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 (including older people's care)	Good
Surgery	Good
Critical care	Good
Maternity and gynaecology	Good
Services for children and young people	Good
End of life care	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

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

During the previous inspection we rated the trust as requires improvement overall. The follow up inspection therefore focussed on those areas rated previously as requires improvement and inadequate.

During our inspection we inspected the following locations:

- Derriford Hospital
- Mount Gould Hospital

We inspected the following core services against the following domains:

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

We rated Derriford hospital as requires improvement overall taking into account the domains we inspected this time and the domains we inspected in 2015. There had been progress in many of the areas where improvements had been required at the previous inspection. The safe domain improved from requires improvement to good for, surgery, maternity, services for children and young people, in outpatients and diagnostic imaging the safe domain had improved from inadequate to good. The responsive domain has been rated as requires improvement overall which is again an improvement on the previous inspection where outpatients and diagnostics and urgent and emergency care were rated as inadequate in 2015. Outpatients and diagnostic imaging had improved from inadequate overall to good overall. Caring was not rated as part of this follow up inspection, but was rated as outstanding overall at the previous inspection in April 2015.

Our key findings were as follows:

Safe:

- There was a positive incident reporting culture with evidence of full investigations taking place and learning being identified and shared with staff to improve safety. Staff were confident in reporting incidents although in some areas, incidents were not graded appropriately.
- Staff were open and honest with patients and their relatives when anything went wrong. We saw evidence of people receiving a sincere and timely apology and being informed about actions taken to prevent future occurrences.
- There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse. All staff we spoke with had a good awareness of safeguarding legislation and many had been given prompt cards to assist them in the identification of abuse. Staff knew what to do when they suspected abuse.

Summary of findings

- Standards of hygiene were monitored by staff with specific roles in infection control and clinical areas were visibly clean, hygienic and well organised. Staff followed trust policies regarding infection control and routinely used protective personal equipment (PPE), hand gel and regularly washed their hands. Although in some areas, sharps waste was not always disposed of promptly, and chemicals were stored in ward areas which patients had access to. Where incidences of infection were found, appropriate action was taken to control it.
- Controlled drugs were stored and checked appropriately, and allergies were clearly recorded on medicine charts. Pharmacy staff worked with staff on the wards to ensure they were aware of safe protocols and any errors were highlighted as soon as possible. Following concerns raised at our last inspection in relation to insulin prescribing the trust had set up a working group to review their policies and procedures. However, intravenous fluids were not always being stored securely and medicines were not always secured on wards where patients were able to self-administer their medicines.
- Staffing levels and skill mix were planned and implemented to keep people safe at all times and staff shortages were monitored and acted on. Managers deployed staff flexibly to cover shortfalls where possible, however in some areas, large numbers of nursing vacancies meant wards were not always staffed to the agreed level. Some gaps were identified in medical rotas and the trust was taking action to minimise the risk, for example, the introduction of doctors' assistants had reduced the burden on junior doctors.
- The trust had set the target for mandatory training to 100%. In many areas this was being met, although in other areas, the figures ranged between 80% to 90%. Most staff we spoke with were aware of how and when to update their training, but in some areas, for example in maternity, clearer processes are required to identify the training needs of staff and compliance with those needs. Related to this, we found staff training was urgently required for emergency procedures using the birthing pool.
- Risk assessments, care plans, triage processes and the use of adult early warning scores kept people safe from the risk of harm, however, the use of a paediatric early warning score was inconsistent and did not ensure children at risk of deterioration were recognised and monitored accordingly. Following the last inspection there were concerns with regard to the insufficient number of child assessments and care plans that had been completed in the children's community nursing team. During this follow up inspection we found the issues had been resolved and patient records were maintained and monitored.
- In the majority of areas, care records were clear, contemporaneous, complete and signed. However in some areas, they were inconsistently completed, and for example in diagnostic imaging, not all images requiring documented evaluations had them recorded.
- Records were kept securely to maintain confidentiality and prevent tampering and were available for staff to view when required in most areas. In oncology outpatients however, we found that records were kept in unlocked trolleys in unlocked rooms overnight and on the paediatric ward, patient details were displayed on an electronic board which visitors could view, potentially compromising a child's confidentiality. In the emergency department, computers were not always logged out to prevent unauthorised access to patient identifiable information.
- Equipment for use in an emergency was regularly checked and prepared for use in all areas. We saw in some areas that faulty equipment had been replaced; however, a number of items had not been serviced within the recommended timescales.
- Improvements had been made to the environment in the clinical decisions unit; a new helipad had opened to provide safer and direct access for patients being transported by helicopter. Some ward areas had been refurbished to meet the needs of patients who lived with dementia, and delivery suite had been partially refurbished following concerns raised during the last inspection. However, there were no plans in place to complete the refurbishments on delivery suite. The emergency department remained cramped in a lot of areas and the paediatric unit was not secure.

Effective:

Summary of findings

- At this inspection we rated the effective domain in end of life care only which was rated previously as requires improvement. Although we inspected the effective domain in outpatient and diagnostic imaging service we did not rate them due to the lack of national data available to the CQC.
- Patient needs were assessed and treated in line with evidenced based guidance. In outpatients and diagnostics, we saw evidence of audit to ensure that practice was monitored ensuring consistency.
- Pain management and the management of nutrition and hydration was assessed, managed and recorded to ensure patients at the end of life were comfortable.
- Following the previous inspection a local 'quality improvements in environment' project had been undertaken. Areas of improvement were planned for example single rooms available for privacy for patients at the end of life, there was a timescale of five two years for the plan to be completed.
- End of life outcomes were monitored against national standards. Outcomes from previous audits had been used to make changes to patients care. There were some improvements seen from the 2016 National Care of the Dying Audit and an action plan put in place to focus on the areas which required further work.
- Ward staff had sufficient training and the ongoing support and help from the Specialist Palliative Care Team to deliver effective care and treatment. There had been an increase to seven day access to the Specialist Palliative Care Team.
- The multi-disciplinary working between the Specialist Palliative Care Team and the wider hospital and local community were outstanding. The integrated working supported continuity of care and prevented avoidable admissions to hospital.
- When people in outpatients and diagnostic imaging received care from a range of different staff, teams or services, this was coordinated well ensuring that all relevant teams were involved in the planning and delivery of peoples care and treatment. Staff discussed with inspectors how important it was to work collaboratively to meet the needs of the patient and could give us multiple examples where this was taking place.
- Improvements were seen in the completion of the Treatment Escalation Plans (TEP) but auditing of improvements was not yet fully completed. The management of Deprivation of Liberty safeguards ensured the safety of patients.
- In outpatients and diagnostic imaging, although most staff could access the information they needed to assess, plan and deliver care to people in a timely way there were still improvements to be made. Although the number had reduced significantly since our last inspection, there were still 2000 temporary notes in circulation meaning that treatment decisions were being made without all relevant clinical information. In diagnostic imaging although it had reduced significantly, there were still 2000 images requiring reporting on a backlog. These were being managed in a proactive way and work was still being done to reduce this.

Caring:

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

Responsive:

- Urgent and emergency care, surgery, outpatients and diagnostic imaging were all rated as requires improvement and medical care and critical care were rated good.
- There was a consistent failure to meet the four-hour performance standard in the emergency department, and frequent crowding was becoming "normalised", although the department had called a risk summit with relevant senior managers and hospital executives to raise their concerns and seek trust-wide solutions to the impact of crowding.
- The trust breached the 18-week referral to treatment target operational standard across all surgical specialties, apart from plastic surgery, from March 2015 to June 2015, when the target was abolished by the government (the operational standard is still used by the majority of trusts to monitor their performance). By February 2016, only one surgical speciality was meeting the abolished operational standard and that was plastic surgery. Performance had deteriorated to under 50% for neurosurgery. Over the entire period, all specialties except for plastic surgery performed below the England average.

Summary of findings

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

improvements in the general/neurosurgical unit, which was discharging fewer patients at night, and this was continuing to improve. There were almost no patients transferred to another hospital due to lack of a critical care bed. There was a high level of flexibility and response from the teams, and patients were admitted to the units when they needed urgent and emergency care.

Well led:

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

We saw several areas of outstanding practice including:

- A new role had been developed within the acute medical units and the short stay ward to enable medicines for patients discharges to be prepared more efficiently. A pharmacy technician was seen to work proactively and support ward staff with monitoring the prescribing, preparation and delivery of medicines for patients being discharged.
- The access for patients to receive care and treatment on the stroke pathway had improved since our last inspection. The staff team were proactive and consistently reviewed their practice to speed up the time from patient arrival to treatment. We saw evidence of where patients had been taken straight to specific treatment areas and were in receipt of treatment in very short timescales. The staff team reviewed patient treatment pathways with a view to looking at where time could be saved and where any marginal gains could improve patient outcome.
- There had been an outstanding response from the critical care teams and the hospital trust to those areas of concern raised in our previous report. The areas we said the trust must or should improve had all been addressed. Not all were fully completed, particularly where funding was an element of the project, but there had been significant improvement in all areas to patient care, treatment and support.

Summary of findings

- The multi-disciplinary working between the hospital and the community services providing end of life care was outstanding. There were processes in place to enable ongoing monitoring of patients in the community and where possible prevent avoidable admissions to hospital.
- The multi-disciplinary working between the hospital staff and the chaplaincy enabled the ongoing parochial and spiritual support of patients and their families at the end of life. Staff felt supported by the chaplaincy and the support provided to patients, whilst not always recorded, was creative in its endeavour to meet the needs of patients at the end of life.
- The use of prompt cards in outpatient areas to give staff easy access to phone numbers and processes involving safeguarding and the management of patients with complex needs.
- The training provided to vascular surgeon trainees by the radiologists to ensure a good understanding of the risks associated with the use of radiation.
- The use of radiologists on the critical care unit to ensure instant information to the clinicians on the unit and to have quick reporting times and added opportunities for learning.
- The use of a mobile phone application in the psychology service to assist in patient initiated contact clinics. This reduced the demand for the clinics and encouraged patients to manage their own care.
- Utilising a patient liaison radiographer to facilitate 'first day chats' in radiotherapy giving more time to patients and to allow the treatment radiographers to have a lessened workload and to ensure the smooth running of the radiotherapy machines.
- The audit processes used (through the fundamentals of care audit and the departmental nursing assessment and assurance framework) to gain oversight and assurance of individual outpatient clinics and diagnostic imaging areas adherence with the regulations in the health and social care act 2010.
- The pathway for patients requiring live-donor kidney transplantation in diagnostic imaging. This ensured that all pre-operative procedures (including a nuclear medicine scan, a chest X-ray, an ultrasound scan and blood tests) completed on one day.
- The diagnostic imaging department achieving Imaging Services Accreditation Scheme accreditation and having ISO accreditation recertified.

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

Importantly, the trust must:

- Formalise the recordings of meetings in the emergency department to ensure adequate assurance that the relevant persons are attending and discussions are held to identify learning points. Also ensure actions are recorded and allocated to a person who can progress the actions and progress is monitored.
- Review performance data in the emergency department to ensure it is accurately captured and reported, allowing adequate monitoring and scrutiny.
- Ensure safeguarding training for staff in the emergency department and across all areas is completed to ensure trust compliance targets are met.
- Ensure the paediatric early warning score is implemented fully and used consistently to ensure children are safely assessed and managed.
- Continue to work with commissioners and the local mental health service provider to ensure mental health patients arriving at the emergency department receive the care they require in a timely manner.
- Continue to ensure the emergency department's four-hour performance improves, with an ultimate aim to achieve the 95% standard.
- Review the storage of intravenous fluids in the emergency department to prevent tampering.
- Ensure that equipment stored on wards and in corridors does not obstruct or impede the access to and through fire exits.
- Ensure all equipment in all areas, and specifically the emergency department, is maintained in accordance with the trust's service schedule. Provide a system to adequately monitor and report on this.

Summary of findings

- Review the available storage to patients who self-medicate and retain their own medicines on the wards.
- Make sure that medical records are stored securely overnight in the oncology outpatients department.
- Ensure audit programmes associated with end of life care carried out in line with the plan and that actions and improvements are reviewed.
- Reduce the number of clinics cancelled and capture the reasons why.

