in the critical care service were also discharged too often at night. In the most recent data provided (the last quarter of the year 2014) around 12% of all patients were discharged between 10pm and 7am when there are known risks associated with this.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	9(3) (a) Assessments of peoples care and treatment needs should include all their needs. Not all children in acute and community settings had a care plan in place that is updated at regular intervals when changes occur.
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Safe Care and Treatment 12- (1) Care and treatment must be provide in a safe way for service users. (2) Without limiting paragraph (1), the things which the registered person must do to comply with that paragraph include- (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experiences to do so safely; (d) ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way; (g) the proper safe management of medicines; (h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated 12 (2) Where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users. Care plans were either not in place or had not been updated to reflect the care and support required or risks that may be associated with the child or young person. 12 (2) (a) The processes and systems in place to identify persons at risk of harm in accordance with the Mental Capacity Act 2005 were not understood in the Chestnut Centre and Ophthalmology.

This section is primarily information for the provider

Requirement notices

12 (2) (b) The environment for patients waiting X-ray did not provide privacy or the ability for patients to call for assistance if required.

The rooms used for recovering children following procedures under general anaesthetic did not always provide line of sight to the trained nurse meaning that deterioration of the child may go unnoticed between nurses carrying out the required observations every five minutes.

The environment for patients who are using Interventional Radiology, must be suitable environment for patients to be recovered in post procedure.

12(2) (g) Staff were not administering medicines in line with NMC standards. Medicines such as intravenous fluids were not stored securely away from access by unauthorised people. Medicines used in obstetric theatres were not locked away when not in use. Policies for medication were not being followed in the outpatient department.

12(2) (h) The delivery suite was not able to be cleaned to an acceptable standard. All rooms were similar; with ripped wallpaper and exposed or missing plaster on the walls, chipped and raw wooden shelving, unfitted and damaged skirting and exposed drilling and fixings on walls where equipment had been removed and not recovered or resealed. Sinks were badly stained and none of the sinks had elbow operated taps. These did not comply with the Health technical memorandum 64, Note 00-10: Part C – Sanitary assemblies (DH, 2014). The radiator covers in the shared patient toilets (one between every two delivery rooms) were rusted.

The unsealed and damaged environment and equipment allowed debris and dirt to collect in areas and on surfaces. These and rusted components could not be cleaned effectively.

Cleaning materials and sharps materials were not stored securely in areas that were accessible to patients or visitors to wards and departments. The sluices contained cleaning materials that were accessible and needles were left on unsecured trolleys in ward corridors.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18:Staffing** 18-(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. Staffing levels did not always meet the ward / departments establishment of nursing staff. Due to the complexities of patients care needs, there were not always sufficient staff numbers on duty to meet their assessed care and treatment needs. The provider failed to deploy sufficient numbers of suitably qualified competent, skilled and experienced persons in outpatients and diagnostic imaging, the Emergency department, children's wards (Neonatal Intensive Care Unit (NICU), Children's Assessment Unit (CAU), Wildgoose Ward and Woodcock Ward) the maternity service, surgical wards and medical wards to make sure that peoples care and treatment needs were met. There were insufficient staff to address the backlog of reporting for diagnostic imaging scans. 18 (2) (a) Not all staff had sufficient knowledge of and implement the Mental Capacity Act in order that patients mental capacity is confirmed to identify patients who lacked capacity to make decisions and so ensure patients best interests were being served. The ratio of supervisor of midwives to midwives did not meet the recommended level of 1:15 (Midwifery Rules and Standards, rule 12, Nursing and Midwifery Council, 2014). Staff working in gynaecology were not supported to have annual appraisals.

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

This section is primarily information for the provider

Requirement notices

Regulation 15: Premises and equipment

15 (1) All premises and equipment used by the services provide must be: (a) clean (b) secure (C) suitable for the use for which they are being used, (d) properly used (e) properly maintained (f) and appropriately located for the use for which they are being used.

15 (1)(a) The environment and equipment on the delivery suite was not fit for purpose and was not able to be effectively cleaned and decontaminated to prevent the risk of cross infection. The delivery suite did not comply with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.

There were insufficient resources to ensure the cleaning of blood and body fluid spillages does not pose a risk that clinical staff are unable to meet the clinical needs of patients in preference to cleaning.

15 (1) (c) cleaning materials and sharps materials were not always stored securely in areas that are not accessible to patients or visitors to wards and departments.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10 : Dignity and respect 10 (1) Service users must be treated with dignity and respect The reception and waiting area in the emergency department did not comply with the disability discrimination act.