In addition Action the hospital SHOULD take to improve includes:

- Translate the vision and values of the organisation and service lines into clear, credible, and well defined objectives for outpatients which are regularly reviewed and remain relevant and achievable.
- Review governance processes within the emergency department to ensure full integration between the medical and nursing teams.
- Strengthen the nursing oversight of the whole emergency department, including majors, minors, resuscitation and the clinical decisions unit for each shift.
- Ensure incidents reported in the emergency department are correctly graded in the severity field.
- Encourage staff to report mixed-sex breaches.
- Use clearer processes in order to be able to identify and evidence, at all times, the percentage of staff across the trust who were compliant with mandatory and role specific training. This would also provide greater safety assurance at service line, care group and trust levels that governance information was reliable and valid.
- Ensure that all wards and departments are adequately staffed.
- Review why surgery has the most complaints
- Consider staffing allocation to allow for management and supervision from senior staff in all paediatric areas.
- Review the arrangements for speech and language accessibility over the weekend to ensure that patients do not remain nil by mouth as a result of waiting for a swallowing assessment.
- Plan to risk assess the impact of the location of the proposed cardiac catheter laboratory, reflecting on the patient journey and pathway.
- Review the environment regarding the safety of patients admitted to wards and departments living with mental illness and especially with the risk of self-harming.
- Continue with the action plan to reduce their referral to treatment times in all surgical specialities.
- Continue to look at ways of reducing the number of cancelled operations and the numbers not re-booked within the 28-day time scale.
- Continue to look at ways of reducing the number of patients who have been waiting for operations longer than 52 weeks.
- Ensure that theatre lists are finalised at 3pm the day before the operations are due to take place.
- Continue to make improvements on the follow up backlog waiting list to meet people's needs and minimise risk and harm caused to patients through excessive waits on follow up of outpatient appointments and excessive waits on the reporting of images.
- Put process in place that ensure all diagnostic imagines that required documented evaluations have one.
- Review the paediatric unit in the emergency department to ensure it is adequately secure to keep children safe.
- Ensure patients in the minors' waiting area in the emergency department are observed so any deterioration can be quickly responded to.
- Ensure all patients awaiting X-ray in the emergency department who are not escorted have access to the portable call bell in accordance with the department's standard operating procedure.
- Ensure patients arriving at the emergency department by ambulance are protected from the elements as best as possible.
- Review the transfer team in the emergency department to ensure that when patients are transferred to a ward a clinically safe handover is completed in all cases.

Summary of findings

- Review the hospital's procedure for crowding in the emergency department to include the actions required by the wider hospital in order to support safe patient care.
- Review plans to increase the space in the emergency department to consider how crowding can be reduced and patient flow improved within current financial constraints.
- Progress the work to install an adequate area for the preparation of medicines in the resuscitation area of the emergency department.
- Ensure wasted controlled drugs in the emergency department are disposed of in accordance with trust policy.
- Ensure that medicine trolleys are not left unattended when unlocked and that medicines are secured at all times.
- Ensure height and weight measurements of children are readily available for staff prescribing medications.
- Ensure only current medicine guidance is available in all paediatric areas.
- Review and upgrade computer systems in the emergency department to allow integration with wider hospital systems.
- Ensure computer records are adequately secured when computers are left unattended to prevent unauthorised access.
- Ensure that patient records are consistently completed and are kept up to date.
- Ensure patient details in children's and young people's services are kept confidential and that only authorised personnel are able to access details of care.
- Ensure that where registered nurses were required to countersign the work of health care assistants this is consistently carried out.
- Ensure that all chemicals are secured and not accessible to patients and visitors to wards and departments. Clinical waste including sharps bins should be sealed and dated correctly and removed from the wards promptly.
- Review the layout of wards which had six beds to a bay as in some areas this impeded access to hand washing facilities and clinical waste bins thus potentially compromising the control and prevention of infection.
- The maternity services should ensure the birth pool cleaning policy demonstrates compliance with any manufactures guidelines and recommendations and incorporates any further recommendations from the trusts infection control lead.
- Review the signage for the ambulatory care unit as it was not clear from the main hospital corridors.
- Ensure staff in the emergency department all have name badges which include the role they are in. Consideration should also be given to providing patients with a leaflet that details the different types of uniforms and what they designate.
- Make sure chemicals and substances that are hazardous to health are secured and not accessible to patients and visitors in the Fal unit sluice area.
- Make sure the resuscitation trolley and equipment identified in theatres as needing service in April 2016 is now serviced.
- Make sure the equipment log is up to date with all servicing of equipment.
- The oxygen cylinder for use in emergencies, kept at the Child Development Centre, should be portable and safe for staff to move.
- Make sure that all staff ideas are listened to and reasons given if they cannot be actioned.
- Continue to pursue (with clinical commissioning groups) the development of a dedicated service in line with NICE guidance CG83 to support patients and those close to them in both general/neurosurgical and cardiac critical care with their psychological and psychosocial needs.
- Complete progress to allow the cardiac critical care service to contribute to the Intensive Care National Audit and Research Centre in order to obtain and learn from valuable benchmarking against other similar units.
- Ensure all patients in the cardiac critical care unit are able to see a clock from their bed.
- Improve the trust website so it has helpful and important information about the critical care services at the hospital.
- Should complete all outstanding refurbishments required on the delivery suite. This includes the remaining nine birth rooms, and the bathrooms and toilets which were shared between patients.
- Should clean the windows on the delivery suite.

Summary of findings

- Should provide more equipment to promote normalising birth and movement during labour and to aid pain relief.
- Consider how to raise an alert to potential safeguarding issues if parents or their children do not book appointments that have been professionally advised.
- Consider how they manage and mitigate the risk to lone workers.
- Consider in-house provision of physical intervention trainers to ensure appropriate staff in the children and young people's service are fully trained.
- Ensure that local audits for the 'Last days of Life Care Plan' are put in place to provide evidence or any changes needed in practice.
- Ensure the ongoing completion of plans in place to develop rooms for privacy for patients at the end of life and suitable environments for private discussion and the delivery of bad news.
- Ensure improvements identified by the end of life 'quality improvement in the environment' project have timescales for completion which will enable patients and families to have a better experience

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 	In the emergency department we found: • Although mortality and morbidity reviews were taking place, there was little evidence of the learning and actions put in place following these. • The environment in the department remained cramped in a lot of areas, the paediatric unit was not secure and a large amount of equipment had not been serviced. • Due to a lack of finances within the hospital the business plan to expand and redesign the emergency department had been put on hold. • Recording of meetings was historically inconsistent, with limited details being captured in meeting minutes, although this had improved over recent months. • There was some disconnect between the medical and nursing leadership in relation to governance processes. • Some staff felt disengaged because they were unable to stay updated or check and respond to emails while at work due to time pressures. • There was a consistent failure to meet the four hour performance standard, and frequent crowding was becoming “normalised”. • Patients’ needs were not always being met, particularly in respect of mental health patients and those patients being held in the central ‘corridor’ area. • Information technology systems were not integrated and delayed access to some services, particularly computerised tomography. • There was no discharge checklist to ensure patients were only discharged if appropriate, or for staff to identify alternative care pathways if discharge was not appropriate but admission was not required. • Complaint responses were not completed in a timely manner. However:

Summary of findings

- There was a positive incident reporting culture and learning was identified and shared with staff to improve safety. Staff were open, honest and provided apologies and explanations when things went wrong.
- The department was visibly clean and organised and staff adhered to infection prevention and control procedures to keep patients safe.
- Improvements had been made to the environment in the clinical decisions unit, a new helipad had opened to provide safer and direct access for patients being transported by helicopter, and emergency equipment was regularly checked and readily available.
- Controlled drugs were stored and checked appropriately, and allergies were clearly recorded on medicine charts.
- Care records were clear, contemporaneous, complete and signed. They were stored appropriately to prevent tampering and unauthorised access.
- Staff were aware of their responsibilities with regard to safeguarding adults and children, and concerns were reported accurately and in a timely manner.
- Risk assessments, care plans, triage processes and the use of adult early warning scores kept people safe from the risk of harm.
- Nursing and medical staffing had been strengthened and plans were in place to further increase numbers.
- There was a clear vision and strategy for the department that included actions needed to meet performance standards and provide safe, effective and responsive care.
- Governance structures and processes were being used to monitor and improve safety and quality.
- Staff were kept informed and updated about relevant risks and the actions being taken to mitigate them. They were encouraged to share their experiences of what went well and what could be done better.
- Staff felt respected and valued, spoke about an open culture and told us they were well-supported by their approachable leaders.

- Some innovation and improvement projects had been completed and were delivering improved services.
- The department had called a risk summit with relevant senior managers and hospital executives to raise their concerns and seek trust-wide solutions to the impact of crowding.
- Improvements had been made to the reception desk to accommodate wheelchair users.
- A new helipad improved the service provided to patients arriving by helicopter.
- The department had access to a rapid admissions avoidance response team who worked to support elderly patients who were unable to cope at home but did not require admission to hospital.
- Patients with learning disabilities were well-supported.

Medical care (including older people's care)

Good

We rated the medical services as good overall although the safe domain was rated as requires improvement.
This was because:

- There were large numbers of nursing vacancies on the wards and departments which meant wards were often staffed below the agreed establishment level.
- Infection control procedures were not always followed promptly regarding the disposal of sharps waste. Not all chemicals were secured in ward areas which patients had access to.
- Patients living with some specific mental illnesses were at risk in some areas of the hospital due to the ligature point risks identified.
- Medicines were not always secured on the ward when patients were enabled to self-administer their medicines.
- Care records were not consistently completed to demonstrate the care and treatment provided to patients.

However:

- Staff reported incidents and were confident that action would be taken to address concerns.

Summary of findings

- The numbers of patients experiencing harm from pressure damage or falls whilst in hospital had reduced.
- Clinical areas were visibly clean and hygienic. Staff followed trust policies regarding infection control and routinely used personal protective equipment such as gloves and aprons, hand gel and regularly washed their hands.
- Equipment for use in an emergency was regularly checked and prepared for use.
- The environment had been refurbished to meet the needs of patients who lived with dementia.
- Staff were knowledgeable on the procedures and actions to take to safeguard patients.
- The numbers of medical outliers had reduced since our last inspection as the trust had provided additional medical beds. This meant that patients received a responsive service and their access to medical staff had improved.
- The trust had developed services to be more accessible to local people and reduce waiting list times.
- The numbers of patients experiencing multiple moves between wards had reduced since our last inspection. Patients did not experience moves late at night as frequently as at our last inspection.
- The acute stroke pathway was responsive to the needs of patients and staff provided a proactive service to ensure patients were assessed and treated promptly on arrival at the hospital.

Surgery

Good

We rated surgery services as good although responsive was rated as requires improvement because:

- The trust breached the 18-week referral to treatment target operational standard across all surgical specialties, apart from plastic surgery, from March 2015 to June 2015, when the target was abolished by the goverment (the operational standard is still used by the majority of trusts to monitor their performance). By February 2016, only one surgical speciality was meeting the abolished operational standard and that was plastic surgery. Performance had

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

- Since our last inspection in April 2015 the number of cancelled operations had risen. The percentage of patients not treated within 28 days of a cancelled operation had also risen. The trust told us they had 67 patients who were waiting 52 weeks or more for some surgery. Of these, 37 had not been given a date for their operation.
- There were periods of understaffing on the surgical wards and theatres where the trust's safer staffing numbers of qualified nurses were not met. Additional non-qualified staff were used at times to cover any gaps in the rota. However, the trust was working hard to address these shortfalls.
- Mandatory training for all staff was not meeting the trust's target.
- Due to pressure for their beds and the demand for their services, some patients had to use facilities and premises not appropriate for the services being provided.
- We found at our last inspection the theatre scheduling system for operating lists were not being managed to make sure they were being utilised effectively, for example, late starts and lists were under or over-populated. The trust had started to implement a new computer system but work was still needed on this. Theatre lists were being reviewed seven days in advance and a daily meeting was taking place within theatres to review lists for the next day. However, not all of the operations lists were finalised and patients were often added after these meetings, which caused issues with staffing and equipment.

However:

- The trust encouraged openness and transparency about incident reporting and incidents were viewed as a learning opportunity. Staff felt confident in raising concerns and reporting incidents. At this inspection we found there had been an improvement in the reporting of incidents by junior doctors.

Summary of findings

- The trust had introduced doctors' assistants since our last inspection to help reduce the junior doctors' workloads. The feedback we received was that this was working well and junior doctors felt they had more time to diagnose and treat patients.
- At our last inspection patient records were not being stored securely meaning there was a potential risk of access by unauthorised people. This had been addressed at this inspection and all patient notes were stored in locked cupboards.
- At our previous inspection we identified concerns with how insulin was being prescribed by junior doctors. The trust had set up a 'Safer Insulin Group' to review their policies and procedures, which was ongoing. We had no reports of errors from staff at this inspection.
- The environment in the interventional radiology department was highlighted at our last inspection due to lack of space, privacy and dignity for patients pre and post-procedure. Since then staff told us that patients who had a general anaesthetic were recovered in theatres main recovery. A curtained area had been provided to screen patients from the corridor. The trust had plans in place for a major refurbishment but these were several years away from completion.
- Leadership of the surgical care group was good and a cohesive clinical governance structure showed learning, change and improvement took place. Managers regularly reviewed the approach to risk management in their specialities. A number of specialty meetings fed into the overall clinical governance systems and provided board assurance.

Critical care

Good

We have rated the responsiveness of the critical care service as good because:

- The services were planned and delivered to meet people's needs and co-existing conditions. The services met with local clinical commissioning groups to plan, evolve and improve their services.

Summary of findings

- There were arrangements for relatives to stay close to the hospital in purpose-provided accommodation. They had access to facilities, including food and drink, and extensive information in bedside folders about all services within the hospital and the wider community.
- In accordance with specialist guidance, a consultant reviewed patients in both the critical care units within 12 hours of their admission.
- A productive and efficient working relationship had been established between the general/ neurosurgical critical care team and the bed management team. This had brought the issues affecting critical care more to the fore and improved access and flow for patients. Cardiac services had been reconfigured to improve delays, access and flow.
- The general/neurosurgical unit had made good progress to reducing the number of patients discharged at night. This was continuing to improve.
- There had been significant progress in reducing the delays in discharging patients from the general/neurosurgical unit. The results showed the unit was now below (better than) the average for similar units for delayed discharges.
- There had been productive consultations between medical teams, and improvements and adaptations to operating theatre lists to help with access and flow in the general/ neurosurgical unit. This had led to new efficiencies and reduced the number of operations cancelled due to lack of a critical care bed. There had also been work undertaken to adapt clinical pathways in cardiac services, and find alternatives to admission to critical care.
- There were almost no patients transferred to another hospital due to lack of a critical care bed. There had been a high level of flexibility and response from the critical care teams to enable almost all patients to be admitted to the units when they needed urgent and emergency care.

- The individual needs of patients were taken into account and patients were well supported. Care was tailored to the needs of patients, and their preferences and circumstances were understood and acknowledged.
- Complaints were listened and responded to, and used to improve patient care and support.
- Patients and their relatives were included in feedback and investigations of complaints, and told when practice had changed because of their input.

However:

- The critical care services had yet to establish the dedicated psychology service, although had made good progress with commissioners, and already obtained partial funding for the new services.
- The cardiac critical care unit had yet to contribute to the Intensive Care National Audit and Research Centre in order to obtain and learn from valuable benchmarking against other similar units. This had been recognised, and work towards producing data was underway.

Maternity and gynaecology

Good

We have rated the maternity and gynaecology services as safe because:

- The delivery suite was consultant led and able to support women with high risk pregnancies or complex health. Patients assessed as having low risks were appropriately supported by midwives.
- Staff were knowledgeable about incidents and learning from these was demonstrated.
- Patients had risk assessments completed and reviewed regularly.
- There were established and thorough safeguarding systems in place to protect vulnerable adults and children.
- The delivery suite had been partially refurbished and some faulty equipment had been replaced, which enabled more effective cleaning.
- Records and medicines were safely stored and equipment had been regularly checked.
- Discharge processes had not been reviewed but this was promptly amended during out inspection.

Summary of findings

However:

- The maternity services should have clearer processes in place in order to be able to identify the percentage of staff who were compliant with mandatory and other safety training. Related to this, we found staff training was urgently required for emergency procedures using the birthing pool.
- There were no plans in place to complete the refurbishments on the delivery suite.
- The cleaning policy and procedure for the birth pool required reviewing.

Services for children and young people

Good

We have rated the safety of services for children and young people as good because:

- There were processes to report incidents with details of full investigations having been completed where appropriate. Learning points were shared with staff. Staff were confident in reporting incidents and always received feedback on progress of the investigations. Staff described being open and honest with patients and their relatives when anything went wrong.
- Standards of hygiene were monitored by staff with specific roles in infection control and areas we visited were visibly clean. Where incidences of infection were found, appropriate action was taken to control it.
- Medicine storage, prescribing and administration was managed to ensure children and young people received the correct medicines at the correct time. Pharmacy staff worked with staff on the paediatric wards to ensure staff were aware of safe protocols and any errors were highlighted as soon as possible.
- Children's weights were available in most cases for staff to prescribe appropriately.
- Safety audits were viewed by the management team to identify areas where practice needed to be improved with actions for monitoring progress.
- Records were kept securely to maintain confidentiality for the patient but were available for staff to view when required.

Summary of findings

- Staff were aware of safeguarding processes and knew how and when to ask for supervision or support.
- Risks to patient safety were identified and reported to senior managers and actions were taken where possible. The last inspection had highlighted concerns over observations of oncology patients following cancer treatment procedures. Delivery of care to these patients had been reorganised and observations were now happening. Risks for children and young people who may harm themselves had been assessed and reduced by adapting the facilities and environment. For example, a room had been identified that was safe for young people to stay in and calm down and ligature risks had been removed. This room also protected children from witnessing disturbing behaviour.
- Emergency equipment appropriate for all ages of children and young people was available for use.
- Numbers of appropriately qualified staff on the ward areas we visited met the levels set out in national guidance. Managers achieved this by using staff flexibly across the paediatric areas. Staffing levels were monitored using a tool to assess how many staff were required to provide care for the number of patients and the level of care they needed.
- Medical staff ensured there were enough senior staff to provide expertise and advice for paediatric care. Medical staff were also providing specialist safeguarding clinics five days a week.
- The community paediatrics team provided a safe 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 workforce at the Child Development Centre and by the children's community nursing service. When clinically required, a visit was carried out at a child's home, nursery, school or other locality setting. This minimised the need for multiple appointments, and duplication of history-taking and documentation.

Summary of findings

- Following the last inspection there were concerns with regard to the insufficient number of child assessments and care plans that had been completed in the children's community nursing team. During this follow up inspection we found the issues had been resolved and patient records were maintained and monitored.

However:

- Safeguarding update training for staff was at 91% which was not compliant with the 100% trust target. There were plans to enable staff to attend this training.
- Mandatory training for staff in one subject area was 80% which was below the trust target level of 100% compliance, although staff we spoke with were aware of when and how to update their training.
- Two pieces of equipment we saw indicated they had not been serviced within recommended timescales.
- In one area we visited there was an out of date Children's British National Formulary alongside the current version creating a risk of staff using outdated prescribing information.
- Patient details were displayed on an electronic board where visitors could view it which could compromise a child's privacy.
- Children and young people needing more intensive support from child and adolescent mental health services were cared for on the ward until a bed became available.
- An oxygen cylinder for emergency use in a community setting was not easily portable.

End of life care

Good

We have rated the service as good for effective because:

- Patient needs were assessed and treated in line with evidenced based guidance. Pain management and the management of nutrition and hydration was assessed, managed and recorded to ensure patients at the end of life were comfortable.
- Following the previous inspection a local quality improvements in environment project had been

undertaken. Areas of improvement were planned, for example single rooms available for privacy for patients at the end of life. The timescale for completion was two years.

- End of life outcomes were monitored against national standards. Outcomes from previous audits had been used to make changes to patients care.
- Ward staff had sufficient training and the ongoing support and help from the Specialist Palliative care Team to deliver effective care and treatment. Access to the specialist palliative care team had increased to seven days a week.
- The multi-disciplinary working between the Specialist Palliative Care Team and the wider hospital and local community were outstanding. The integrated working supported a continuity of care and the prevention of avoidable admissions.
- Improvements were seen in the completion of the Treatment Escalation Plans (TEP) but auditing of improvements was not yet fully completed. The management of Deprivation of Liberty safeguards ensured the safety of patients.

Outpatients and diagnostic imaging

Good

We rated the outpatients and diagnostic imaging service as good overall and as requires improvement for responsive because:

- We found that some medical records were not being stored securely overnight in the oncology outpatients department.
- With limited capacity within the outpatients unit, people were still waiting too long for a follow up appointment in outpatients increasing the risk of harm being caused as a result of waiting.
- The strategy for outpatient services was not well represented in service line strategy's meaning that there were limited well defined objectives based on the trusts vision and values.
- We found that although there were still people waiting too long for their follow up appointment the numbers of patients waiting had significantly reduced with work ongoing to reduce this further. Innovative approaches to care, such as overbooking and patient initiated contact had

reduced waiting lists by thousands of patients making the demand more manageable. We also saw that clinics were being well utilised with minimum clinic spaces not being used.

- There were innovative approaches to managing the capacity and demand of outpatient's clinics which was under constant review and scrutiny from senior managers. We were told by senior managers that the Director of Transformation was having a hugely positive impact on facilitating changes within the outpatients service.
- There was an open and honest safety reporting culture which all staff were engaged with. All staff we spoke with were able to describe their responsibilities to report incidents, could give examples when they last reported an incident and could describe learning from incidents which were shared in several forums.
- Although some service lines had minimal vacancies most were fully staffed and staff were able to utilise their time well to manage the needs of patients. Staff records showed that mandatory training rates were the highest in the trust (although slightly below the trusts target of 100%). Access to additional training and competencies was good and appraisal rates were high.
- There was a positive patient centred culture within the outpatient and diagnostic imaging services with many areas being designed to support people living with dementia or learning difficulties. Some areas such as MRI and the physiotherapy department had made changes to support bariatric patients. All staff were trained in dementia (as part of their mandatory training) and staff in outpatients used prompt cards to access support services such as the learning disability team, dementia team and safeguarding teams.
- The trust had good oversight of compliance with the health and social care act 2010 regulations through the use of 'fundamentals of care' and the 'Departmental Nursing Assessment and Assurance Framework' to gain assurance of individual clinics.

Summary of findings

However:

- We found that although there were still people waiting too long for their follow up appointment the numbers of patients waiting had significantly reduced with work ongoing to reduce this further. Innovative approaches to care, such as overbooking and patient initiated contact had reduced waiting lists by thousands of patients making the demand more manageable. We also saw that clinics were being well utilised with minimum clinic spaces not being used.
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Summary of findings

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Derriford Hospital

Detailed findings

Services we looked at
Urgent and 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 and 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 has an integrated Ministry of Defence Hospital Unit which has a staff of approximately 150 military personnel who work within a variety of posts from lead doctors to trainee medical assistants

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

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

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

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

The trust has 12 registered locations:

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

The trust has 1,055 beds consisting of:

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

There are 5,861.63 whole time equivalent staff employed at the trust, consisting of:

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

Secondary care services include emergency and trauma services, maternity services, paediatrics and a full range of diagnostic, medical and surgical sub-specialties. Specialist services include kidney transplantation,neurosurgery, pancreatic cancer surgery,

Detailed findings

cardiothoracic surgery, bone marrow transplant, upper GI surgery, hepatobiliary surgery, plastic surgery, liver transplant evaluation, stereotactic radiosurgery and high risk obstetrics. The trust is a designated cancer centre, major trauma centre and level 3 neonatal care provider.

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

Our inspection team

Our inspection team was led by:

Chair: Jan Filochowski, retired NHS chief executive.

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

The team included CQC inspection managers, inspectors, assistant inspectors and a variety of specialists:

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

How we carried out this inspection

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

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

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

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

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

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

Detailed findings

Facts and data about Derriford Hospital

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

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

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

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

Inspection history:

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

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

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

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.
2. We only inspected and rated the domains of core services that required improvement from the previous inspection in 2015. However we have aggregated the ratings from the previous inspection to give an overall rating for each core service and Derriford hospital.

Urgent and emergency services

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

Information about the service

Urgent and emergency care and treatment is provided by Plymouth Hospitals NHS Trust on the Derriford Hospital site. There is an emergency department operating 24-hours-a-day, seven-days-a-week. In the year 2015/16 the department saw 77,331 adult patients and 17,013 children. Weekly attendance numbers ranged between 1,598 and 1,962.

The emergency department is a designated major trauma centre for adults, providing care for the most severely injured trauma patients from across the south west. Additionally, the department provides trauma unit facilities for children, meaning it can receive and stabilise children prior to them being transferred to an appropriate paediatric major trauma centre.

There are separate entrances for ambulance patients and those who make their own way to the department. The reception has a seated waiting area and a glass-fronted reception desk with a lowered counter for wheelchair users.

A separate seated waiting area exists for patients requiring assessment and treatment of minor illness or injury. The minor illness and injury treatment area has two cubicles for triage, five cubicles for treatment and two cubicles dedicated to fast assessment and treatment.

Within the major illness and injury treatment area there are 17 cubicles and four resuscitation bays in a separate resuscitation area, one of which is designated for children if required. Within the resuscitation area there is an overhead X-ray facility.

There is a small paediatric area, including a children's waiting area and three treatment rooms. This area is open between 10am and 2am.

A 10-bedded clinical decision unit is located within the department, split into two bays of four and six beds. This unit also has a seated waiting area/lounge and a dedicated mental health assessment room.

We visited the department on Wednesday 20 and Thursday 21 July 2016 as part of an announced inspection at the hospital to follow-up on areas for improvement that had been identified during our previous inspection in May 2015. We also undertook an unannounced inspection on Friday 12 August 2016.

We only inspected the safe, responsive and well-led domains as these were the areas of concern following the inspection in 2015. The 2015 inspection found the service to require improvement in the safe and well-led domains, and to be inadequate in the responsive domain.

During our inspection we spoke with 46 staff, including doctors, nurses, managers, support staff, allied health professionals and ambulance staff. We also spoke with five patients and relatives and reviewed 16 care records. We observed care and treatment, handovers and meetings, and reviewed data about the department received before, during and after the inspection.

Urgent and emergency services

Summary of findings

In the emergency department we found:

- Incidents were not always graded correctly on the incident reporting system.
- Although mortality and morbidity reviews were taking place, there was little evidence of the learning and actions put in place following these.
- The environment in the department remained cramped in a lot of areas, the paediatric unit was not secure and a large amount of equipment had not been serviced.
- Due to a lack of finances within the hospital the business plan to expand and redesign the emergency department had been put on hold.
- Recording of meetings was historically inconsistent, with limited details being captured in meeting minutes, although this had improved over recent months.
- There was some disconnect between the medical and nursing leadership in relation to governance processes.
- Some staff felt disengaged because they were unable to stay updated or check and respond to emails while at work due to time pressures.
- There was a consistent failure to meet the four hour performance standard, and frequent crowding was becoming "normalised".
- Patients' needs were not always being met, particularly in respect of mental health patients and those patients being held in the central 'corridor' area.
- Information technology systems were not integrated and delayed access to some services, particularly computerised tomography.
- Complaint responses were not completed in a timely manner.

However:

- There was a positive incident reporting culture and learning was identified and shared with staff to improve safety. Staff were open, honest and provided apologies and explanations when things went wrong.
- The department was visibly clean and organised and staff adhered to infection prevention and control procedures to keep patients safe.
- Improvements had been made to the environment in the clinical decisions unit, a new helipad had opened to provide safer and direct access for patients being transported by helicopter, and emergency equipment was regularly checked and readily available.
- Controlled drugs were stored and checked appropriately, and allergies were clearly recorded on medicine charts.
- Care records were clear, contemporaneous, complete and signed. They were stored appropriately to prevent tampering and unauthorised access.
- Staff were aware of their responsibilities with regard to safeguarding adults and children, and concerns were reported accurately and in a timely manner.
- Risk assessments, care plans, triage processes and the use of adult early warning scores kept people safe from the risk of harm.
- Nursing and medical staffing had been strengthened and plans were in place to further increase numbers.
- There was a clear vision and strategy for the department that included actions needed to meet performance standards and provide safe, effective and responsive care.
- Governance structures and processes were being used to monitor and improve safety and quality.
- Staff were kept informed and updated about relevant risks and the actions being taken to mitigate them. They were encouraged to share their experiences of what went well and what could be done better.
- Staff felt respected and valued, spoke about an open culture and told us they were well-supported by their approachable leaders.
- Some innovation and improvement projects had been completed and were delivering improved services.
- The department had called a risk summit with relevant senior managers and hospital executives to raise their concerns and seek trust-wide solutions to the impact of crowding.
- Improvements had been made to the reception desk to accommodate wheelchair users.
- A new helipad improved the service provided to patients arriving by helicopter.

Urgent and emergency services

- The department had access to a rapid admissions avoidance response team who worked to support elderly patients who were unable to cope at home but did not require admission to hospital.
- Patients with learning disabilities were well-supported.

Are urgent and emergency services safe?

Requires improvement

We have rated the safety of the emergency department as requires improvement because:

- Incidents were not always graded correctly on the incident reporting system.
- Although mortality and morbidity reviews were taking place, there was little evidence of the learning and actions put in place following these.
- The environment in the department remained cramped in a lot of areas, the paediatric unit was not secure and a large amount of equipment had not been serviced.
- Intravenous fluids were not being stored securely.
- Computers were not always logged out to prevent unauthorised access to patient identifiable information.
- The use of a paediatric early warning score was inconsistent and did not ensure children at risk of deterioration were recognised and monitored accordingly.
- There was a lack of senior nursing shift leadership and oversight for the whole department and there were some gaps in medical rotas.

However:

- There was a positive incident reporting culture and learning was identified and shared with staff to improve safety.
- Staff were open, honest and provided apologies and explanations when things went wrong;
- The department was visibly clean and organised and staff adhered to infection prevention and control procedures to keep patients safe.
- Improvements had been made to the environment in the clinical decisions unit, a new helipad had opened to provide safer and direct access for patients being transported by helicopter, and emergency equipment was regularly checked and readily available.
- Controlled drugs were stored and checked appropriately, and allergies were clearly recorded on medicine charts.
- Care records were clear, contemporaneous, complete and signed. They were stored appropriately to prevent tampering and unauthorised access.

- Staff were aware of their responsibilities with regard to safeguarding adults and children, and concerns were reported accurately and in a timely manner.
- Risk assessments, care plans, triage processes and the use of adult early warning scores kept people safe from the risk of harm.
- Nursing and medical staffing had been strengthened and plans were in place to increase numbers even further.
- Staff were aware of their responsibilities and the actions to be taken in the event of a major incident.

Incidents

- All staff were aware of their responsibilities to report incidents and we saw evidence that reports were being made. Incidents reported included near-misses, as well as incidents where harm had occurred. Staff told us they felt supported to report incidents and received feedback when they did. This was an improved position from our previous inspection.
- Staff received incident reporting training, which helped them understand their responsibilities, how to use the electronic reporting system and the types of incidents to report.
- The grading of incidents on the reporting system did not always align with the level of harm that occurred. We reviewed a large number of reported incidents between February and June 2016 and a high proportion of these had been given a severity of 'no harm', even though some related to patient harm. We explored this with the department's new governance lead who agreed it was unlikely such a high proportion of reported incidents would have resulted in 'no harm'. The governance lead had not previously been aware of the numbers reported as 'no harm' and told us they would review this.
- The incident reports we reviewed had been completed thoroughly. They demonstrated immediate actions taken to reduce or treat any harm or risks, and areas of learning.
- Learning from incidents was identified and shared with staff. The management team used a variety of methods to share learning within the department, including daily team reviews, a safety and governance newsletter, safety alerts, simulation-based training and twice-yearly safety days.
- There had been no never events in the emergency department in the previous 12 months. A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.
- There had been two serious incidents in the previous 12 months; one relating to a medication error and another relating to a delayed diagnosis. We reviewed the investigations for both incidents and found opportunities for learning had been identified, and actions had been planned or completed to reduce the likelihood of a similar incident happening again. The learning and actions had been shared with staff.
- Mortality and morbidity reviews took place as part of the emergency department's safety and governance processes. Although these took place monthly, the minutes and registers of attendance were poor and did not effectively demonstrate how lessons were learnt.

Duty of candour

- Staff were familiar with their responsibilities under the Duty of Candour regulation. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This Regulation requires the provider to notify the relevant person that an incident causing moderate or serious harm has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. Staff throughout the department demonstrated an understanding of this and the actions that needed to be taken when patient treatment and care had gone wrong or not been satisfactory. We saw evidence that the duty of candour was being applied where necessary, with incident reports and investigations recording duty of candour actions.

Cleanliness, infection control and hygiene

- Systems and processes ensured good cleanliness, infection control and hygiene. All staff were bare below the elbow and followed good handwashing procedures before, during and after patient contact and procedures. Personal protective equipment, for example gloves, aprons and masks were readily available and staff used these when appropriate.
- Hand wash basins, soap and alcohol hand gel were readily available throughout the department for both staff and visitors to use.
- Regular audits demonstrated good compliance with hand hygiene procedures. Between July and September

2015 and January and March 2016 the emergency department consistently achieved 100% compliance, while the clinical decisions unit achieved 100% in all but two months (98% in September and 95% in February). Compliance over 95% was considered to be a 'pass'.

- The department was visibly clean and a dedicated cleaning team was available in the department. We saw nursing and support staff regularly cleaning equipment, surfaces and floors. 'I am clean' stickers were applied to appropriate pieces of equipment to identify they were ready for use.
- Regular cleanliness audits demonstrated standards were being consistently met. In the nine months between July 2015 and March 2016 the emergency department achieved over 95% compliance for eight of the months, and 93% for the remaining month (September 2015). The clinical decisions unit achieved over 95% compliance in seven months, 94% in one month (October 2015) and was not audited for one month (December 2015).
- In the previous year there had been no cases of methicillin-resistant Staphylococcus aureus (MRSA), methicillin-susceptible Staphylococcus aureus (MSSA) or Clostridium difficile associated with the department.

Environment and equipment

- We were concerned that not all equipment was serviced in accordance with service schedules. The trust was asked to provide details of all equipment and the servicing schedules and last service date. Data provided showed of the 650 items of equipment recorded on the trust's service schedule as being in the emergency department, 401 items (61.7%) were out of date. 290 items (44.6%) had last been serviced in 2014 or earlier, despite having a 12-month service schedule. There were 12 items of equipment that had not been serviced since April 2009. This may have meant equipment was at risk of failing, potentially delaying patients' care and treatment. However, the trust subsequently advised the information provided could not be relied on to provide the assurances we needed. The trust submitted further evidence; however, this also did not provide the necessary detailed information to be assured that all equipment was serviced and monitored as required. We were advised the equipment management system was under review because it was recognised the reporting was "complicated".
- In the clinical decision unit the wall-mounted oxygen flow meters and suction gauges were all overdue servicing by more than 12 months. The unit manager told us this had been raised with the medical equipment management service but they had been unable to provide a date for when the servicing would be completed. Staff on the unit were completing daily functionality testing to ensure the units were in working order.
- The emergency department had a dedicated paediatric unit; however, this was not secure. The paediatric unit was located next to the reception area, behind the minors' cubicles. Although the access doors did have a keypad lock, this was not used. The nurses allocated to the unit were not always present, and at times were in a cubicle and not able to see the entrance doors. This meant children were not always protected from the risk of harm from unauthorised persons accessing the unit.
- Patients arriving by ambulance were not protected from the weather. The ambulance parking area outside the department provided no shelter for patients from the weather. Patients were off-loaded onto an uncovered pavement before being transferred into the department. Patients were at risk of getting wet and cold during this transfer. We were told about plans to build a canopy, but there was no timescale given for this work to be completed.
- The lack of a protected medicines preparation area within the resuscitation area increased the risk of medicines being administered incorrectly. A recent serious incident investigation following a medication error identified the need for an area where staff could prepare medicines without being distracted. The department had responded to this and plans had been drawn up to convert a section of the unit into a medicines preparation area. Although the work was planned, there was no date available for when this would be completed.
- The design and layout of the department generally kept people safe, but some areas increased patient risk. While there was good visibility of most areas, patients waiting in the minors' waiting room were frequently unobserved. This meant a patient could deteriorate and not be identified for several minutes. Although X-ray facilities were available in the resuscitation area,

computerised tomography (CT) services were not co-located with the department and involved a full resuscitation team and equipment escorting the patient through the majors' department and past X-ray.

- All areas of the department were cramped. In particular, the resuscitation bays were small and provided cramped working conditions for the numbers of staff required to attend a patient, especially in trauma cases. Crowding in the department impacted on available space, with patients having to lie on trollies in the central 'corridor' area of majors. The department recognised the need to rebuild or redesign, but there was no funding available for this.
- Staff in the clinical decision unit were able to immediately summon help if required. At our last inspection we were concerned that staff in the clinical decision unit were not able to call for assistance, except for in the event of a cardiac arrest. This placed staff and patients at risk, particularly if a patient became violent. The department had introduced personal alarms for the staff working in the unit and linked these directly into the emergency department. On hearing the alarm staff from the emergency department would call security and attend to the unit to provide immediate assistance. At the time of our inspection the estates department were exploring a direct link from the clinical decision unit to security to further reduce response times. The trust has since confirmed this has been completed.
- Mental health patients were assessed in a safe environment. During our previous inspection we raised concerns that a small office was being used to assess patients with mental health needs. This room had not been safe for patients and staff. Work had now been completed to make this room safe, providing fixed furniture and an alarm strip so help could be summoned if required.
- Resuscitation equipment was readily available and regularly checked. The resuscitation trolleys were tamper-evident, enabling staff to see if the trolley had been opened since the last check. Checks of the trolley were completed daily, with a full contents check being completed weekly or after use. We checked the record book and saw all checks had been recorded as complete. We also checked the contents and found all items were present and in date.
- The sluice was clean, tidy and well-organised. We noted the room was kept locked at all times, preventing unauthorised access to dangerous chemicals.
- Since our last inspection the main reception doors had been replaced, improving security and access to the department.

Medicines

- Most medicines were appropriately stored in locked cupboards or fridges. However, intravenous fluids in the majors and minors preparation area were stored in an unlocked cupboard. Intravenous fluids, including various presentations of glucose, sodium chloride and compound sodium lactate, are vulnerable to tampering and should be kept in a locked store. While the preparation area was not in a public thoroughfare, it was not observed at all times and unauthorised persons could have gained access without being challenged. We asked one of the senior nurses about this and were told the pharmacy department had approved this; however, there was no risk assessment or mitigating actions available.
- Controlled drugs were kept locked away and regularly checked. We reviewed the controlled drug record books and saw regular checks of stock and expiry dates were being completed. Morphine was countersigned in all but four entries over a six-week period.
- The disposal of medicines was completed in a safe manner, with one exception. In accordance with trust policy, unopened and unused medicines were returned to pharmacy for disposal. Part-used (wasted) controlled drugs were disposed of in a sharps bin; however, we observed one nurse dispose of a controlled drug in a clinical waste bin.
- Allergies were clearly documented on medicine charts and antibiotics were prescribed according to local protocols.
- Refrigerators were not always checked. Over the eight-week period we reviewed there had been 17 days where the refrigerator check in the paediatric unit had not been recorded on the daily checklist. On the electronic recording system there were five days out of 28 where the refrigerator temperature had not been recorded. In the emergency department we saw periods of up to five consecutive days where the daily checklist had not been completed. There were four days where the electronic recording system had not been completed. All recorded temperatures were within the acceptable range.

Records

- Patients' care records were written accurately, clearly and contemporaneously and stored appropriately. Paper-based records were being used in the emergency department. These were available for all staff involved with a patient's care to review and update. In the clinical decision unit all records were stored securely in a locked cabinet. In the emergency department, where records were needed quickly, they were stored unlocked in racking behind the nursing station. We noted this area was observed at all times, and therefore the risk of a data confidentiality breach was negligible.
- A hospital audit of the care records in the emergency department showed between October 2015 and May 2016 100% of records reviewed had been signed and printed by the staff member completing the entry.
- Previous care records were not always readily available. While some care records were stored in the reception area before being sent for storage, the information retained in the department varied widely. We were told that in some cases only the emergency department's cover sheet was retained, while in other cases copies of the complete care record were retained. This depended on the information that was transferred with the patient when they were admitted to the hospital. Older care records were stored securely off site. During the day these could generally be accessed and on site within 30-60 minutes, but out of hours the process to access them took longer.
- Computer records were not always secured. The emergency department used an electronic system to record the basic information of patients in the department. We observed on one occasion an unattended and unobserved triage room where the computer had been left logged. The display facing the door showed the names, ages, sex and presenting problem for 16 patients. This was a data protection issue because an unauthorised person could have accessed these details. We informed a member of staff who closed the system while the room was not being used.

Safeguarding

- Staff were aware of their responsibilities to protect vulnerable adults and children. They understood the safeguarding procedures and knew how to report concerns. We saw evidence of safeguarding concerns that had been reported both through the incident reporting system and the safeguarding referral process. These were both completed electronically and staff told us they were simple to use.
- We saw one example where a safeguarding referral had not been completed and the patient was re-admitted the following day. An investigation had identified a breakdown in communication between the emergency department and the clinical decision unit. Staff were reminded at the team review about responsibilities for completing referrals and ensuring handover documentation was accurate.
- Safeguarding training had not been completed by all staff. While at the time of our inspection 100% of staff had completed safeguarding level one training, only 90% had completed level two and 79% level three. Only 79% of staff had completed child protection level three training. The trust target for all these was 100%. The trust told us they were having difficulties accessing the training from their external provider. We were advised at least one member of staff with level three child protection was on duty on the paediatrics unit at all times.

Mandatory training

- Not all staff were up to date with their mandatory training. The hospital's target for completion of mandatory training was 100%. For manual handling, 92% of staff had completed the training. For resuscitation it was 90%, trust update was 87% and medicines management was 83%. However, 100% of band six and registered children's nurses had completed advanced paediatric life support.
- The emergency department had a mandatory training 'hit list' in the morning handover room. This list identified the staff who had not completed their mandatory training, and reminded them of the topics they needed to complete.
- Mandatory training was delivered mostly through online learning. Staff told us they were able to access the system, but finding time was often difficult because the department was so busy.

Assessing and responding to patient risk

- The emergency department was using a recognised triage tool to ensure an appropriate initial assessment and prioritisation was completed.

- Patients arriving by ambulance were met promptly and allocated to a bed space for assessment at the earliest opportunity. Data provided by the trust showed the initial assessment time was consistently within one minute. However, this data was not accurately recorded. The ambulance crew took observations while waiting to handover to the nurse in charge. When the nurse in charge took the handover they entered the patient's details on the computer system and simultaneously recorded the first assessment time. This system did not reflect the time the patient had been waiting prior to the handover starting and therefore was an inaccurate record of the 'time from arrival to first assessment'.
- Fast assessment and treatment of patients took place at the busiest times in the department, and when there were sufficient staff on duty. There were two cubicles in minors dedicated to this system, which enabled early senior decision-making to provide prompt treatment and care and reduce the time patients spent in the department.
- Staff were receiving additional training to recognise and respond to deteriorating patients with a critical illness. The emergency department was rolling out enhanced training to its staff to further support patients with a critical illness. Acute life-threatening events recognition and treatment (ALERT) training had been completed by 58 staff members, with a further 11 due to complete the course later this year. The training provided a structured and prioritised system of patient assessment and management to allow a more pre-emptive approach to critical illness. It provided staff with a better understanding of the recognition of impending deterioration and how to manage this.
- Early warning scores were used to identify, monitor and respond to patients' who were, or were at risk of, deteriorating. Using a simple scoring system taken from the patient's observations, different actions and escalations were required. We saw the adult early warning scores being used consistently to provide safe care and treatment; however, the paediatric early warning scores were not being used consistently. The paediatric early warning score was only introduced to the department within the last six weeks, and staff told us they were still familiarising themselves with it. The scoring system was not always being completed at triage and, when it was being used, was not being completed consistently. A recent governance and safety newsletter had acted as a reminder to staff that it must be used for all children. Of the 10 records we reviewed, seven children had not had observations completed at the time indicated by their early warning score.
- Children did not always have their vital signs adequately recorded. In the national vital signs in children clinical audit 2015/16 it was found that only 10% of children attending the emergency department had a full set of vital signs completed. 46% of all patients in the audit had not had their vital signs recorded as part of a formalised scoring system (for example the paediatric early warning score). Other than a reminder to staff in the safety and governance newsletter to use the paediatric early warning score we did not see evidence of any other actions being taken to improve this position.
- Risk assessments and care plans were used to manage patient risk. These included falls, skin care, venous thromboembolism and sepsis. We saw these being completed and followed consistently in all the records we reviewed. An additional mental health risk assessment was also being used to assess if these patients were suitable to be admitted to the clinical decision unit, something that was not in place at our previous inspection.
- Patients waiting for X-rays were not always adequately monitored or able to call for assistance. At our previous inspection we raised concerns that patients waiting for X-rays were not adequately observed or able to call for help, putting them at risk in the event of deterioration. Although the emergency department had responded with a new standard operating procedure, this was not always followed. The new procedure required patients to be escorted if they required any form of monitoring, if they were immobilised, confused, at risk of falls or had dementia, if they had a reduced consciousness level, were clinically unstable or were unable to use a portable call bell. While we didn't see any patients unattended who should have been escorted, we did see several patients who had not been left with the portable call bell so had no means to summon assistance if required.
- Reception staff were able to call for help if a patient deteriorated in the waiting room. When patients self-presented to reception they were asked what the problem was. If the receptionists had any concerns about a patient, for example if they had chest pain or breathing difficulties, they could call straight through to majors either by telephone or using an emergency call

bell. There were some blind spots in the waiting area, for example by the taxi and payphones, where a patient could deteriorate and not be observed; however, there were no seats in this area so it was unlikely patients would wait there. The rest of the waiting room was visible, albeit with the assistance of a mirror to see in the back corner.

- Children and their parents were not always observed or able to call for assistance. We observed on one occasion both members of staff from the paediatric unit leave to attend a safety huddle. They did not explain to the three children or their parents in the waiting area where they would be or how they could call for help if something happened. We raised this with the matron before we left and were advised this would be reviewed immediately.

Nursing staffing

- Since our previous inspection additional nursing staff had been recruited with six more registered nurses due to commence in post in September 2016. Additional registered children's nurses had been successfully recruited and this had allowed the department to ensure at least one was on duty every shift. Gaps on shifts were filled with bank and agency staff when needed. The department was currently providing one nurse for every five patients in the majors department, but were hoping to increase this to one nurse for four patients when the additional six registered nurses started.
- The military committed to providing staff for four of the emergency department rota lines. We were told that in the event of these staff being deployed the military paid for any agency or bank staff needed. Additional supernumerary staff were also deployed in the department when they were available.
- Staffing in the clinical decisions unit had been strengthened since our previous inspection. At our inspection in 2015 we found the clinical decision unit was often understaffed and did not always provide safe staffing levels for patients. However, this time we found there were always the required two nurses on duty with one healthcare assistant. A new manager for the unit had started in post and they had strengthened the position further by ensuring staff were protected and not moved to other areas of the department when they were short-staffed.
- Senior nursing oversight of the whole department was difficult. The band six nurse in charge had responsibility for the oversight and management of nursing in majors, minors, resuscitation and the clinical decision unit. Because the department was often busy, the majority of the nurse in charge's time was focused on providing nursing leadership to majors and resuscitation. Although the band seven senior nurses did assist with clinical time during the day, this was limited and therefore did not provide oversight of the whole department. We found in particular that the numbers of patients, waiting times and flow through minors was not appreciated by the nurse in charge at all times.
- The department was continuing to invest in emergency nurse practitioners and advanced nurse practitioners. There were 12 band six emergency nurse practitioners and four advanced nurse practitioners, all following or attached to medical rotas. They were able to provide additional skills throughout the department in support of safe patient care and treatment.
- Nursing handovers between shifts ensured patients were kept safe. We observed one handover and noted all patients in resuscitation and majors were discussed in turn. This ensured the oncoming staff knew what was wrong with the patients and what assessments and treatment had been completed and was still needed. Any special patient information, for example mental health or learning difficulty considerations, was also handed over. This handover time was also used to complete a daily team review, which included highlighting new safety information and learning from incidents.
- Two additional healthcare assistants had been employed to form a transfer team. These staff members assisted with basic care in the department and supplemented the portering arrangements to release registered nurses when a patient was transferred to the ward. A standard operating procedure was in place trust-wide to ensure appropriately trained staff completed the patient transfer in accordance with their care requirements. Verbal handovers (by telephone) were required by the consultant and nurse as part of any transfer.

Medical staffing

- The emergency department had 19 consultants working to cover 10.5 whole time equivalent rota lines. Three of these consultants were provided by the military and a fourth military consultant also worked in the department on an additional supernumerary basis.

Urgent and emergency services

Consultant cover was rostered 8am to 12am, with the remaining overnight period being covered on an on-call basis. We were told by a number of staff that the consultants often remained on site after midnight, and would not leave the department until it was safe to do so. Because they worked annualised hours, any additional hours worked would be balanced out later in the year, or could be paid if preferred.

- Although the major trauma centre requirements are for 24 hours-a-day, seven-days-a-week consultant cover, the trust had received dispensation from NHS England because they received few trauma admissions overnight. Consultants remained on-call and could attend the department within 20 minutes.
- We reviewed the medical rotas and saw there were some occasional shifts that were unfilled. These occurred particularly at weekends and within the middle and foundation grades. The lead consultant told us medical staffing at weekends could be difficult. The staffing position was challenging because there were four deanery posts unfilled and some vacancies in the foundation grades. Funding for long-term locum cover had been requested but was refused by the hospital because the cost was above the capped rate. As a result, consultants and one-off locums were covering additional shifts to fill the gaps in the middle grade rotas. While there was no evidence of this having an impact on patient safety, there was a risk that when the department was crowded there would be delays in patient diagnosis and treatment.
- At the time of our inspection there was only one registrar on overnight. However, a plan to increase this to two registrars was in the process of being signed off. The plan suggested this would keep patients safer because there would be increased medical cover, and would also reduce the additional hours consultants have to remain in the unit after midnight.
- The medical handover was well-structured and detailed. We observed one handover between the night and day shift and noted every patient was discussed in detail. Plans were discussed and a doctor or nurse practitioner was assigned to every patient.

Major incident awareness and training

- Staff were aware of their responsibilities and actions to be taken in the event of a major incident. The emergency department had a dedicated major incident plan, which included report forms, staff action cards, guidance for different types of incidents (paediatric, medical, burns, CBRNE), and the procedures to be followed with assistive pictures. Staff were aware of the policy and knew how to access it in the event of an emergency.
- Although we didn't see any evidence of the numbers of staff who had completed major incident training, several staff told us they had received training within the last six months.
- Staff told us about a recent train crash in Plymouth that generated a large number of casualties and caused the major incident plan to be used. They told us this had worked well, and a debrief had been held after the incident to identify any learning points.
- Personal protective equipment and decontamination facilities were readily available to deal with a chemical, biological, radiological, nuclear or explosive (CBRNE) incident. In the event that decontamination was required, the equipment would be erected outside the department by staff trained in its construction and use.
- The security office was located outside the emergency department and provided a quick response when needed, for example if patients or staff were at risk from violence. Staff in the department could activate panic alarms or telephone through to the office to alert security to an incident requiring their attendance.

Are urgent and emergency services effective?
(for example, treatment is effective)

Good

Are urgent and emergency services caring?

Good

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

Urgent and emergency services

Requires improvement

We have rated the responsiveness of the emergency department as requires improvement because:

- There was a consistent failure to meet the four-hour performance standard, and frequent crowding was becoming "normalised".
- Patients' needs were not always being met, particularly in respect of mental health patients and those patients being held in the central 'corridor' area.
- Information technology systems were not integrated and delayed access to some services, particularly computerised tomography.
- Complaint responses were not completed in a timely manner.

However:

- The department had called a risk summit with relevant senior managers and hospital executives to raise their concerns and seek trust-wide solutions to the impact of crowding.
- Improvements had been made to the reception desk to accommodate wheelchair users.
- A new helipad improved the service provided to patients arriving by helicopter.
- The department had access to a rapid admissions avoidance response team who worked to support elderly patients who were unable to cope at home but did not require admission to hospital.
- Patients with learning disabilities were well-supported

Service planning and delivery to meet the needs of local people

- Access to the department was relatively straightforward with parking nearby and a drop-off area outside, adjacent to the ambulance parking area.
- The emergency department provided its services to a wide geographical area. The major trauma centre provided services to an even wider geographical area within the south west across Devon and Cornwall. A new helipad had been constructed to allow larger helicopters to land, and to provide landing facilities overnight. This provided easier access to these services for those patients living further away.
- There was sufficient seating provided in the waiting rooms, as well as refreshment facilities, payphones and a free taxi company phone.
- Information in the waiting room was displayed on a large screen. This informed patients of free Wi-Fi provision, restaurant services, research projects, flu prevention and hand hygiene. An additional whiteboard displayed the current waiting time and was updated by the receptionists depending on the demand in the department.
- The department was working with commissioners and the local mental health services provider to review the provision of mental health services in the department.
- Toilet facilities were not always conveniently or obviously located, and signage did not make it easy for patients to find them. In particular, there was no disabled toilet in the waiting room. A disabled toilet was provided just inside the minors' area, but this was not clearly signposted from the waiting room.
- The reception desk was able to accommodate wheelchair users. At our previous inspection we raised concerns that wheelchair users were unable to use the reception desk because it was too high. Following that inspection the department had lowered a section of the reception desk to allow wheelchair users better access.
- Not all staff had name badges and roles were not always easily recognisable. Some name badges did not display the role the staff member held, and the number of different uniforms was confusing for patients.

Meeting people's individual needs

- The emergency department had access to a rapid admissions avoidance response team for patients who were aged 65 years or above. This service was available seven-days-a-week between 8.30am and 4.30pm. The team assisted by ensuring patients were not admitted solely because they would not be able to cope at home, and instead looked at alternative options to allow patients to be safely discharged.
- Wheelchairs were readily available for patients who arrived at the department and were unable to walk. There were enough wheelchairs provided and they were located just inside the reception area.
- Patients with learning disabilities were well-supported. The department had communication aids available, and a learning disability team was able to attend to support patients if required. We saw the learning disability team assisting with a patient in the department following an

episode of self-harm. The computer system had the means to 'flag' patients with learning disabilities. This meant staff in the department were aware of the learning disability, and an alert was sent to the learning disability nursing team.

- Translation services were available over the telephone and staff knew to access these. Staff told us the service was generally quick to respond, but on rare occasions they experienced delays accessing a translator.
- Patients with mental health conditions did not receive an adequate service in the emergency department. Mental health services were not provided by the hospital trust. The psychiatric liaison service was only available between 9am and 9pm, although staff told us that reviews generally didn't start until 11am. We saw one patient who was in the emergency department for almost 12 hours before they were able to be transferred to an appropriate facility. Although the service was not provided by the emergency department, they were working with the service provider to improve the services and the hospital were considering employing their own psychiatric liaison nurse.
- When the department was crowded patients were located in the central area of the department. If these patients were unable to mobilise and needed the toilet they had to be swapped with a patient in a cubicle.

Access and flow

- The emergency department was consistently failing to meet the standard that requires 95% of patients to be discharged, admitted or transferred within four hours of arriving at the department. In the year 2015/16 the department had not met the standard in any month and consistently performed below (worse than) the national average. Monthly performance ranged between 80% and 90%. A monthly performance trajectory plan had been agreed with NHS Improvement, but this plan recognised the department would not meet the standard in any month this financial year. In April 2016 the department exceeded the performance trajectory target of 82.9%, achieving 86.3%. However, in May 2016 the performance had dropped to 79.1% and was below the 83.2% trajectory target. In June 2016 the department achieved 87.2%, again exceeding the trajectory target of 83.3%. A review of the performance breaches identified the majority occurred overnight, between 7pm and 5am.
- The department employed a flow coordinator to monitor patient flow through the department. Their role was to monitor the movement of patients throughout the department and identify patients who had been in the department approaching four hours. Staff were then encouraged to consider a move to another place in the hospital if the patient's condition allowed. Staff held a daily review of all the breaches to determine the breach reasons and identify those which were not due to a clinical need. These were reported monthly within performance reviews and shared with the clinical site team.
- Crowding in the emergency department was on the risk register as a "serious risk". The risk had been reviewed and rewritten as a new entry on the register in June 2016 and several mitigating actions had been identified, including the progression of a strategic business case to expand and redesign the emergency department, with a target completion date of September 2016. However, we were told the redevelopment had been put on hold because there were no finances available for it. The cause of crowding was attributed to a "lack of inpatient flow and excess demand". Crowding occurred when the numbers of patients in the department were greater than the numbers of available assessment and treatment spaces, and the numbers of staff on duty. We saw patients in the central 'corridor' area of the department every day during our inspection; however, we noted these were only for short periods of time. Crowding is associated with increased mortality and reduced quality of care. The issue of crowding was recognised throughout the trust and work was ongoing to improve patient flow in support of the emergency department. The emergency department's 2016/17 strategic plan reported that "ED crowding is frequent and is becoming normalised." The main causes of crowding were recorded as exit block (a lack of access to inpatient beds), understaffing relative to demand, access to imaging and responsiveness of speciality teams, and demand outgrowing the physical space. The department had called a risk summit with senior managers and the hospital's executive team to escalate their concerns and seek solutions. There had been no action to date as a result of the risk summit, but work was ongoing to review possible solutions.
- The hospital had a procedure to follow when crowding occurred in the emergency department. There were trigger points based on performance and capacity which

required action to be taken, included liaising with the ambulance service, escalating the situation to the site management team, the redeployment of staff and moving patients at risk of pressure ulcers onto appropriate beds. However, there was no detail about the actions the rest of the hospital could, would or should take in order to support patient flow, care and treatment and safety.

- Staff told us that when majors reached capacity there were times when minors' cubicles were used to assess and treat majors' patients. We were told this impacted performance, patient flow and patient experience within the department.
- Computer systems used in the department were isolated and slowed down access to some services. For example, for computerised tomography requests staff in the emergency department had to complete a request online but then print and take the form in person to CT, where the form was scanned onto the imaging department's computer system before being reviewed by a radiographer. Staff then received a phone call to advise when the imaging department was ready for the patient.
- The percentage of patients leaving the department before being seen was below the national average. Between March 2015 and February 2016 two to three percent of patients left the department before they had been seen. With the exception of June to August 2015, where there was a slight increase that peaked in July, this was consistently below the national average.

Learning from complaints and concerns

- Complaints were handled in accordance with trust policy. The trust had a target for 90% of complaint responses to be returned to the patient within the agreed timeframe (this varied depending on the nature and complexity of the complaint). We were unable to evidence how the department was performing against this target because the performance data used referred to the time taken to return the investigation to patient services. In April 2016 only 50% of complaint investigations were returned to patient services within the agreed timeframe.
- When a complaint was received by the patient services team it was passed to the emergency department for investigation. Investigations were completed by the matron or a senior nurse if they related to a nursing issue, a consultant if it related to a medical issue, or jointly if both staff groups were involved. We reviewed a number of complaints and found in most cases they were well-investigated and appropriate action plans were created. Staff were involved with, and supported through, any investigations and learning was shared through the safety and governance newsletter or at the team review. Response letters were often written by the consultant undertaking the investigation, and were subject to a quality review process before being sent to the complainant with a cover letter from an appropriate member of the trust's executive team. One complaint we reviewed had several points raised about the nursing staff, as well as the medical care. We discussed the investigation with the matron but they had not been involved with the investigation process and had only become aware of the complaint when actions were needed to speak with the staff concerned.
- Learning from complaints was shared at daily team reviews, in safety and governance newsletters and by email.

Are urgent and emergency services well-led?

Good

We have rated the emergency department to be good for well-led because:

- There was a clear vision and strategy for the department that included actions needed to meet performance standards and provide safe, effective and responsive care.
- Governance structures and processes were being used to monitor and improve safety and quality.
- Staff were kept informed and updated about relevant risks and the actions being taken to mitigate them, and were encouraged to share their experiences of what went well and what could be done better.
- Staff felt respected and valued, spoke about an open culture and told us they were well-supported by their approachable leaders.
- Some innovation and improvement projects had been completed and were delivering improved services.

However:

- Due to financial constraints the business plan to expand and redesign the emergency department had been put on hold.
- Recording of meetings was historically inconsistent, with limited details being captured in meeting minutes, although this had improved over recent months.
- There was some disconnect between the medical and nursing leadership in relation to governance processes.
- Some staff felt disengaged at times because they were unable to stay updated or check and respond to emails while at work due to time pressures.

Vision and strategy for this service

- The emergency department had a strategy which covered their vision and plans covering 2014/15 to 2018/19. The four year approach to improving care and services for patients highlighted the need to redesign and extend the department because the existing space was "obsolete and not fit for purpose". The strategy was almost two years old and other than some staffing changes, there was little evidence of the timelines being met. Although a business case for the redevelopment of the department had been submitted, this had been put on hold because there were no finances to cover it. It was unclear if and when any expansion and substantial redesign would be able to be delivered.
- A further strategic plan for 2016/17 outlined investments and changes required to provide clinical, operational and financial sustainability. The plan proposed additional medical, nursing and support staff to give the department the "best chance of meeting the four hour target when exit block is removed". It recognised there would be a cost implication, but also identified some cost savings. This plan had been signed off within the service line but had yet to be approved by the board.
- Staff we spoke with knew about the visions and plans for the department, and were able to explain some of the improvements to staffing that had already been realised.

Governance, risk management and quality measurement

- Regular meetings were used to monitor and manage safety, risks and quality; however, the recording of these was inconsistent. Meeting minutes lacked attendance records, discussion detail and action logging. Some meeting minutes were made up of just a few bullet points. We spoke with the newly appointed governance lead consultant and the department lead consultant and were advised the meetings had historically lacked administrative support. We were told this had now been rectified and administrative support was now provided. We saw some more recent minutes and noted these now included attendance registers and more detailed records of the discussions that took place. Actions were being identified, but there was still no action log to track the progress being made.
- The department had good governance structures in place that fed into the care group and trust governance systems. However, the senior nursing team and lead consultants were not always integrated. For example, we asked how one of the standard operating procedures used in the department had been written, agreed, authorised and published. The medical leadership advised it had been written and signed off internally within the department, and told us it was normal for these documents not to be checked externally first. However, the matron told us the same procedure had been through a quality assurance process and been approved by the Head of Nursing prior to being published. We were not assured that the nursing and medical governance processes were appropriately aligned and saw evidence that the nursing team were not adequately represented at governance meetings in the department.
- A new governance toolkit introduced in the medical care group was about to be introduced to the emergency department. The new toolkit included resources to ensure governance systems were consistent throughout the care group and enabled service lines to provide regular assurance reports to the care group management team on a quarterly basis. However, we were told that all the governance leads were medical staff and that there was no nursing input at the quarterly governance leads meeting.
- The emergency department had a risk register and this was regularly reviewed and updated. The departmental risks reflected the concerns shared with us by managers and staff. All entries were dated and graded, and actions required to reduce the risk were recorded, along with a date by which they were expected to be completed. Each action had a named owner who was responsible for progressing the action and providing updates on progress. The risk register was reviewed monthly by the department's senior staff.

- A dedicated governance noticeboard in the staff handover room kept staff updated. Information was included about incident report trends, items on the risk register, complaints received and department performance. Any new information was highlighted to staff during the daily team review. Additionally, a safety and governance newsletter was produced on a regular basis to update all staff in the department on topics including learning from incidents, audit feedback, policy changes and changes to standard equipment.
- There was some internal quality audit undertaken, as well as participation in national audits. We saw the trust had participated in a number of national audits, and had completed some local audits to explore quality and safety issues. However, due to the lack of historical governance recording there was no evidence of any discussions taking place and actions being taken specifically in relation to the results of these audits. There was some evidence that action was being taken, for example a reminder to all staff to use the paediatric early warning score, however this was not linked directly with the audit work.

Leadership of service

- Staff told us they felt well-supported by their medical and nursing leadership team. They told us their leaders were visible, accessible and supportive and had good oversight of the department and staff.
- Senior nursing leadership had been improved, but still lacked overall oversight of the whole department during a shift. Following our previous inspection we raised concerns that the band seven nurses were not often seen working clinically within the department. During this inspection we found a band seven nurse was rostered to work clinically in a supernumerary role between 10am and 8pm daily. However, during our inspection the band sevens only worked clinically for short periods at a time, which could be confusing for staff wanting to know who was 'in charge' of the department. Additionally, the band six nurse in charge was still expected to have oversight of the whole department, which was too much for them while trying to manage majors and resuscitation. We were told the nurse in charge often felt “out of touch” with what was happening in minors.
- Nursing leadership within the clinical decision unit had been improved since our last inspection. We previously raised concerns that the senior nurse lead for the clinical decisions unit did not work clinically within the area. A new senior nurse had since been appointed and staff told us they regularly worked in the unit.

Culture within the service

- Staff told us they felt respected and valued by their colleagues and the leadership team within the emergency department.
- There was a strong sense of teamwork which encouraged candour, openness and honesty. Staff felt well-supported by their colleagues, particularly at times of high demand and pressure.
- The department had close links with the military and the British Antarctic Medical Survey Unit. Military staff worked alongside their civilian counterparts and were included as part of the team.

Public and staff engagement

- Patients were encouraged to provide feedback on their experience through the NHS Friends and Family Test, and posters for the Patient Advise and Liaison Service encouraged service users to share their experiences.
- Staff were encouraged to provide feedback to senior managers through the ‘What went well, even better if…’ template. This simple document was displayed on a noticeboard in the handover room and staff were encouraged to record their reflections from their shift, especially where things could be improved. Suggested actions were reviewed and staff were encouraged to take a lead in progressing these, with updates being recorded on the form.
- Some staff felt they had little time while at work to keep up to date with emails and updates, and this meant they felt disengaged at times. They told us they would often log in to the systems from home, but only to do the bare minimum to keep on top of things.

Innovation, improvement and sustainability

- Following concerns about contaminated blood cultures a piece of research was completed by one of the doctors. Following this research all the equipment needed for blood cultures was put together in bundled kits. This had reduced contamination rates from 4.7% down to 3.8%. Further work had been identified as needed to reduce the rates to below the recommended level of 3%. Training needs had been identified and sessions had been planned to educate relevant staff.

- A consultant from the emergency department had worked with the information technology team to develop a new piece of software that helped with the review of investigation results. This programme imported results from a number of different systems from the previous 24 hours into a single location. It enabled doctors to identify abnormal results or missed diagnoses more quickly, allowing earlier action to be taken.
- A new trauma transfer board had been introduced in resuscitation to reduce the risk of log rolling and moving trauma patients. Staff in the emergency department had received a demonstration of the device before trialling it in the unit. Feedback from staff and other hospitals already using the equipment was sought, and the hospital's manual handling team also reviewed the board. Following review it was agreed the transfer board reduced risks to patients and staff by removing the need to transfer patients off the board prior to receiving a computerised tomography scan. A business case was produced and the trauma network purchased the boards and additional equipment needed for the first year. We saw the equipment being used and noted the patient appeared comfortable. Their journey through imaging was sped-up and manual handling was reduced.

Medical care (including older people's care)

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

Information about the service

We have rated the medical services as good overall

We carried out an inspection of the medical services at Derriford Hospital in April 2015. The 2015 inspection found that the medical services were required to make improvements in the safety and responsive domains. This inspection in July 2016, was to follow up on those domains to identify if improvements had been made

The medical wards and departments weare managed by the medical care group which also included emergency medicine. There were 21 medical wards or clinical areas at Derriford Hospital comprising of 447 inpatient beds and 32 day-case beds. Whilst we visited and reported on the cardiac catheter laboratories within this medical care report, the management for the laboratories was provided by the surgical care group. The oncology department was managed by the clinical support services care group.

During the inspection we visited a number of wards and departments including;

- the acute medical units (AMU) Thrushel and Tavy,
- the ambulatory care centre (ACU),
- the oncology department,
- the short stay unit (SSU) Tamar,
- endoscopy,
- the cardiac catheter laboratories
- Cardiology day case unit
- Planned investigations unit (PIU)
- Bickleigh ward
- Braunton ward
- Hartor ward
- Hembury ward
- Hexworthy ward
- Honeyford ward
- Mayflower ward
- Merrivale ward
- Monkswell wad
- Shipley ward
- Torcross ward.

We talked to 59 members of staff of various roles including, senior managers, consultants, junior doctors, matrons, registered nurses, doctors assistants, therapists, health care assistants, porters and domestic staff to seek their views on working at the trust.

We reviewed 19 sets of medical and care records to review the standard of care and treatment delivered and how staff recorded this.

Medical care (including older people's care)

Summary of findings

We rated the medical services as good overall

This was because:

- Staff reported incidents and were confident that action would be taken to address concerns.
- The numbers of patients experiencing harm from pressure damage or falls whilst in hospital had reduced.
- Clinical areas were visibly clean and hygienic. Staff followed trust policies regarding infection control and routinely used personal protective equipment such as gloves and aprons, hand gel and regularly washed their hands.
- Equipment for use in an emergency was regularly checked and prepared for use.
- The environment had been refurbished to meet the needs of patients who lived with dementia.
- Staff were knowledgeable on the procedures and actions to take to safeguard patients.
- The numbers of medical outliers had reduced since our last inspection as the trust had provided additional medical beds. This meant that patients received a responsive service and their access to medical staff had improved.
- The trust had developed services to be more accessible to local people and reduce waiting list times.
- The numbers of patients experiencing multiple moves between wards had reduced since our last inspection. Patients did not experience moves late at night as frequently as at our last inspection.
- The acute stroke pathway was responsive to the needs of patients and staff provided a proactive service to ensure patients were assessed and treated promptly on arrival at the hospital.

However

- There were large numbers of nursing vacancies on the wards and department which meant wards were often staffed below the agreed establishment level.
- Infection control procedures were not always followed promptly regarding the removal of sharps waste
- Not all chemicals were secured in ward areas which patients had access to.
- Patients living with some specific mental illnesses were at risk in some areas of the hospital due to the ligature point risk identified.
- Medicines were not always secured on the ward when patients were enabled to self administer their medicines.
- Care records were not consistently completed to demonstrate the care and treatment provided to patients.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Safety in the medical services was rated as requires improvement. This was because:

- There were large numbers of nursing vacancies on the wards and departments which meant that often wards were staffed at below the agreed establishment level.
- Infection control procedures were not always followed promptly regarding the removaldisposal of sharps waste. Not all chemicals were secured in ward areas which patients had access to.
- Patients living with some specific mental illness were at risk in some areas of the hospital due to the ligature risks identified.
- Medicines were not always secured on the ward when patients were enabled to self-administer their medicines.
- Care records were not consistently completed to demonstrate the care and treatment provided to patients.

However:

- Staff reported incidents and were confident that action would be taken to address concerns.
- The numbers of patients experiencing harm from pressure damage or falls whilst in hospital had reduced.
- Clinical areas were visibly clean and hygienic. Staff followed trust policies regarding infection control and routinely used protective personal equipment (PPE), hand gel and regularly washed their hands.
- Equipment for use in an emergency was regularly checked and prepared for use.
- The environment had been refurbished to meet the needs of patients who lived with dementia.
- Staff were knowledgeable on the procedures and actions to take to safeguard patients.

Incidents

- Between June 2015 and May 2016, Plymouth Hospitals Trust reported a total of 24 serious incidents requiring investigation (SIRIs) to the Strategic Executive Information System (STEIS). All organisations providing NHS funded care are required to report such incidents in this manner.
- Of the 24 SIRIs reported, 17 were relating to slips, trips and falls, four were regarding pressure ulcers which met the SIRI criteria, two were diagnostic incidents including not acting on test results and one was an information governance breach.
- Between 30 June 2015 and 29 June 2016 Medical Care reported 4885 incidents via the National Reporting & Learning System (NRLS). This was 36% of the overall number of incidents reported by the trust in this time period. 81.1% (3962) were incidents which did not result in harm to the patient. The most frequently reported incident category was 'Implementation of care and on-going monitoring/review' with 41% (2003). 79% (3856) of all incidents were reported within 30 days.
- Staff said there was a good reporting culture within the trust and they were able to report any concerns without fear of reprisal. We did hear however that staff did not always report short staffing levels as an incident as they did not feel this resulted in action being taken.
- We saw that individual wards and departments within the medical care group reviewed any incidents which had been reported through their service. Action was taken to reduce the risk of the same incident reoccurring.
- An incident had been reported which showed staff monitoring a patient had not escalated concerns around the patient's physical observations to the medical staff appropriately. Following this reported incident, senior staff from the department carried out spot checks on the observation recording sheets the next day and found a further discrepancy. Additional education and training was provided for staff and senior nurses on the ward carried out additional checks of the recording tool.
- We saw a number of incidents related to patients who had fallen in hospital. A full investigation was taken following a fall with harm and the falls team lead followed up and reviewed the incident reports with the ward staff, for those patients who had experienced moderate or severe harm. Themes and learning had been developed from these reports. For example, it had been found that 80% of the falls within the trust were with patients who were living with dementia. Joint working had taken place with the dementia steering group to address this. As a result of this work, additional

alerts were put into place to identify patients at risk of falling, either by an icon on the electronic whiteboard system and more specifically an alert in patient notes relating to particular treatments.

- Staff consistently reported any incidences where patients were seen to have sustained pressure damage. The tissue viability lead nurse for the trust was made aware of all incidents of pressure damage and carried out a review. Any learning from the incident was disseminated throughout the trust.
- Each ward and department held a team briefing each morning which all staff attended. We observed two team briefs and found that any relevant reported incidents and associated learning was discussed at the team brief. This included learning from the wider trust as well as the individual ward and department.
- All reported incidents relating to the use of insulin were reviewed and reported upon during a safe use of insulin governance meeting. From the meeting held monthly, actions and recommendations were identified and shared with staff on the medical inpatient wards. For example, the policy and procedure relating to administration of insulin when run concomitantly with a nasogastric feed was required to be reviewed and developed following an incident reviewed in the April meeting. This demonstrated the trust learned from incidents and took actions to reduce the risk of the incident reoccurring.
- The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. Figures provided for the neurology and stroke services identified that a specialty mortality SHMI of 74 % against a national average of 73% was comparable to elsewhere in the country.
- Mortality and morbidity (M&M) meetings took place in all specialities and the findings from these meetings were reported to the medical care group through their governance meetings. The trust informed us that a summary from the service lines M&M meetings were reviewed annually on a rotational basis by the trust's mortality review panel. Feedback was then provided from all specialities to the medicaline care group meetings. This ensured that the management team of the medicine service line had insight into their care group.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Incident reports for the last four months identified that when patients had suffered harm while in hospital an apology was provided to the patient and if appropriate to their relatives/representatives.
- Individual staff gave us examples of when Duty of Candour processes had been followed within the hospital which demonstrated a good understanding of the legislation.

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care.
- Individual wards displayed a safety cross to identify the numbers of falls on the ward or department.
- At Plymouth Hospitals Trust there were 19 pressure ulcers (grades 2 to 4), 25 falls with harm and 18 catheter urinary tract infections recorded via the Patient Safety Thermometer between March 2015 and March 2016.
- A review of all patients admitted to the hospital identified that the number of patients per every 100 surveyed that had developed pressure damage had increased in September 2015 to March 2016. The data showed this was not a steady increase and at times the numbers dropped and then increased again.
- The total number of falls experienced per every 100 patients showed a significant decrease from May 2015 to March 2016.
- An additional member of staff had been recruited to lead the falls team and had been in post for three months prior to our inspection. The falls team reviewed the analysis forms which were completed by the wards, of any falls that had occurred within the hospital on the day or day after the fall had occurred. They worked with the ward staff to establish if any proactive measures could have prevented the fall. Education was provided

to staff following each review when necessary. Staff who worked on wards which had reported a higher number of falls were provided with training and education regarding falls prevention.

- The numbers of patients with urinary catheters experiencing a urinary tract infection had remained stable from March 2015 until February 2016 when an increased number was identified. This reduced again in March 2016.
- Wards and departments carried out monthly falls, pressure damage and venous thromboembolism (VTE) (potentially life-threatening blood clots) audits. Information was displayed for patients and visitors to the ward to see the results from such audits. We saw notices which showed the numbers of harm free care on the ward or department. For example, certificates were awarded based on the number of days the ward or department had been free from a patient experiencing any pressure damage or cannula/peripheral line infection. We saw a number of wards displayed consistently good outcomes for patients.

Cleanliness, infection control and hygiene

- Wards and departments we visited were visually clean. The cleaning services were provided by an external organisation and staff were complimentary about this service.
- 86% of staff within the Medicine core service had completed their mandatory trust update training, which included infection prevention and control training. This was below the trust's target of 100%.
- Between April 2015 and March 2016, the medical care group reported no incidents of methicillin-resistant Staphylococcus aureus (MRSA), 23 incidents of Clostridium difficile (C.diff) and 21incidents of Meticillin sensitive staphylococcus Aureus (MSSA). Compared to the national England average the trust generally had a lower number of cases of c.diff and MRSA than other trusts between March 15 and February 2016. However, when comparing the numbers of MSSA cases we found that the trust experienced a higher number of cases than the England average.
- We observed patients with infections were nursed within side rooms and appropriate signage was in place to inform staff and visitors prior to entering the room. Infection control risks were highlighted on the electronic white board so that staff were alerted to additional measures they were required to take.
- Protective personal equipment, such as gloves and aprons alcohol based hand gel was located throughout the wards and outside of each side room. We observed that staff used the hand gel regularly and wore gloves and aprons when attending to patients.
- Hand hygiene audits were carried out each month on the wards by a process of observation. The audit included ensuring staff made use of hand gel and followed the trust hand washing policy and procedure. The infection control team carried out an unannounced visit to each ward and department every three months to observe the practices and systems in operation. The results from these visits were fed back to the ward by e-mail by the infection control team. Wards and departments displayed the outcomes from the hand hygiene audits on the walls for patients and visitors to see. The results displayed on the wards we visited showed compliance with the hand hygiene protocols in the hospital.
- Infection control procedures were not always followed promptly regarding the disposal of sharps waste. Staff used appropriate containers for disposing of sharp materials, such as used needles and cannulas. Once full, the bins were removed from the ward to designated secure clinical waste areas. However, on some wards this was not carried out promptly and on one ward we saw eight bins stacked up in the sluice which were impeding the access to the sink and on another ward there were six sharps bins which had been left in the sluice. Only one of these had been closed securely so ran a risk of staff injuring themselves from the contents enclosed.
- We noted at the last inspection, chemicals were not secured in ward areas where patients could have accessed. We saw at this inspection, not all wards secured the sluice room and chemicals were stored in unlocked cupboards. This meant patients and visitors to the ward were able to access these areas. On Burrator, Thrushel and Monkswell wards we saw chlorine releasing tablets for cleaning purposes were stored in the unlocked sluice. Furthermore, these chemicals were not in a locked cupboard and therefore were a potential risk for patients who could access the room. Other wards ensured chemicals were secured
- Staff identified when equipment had been cleaned by the use of labels which stated the date and time of when the equipment was cleaned.

- A concern had been noted within the cardiac catheter laboratories regarding the swabs used during surgery. Staff had noted that the swabs were not always clean and gave examples that specks of dirt, a dead fly and small splinters of wood had been found in swab packs. As a result of this changes had been implemented to promote safe practice and an additional check of the swabs once opened had been put into place.

Environment and equipment

- Since the last inspection the trust had reviewed the storage of equipment. At the last inspection we saw phlebotomy trolleys (used for the taking of blood samples) were left unattended. The trolleys held needles and syringes and would be a risk if accessed by patients and visitors to the ward. During this inspection we noted these were stored securely when not in use and were not seen to be unattended in patient or visitor areas.
- We observed that on some wards there were six beds in a bay. This made the space between the beds feel confined, particularly when the curtains were drawn to provide patients with privacy. Staff commented that at times there was insufficient room for equipment required to provide care and treatment to patients and that it was difficult to access the handwashing facilities in the bays. We observed that when the curtain was around the bed next to the sink and clinical waste bin there was a small space to access this area. On some wards the bays had been reduced to five beds in a bay which alleviated the issue.
- An emergency trolley containing resuscitation equipment and emergency medications was available on each ward and department. We saw these were secured to be tamper evident and were checked each day and following use. A further, more in depth check took place on a weekly basis and again these checks were completed in all areas. Each trolley had portable oxygen, suction and a defibrillator which meant that in the event of an emergency this equipment would be available promptly.
- Staff had access to specialist equipment where necessary. For example, on the cardiology ward there were eight centrally monitored beds and an additional eight mobile monitoring devices for patients who were mobile around the ward but still required monitoring.
- Equipment was tested and serviced at regular intervals. Stickers attached to the equipment showed the last date of servicing or maintenance and when it was next due for further attention. We noted that one mattress pump had been due for servicing in June 2016 but this had not been completed.
- Additional equipment had been purchased and was available throughout the medical wards and departments to reduce the risk of patients falling. Sensor mats were in operation, with each ward having access to mats. Grip socks were in use throughout the hospital and staff provided with education on how to assess patient's footwear and when appropriate to recommend the use of grip socks.
- A planned replacement programme for pressure relieving equipment was in place to update the pressure relieving mattress and cushions used in the hospital. This meant this type of equipment was monitored and replaced when necessary. Staff confirmed they had access to sufficient equipment to meet the assessed needs of patients on the wards.
- We observed that where escalation beds had been opened on one ward, there was no piped oxygen or suction by the bedside of these additional beds. To reduce the risk to patient's portable suction and oxygen was placed within close proximity to these beds. The resuscitation trolley had also been relocated to be nearer to these beds as this also carried oxygen and suction. This meant that in an emergency staff would have access to equipment sooner.
- Each bed space had a call bell facility for patients to be able to summon help when needed. We saw that if the call bell was broken the bell would ring continuously. Staff commented that the estates department were accessible and responded promptly to deal with this issue including out of hours.
- We noted that following our last inspection the provision of comfortable seating in the ambulatory care unit had been addressed. Patients now had access to comfortable arm chairs whilst waiting for tests or to see clinicians.
- We observed that the signage in the hospital to direct visitors to wards and departments was generally clear and helpful. However, there appeared to be a lack of signage to the ambulatory care unit from the main corridors for the hospital. The ambulatory care unit was located in the middle of the two acute medical units. Once on one of these wards, there were signs to direct you to the ambulatory care unit.

- We were told discussions had been held with clinicians in the ambulatory care unit and the trust regarding expanding the environment, as additional consulting rooms were required to meet the demands of the service. We saw there were four private consulting rooms available in the department and six couches on which patients were assessed and received treatment and care. Only two of the couches had curtains to screen the patient in order to respect their privacy. Consequently, staff spent time moving patients around the bay in order for their assessment or treatment to be carried out and their privacy and dignity to be respected. This meant that at times patients experienced a delay in care and treatment whilst waiting for a screened couch to be available. We observed that conversations within this bay could be heard by other patients which did not ensure the confidentiality of patients.
- We observed staff on Monkswell ward stored equipment such as mobility aids and chairs in the corridors of the ward. On the day of the unannounced inspection the fire exit at the far end of the ward was blocked by equipment for a period of at least one and a half hours before it was moved. A bed was also moved in front of the fire exit for a short period of time while cleaning took place. The equipment stored in the corridor would have impeded the access to the fire exit of patients in wheel chairs or carry chairs, although it was passable by people who were mobile.
- The healthcare of the elderly wards had day rooms which had been decorated in a homely style to replicate a front room. We saw there were fire places, silk flowers, clocks and televisions in the rooms. Equipment to engage people with activities were available on these wards such as jigsaws, magazines, books and age appropriate colouring books.
- Staff on the wards told us that at times they provided care and treatment to patients who had ongoing mental health concerns. We noted that the environment was not safe for patients who were at risk of self-harm as there were ligature points throughout the wards. The trust had installed call bell leads in the toilets and showers that had a clip so that they would break if a heavy weight was placed on them and there were holes to reduce the strength of the fabric. However, there were hooks for towels or clothes in the shower and toilet cubicles. In some of the toilets there were high cisterns with chains to pull the flush.

Medicines

- At trust level, 82% of staff within the Medicine core service had completed their Medicine Management training.
- Additional training was provided for junior doctors regarding insulin safety and the management of patients with diabetes. The junior doctors completed an on line diabetic safety module before starting employment. The module was designed initially by NHS Diabetes and updated locally with pharmacy involvement.
- Since the last inspection the medicines management in the hospital had been reviewed and systems and processes changed. Intravenous fluids were now stored securely so not to be accessible by patients and visitors to the wards.
- Patients were enabled to use their own equipment for self-administration of insulin if this is what they were used to doing at home. This included the use of 'pens' which enable patients to draw up pre-determined amounts of insulin and reduce the risk of error. Where nurses supported patients with the administration of their insulin using equipment brought in from home, it had been identified that there was a risk of needle stick injury which had been reported to the safer sharps group for review and action. Needle stick injuries occur when staff break their own skin with a needle that has been used by another person. This ran the risk of cross infection and transference of blood borne diseases.
- On some wards there were no bedside drug cupboards and we saw patients who were self-medicating had their medicines unsecured at their bedside. For example, a patient with diabetes had their insulin and administration equipment in an unlocked bedside cupboard. We saw inhalers and medicated creams and ointments on bedside tables. This did not ensure the security of the medicines and protect patients and visitors to the ward from accessing medicines.
- We observed the drug trolleys on the ward used for the administration of patients medicines were provided with equipment to lock them and secure them to the wall when not in use. We observed one nurse who left a drug trolley open in the corridor of the ward when away from it during the medicine round. The same nurse left two tablets unsecured in a pot on the medicine trolley when not in attendance. This was observed by another member of staff and addressed immediately.

- The controlled drugs were stored securely throughout the medical wards and departments. We saw the controlled drug registers were completed appropriately and reflected the stock balances on the wards.
- Medicine which required cool storage was stored within fridges specifically for this purpose. Staff checked the fridge temperatures on a daily basis to ensure the correct temperatures were attained for the medicines.
- Fluids for intravenous use were stored securely in locked cupboards so that they were not accessible to visitors or patients on the wards.
- At our previous inspection we were told delays in patient discharges had been experienced due to waiting for the medicines patients needed to take home. We met with a pharmacy technician who worked on the acute medical unit and also provided support to the short stay unit. This member of staff ensured patients medication was prescribed by the medical staff, prepared and dispensed in a timely way. Staff were positive about this role and the difference it had made to enabling ward staff to discharge patients earlier in the day thus having beds available for patients to be admitted to the ward. The pharmacy technician was able to see from the electronic whiteboard when the doctors had prescribed the medicines and we observed they were fully aware of who was being discharged and followed the prescription up with medical staff when necessary.
- We saw staff administered pain relief to patients when required. Pain reviews were carried out to assess whether the medicine given was suitable. We observed registered nurses asked patients if they had any pain during the medicine administration round and where able provided pain relief promptly.
- Concerns had been raised within the oncology department regarding frequent delays with obtaining medicines. A system was in place which produced a list of patients expected at each clinic every day and generated orders for the pharmacy department. The chief pharmacist was aware of the issues and told us each incident is investigated the most common root cause was late prescribing. Considerable work had been undertaken to rectify the situation and they were working to improve medical engagement.

Records

- We reviewed 19 sets of care documentation and medical records across the wards and departments we visited. This was to review the quality of the records staff maintained regarding patients' care and treatment.
- We found medical records were stored securely in locked notes trolleys on the wards. On some wards the care plan documentation was also stored in these trolleys while on other wards the care plan and associated documentation was to be found at the end of the beds.
- The falls team audited a minimum of ten sets of patient notes each month to ensure they were completed appropriately. The outcome from these audits were made available to all staff. A recent reminder had been sent to staff regarding the completion of lying and standing blood pressures for patients who were at risk of falls as it had been identified these were not consistently carried out. However, we saw gaps in the falls assessments where these tests had not been completed. For example, in four sets of notes we reviewed, the lying and standing blood pressure and urine test had not been carried out.
- Staff completed assessment documentation which provided guidance for staff on the care and treatment needs of each patient. The assessments included a risk assessment regarding the use of bed rails, nutritional status, manual handling, falls, pressure damage and the patients' dependency rating. Care plans were in place but were generic and had not been consistently personalised to reflect the individual care needs of each patient. However, we did see care plans which had been personalised regarding wound care and infection control procedures.
- Staff monitored the food and fluid intake for patients where concerns had been raised, or their care and treatment plans required this. We observed that three fluid charts had not been totalled at the end of the 24 hour period. This did not provide a clear record of the total amount of fluid in and out for the patient which would not have alerted staff to any potential problems or issues. We saw two care plans which lacked detail in the action staff were to take should the patient decline meals or food frequently. We identified the patient did refuse their meals from the food diary maintained, but could not ascertain the action staff had taken regarding this.
- We found patient handling risk assessments and associated care plan documentation had not been

consistently completed. For example, we observed that one patient had moving and handling equipment located at their bedside. Other information in the care documentation said the patient was bedbound, and we also heard the patient request staff to assist them with repositioning in the bed. This did not ensure staff had up to date and full information on the action to take to meet the patients assessed care needs safely. Another patient had a moving and handling risk assessment which stated the person needed help with moving and was at risk of falls. However, their nursing needs assessment stated the patient was independently mobile. This did not ensure staff had clear guidance to follow to ensure the patients' needs were met safely.

- Staff completed intentional rounding forms which showed the care and treatment provided to patients at two hourly intervals. If a patient required more frequent care we saw this was identified on the form.
- Checklists were completed regarding the care and treatment for patients with cannulas or urinary catheters inserted. These checklists showed when the cannula or catheter had been inserted, checked and removed or replaced. This helped to reduce the risk of and control of infection.
- A foot assessment tool had recently been introduced for diabetic patients and training provided to staff on its use. We saw the assessments being completed on a number of the wards.
- Detailed daily evaluation records were seen in the care plan documentation folders which evidenced the care and treatment provided to patients. The information also included relevant information relating to planning around their discharge.
- Hospital records were stored off site and a courier system was in operation to ensure patients' medical records were available promptly when requested. Staff who worked in day case units told us the access to notes had much improved.

Safeguarding

- Staff were provided with safeguarding training. Data showed 97% of staff within the Medicine core service had completed their Safeguarding Level 1 training, 92% of staff had completed their Safeguarding level 2 training, and 75% had completed their Safeguarding Level 3 training, compared to the trust target of 100%. The level of training each member of staff was required to complete was role specific and therefore, not as many staff were required to complete the level 3 training.
- A separate training programme was available regarding child protection and 75% of staff within the medicine core service had completed this.
- Staff we spoke with were knowledgeable about their responsibilities for safeguarding patients. On one care of the elderly ward staff gave good examples of when safeguarding alerts had been raised following concerns on the patient's well-being on admission.

Mandatory training

- A programme of mandatory training was provided for all staff.
- Trust data showed that staff compliance for the mandatory training within the medicine care group was as follows; 90% of the staff had completed resuscitation training, 86% a trust update, 93% manual handling, 97% safeguarding level 1, 92% safeguarding level 2, 75% safeguarding level 3, 82% medicine management and 75% child protection level 3. The trust update training included mandatory topics such as infection control and information governance.
- The trust aim for compliance with mandatory training was 100%. Factoring in sickness and emergency leave the trust recognised 100% compliance was not always achievable and therefore 'rag' rated the training as follows: a green rating or acceptable compliance level being between 95 and 100%, amber rating at 85-95% compliance and below 85% a red rating. A programme of training was in place so that staff were enabled to complete their mandatory training.
- The last inspection in 2015 identified that not all staff were trained and knowledgeable in the Mental Capacity Act (MCA) legislation, including Deprivation of Liberties (DOLs) when patients did not have capacity to make decisions for themselves. Since our inspection there had been an increased number of training sessions put in place, including 15 sessions for staff to attend MCA and DOLs training. This topic had been included on the mandatory training programme for 2015-16 and would be included in the induction programme for new staff.

Medical care (including older people's care)

- The medical care group held a service line governance meeting every three months. At this meeting, the mandatory training compliance figures were reviewed, including an analysis of trends, such as which staff groups or teams were not compliant.
- The endoscopy unit ran a comprehensive training programme for all new staff. Mandatory training was up to date in this department for all staff with the exception of those on long term sick leave.

Assessing and responding to patient risk

- A system of early warning scores (EWS) was used in the hospital to alert staff to the deteriorating patient. The scores were based on a series of physical observations which were recorded and scored according to predetermined levels. The scores alerted the nursing staff when there was a need to escalate a deteriorating or unwell patient to the medical team. We saw that when a patient's observations highlighted deterioration in their physical condition the nursing staff had consistently and appropriately escalated this. On the cardiology wards, the patient's physical observations were often outside of normal ranges due to their cardiac condition but the patient remained clinically stable. In these situations the senior nurses made the decision of when to escalate to the medical staff.
- The observation charts were frequently completed by health care assistants and escalated to the registered nurse when indicated as necessary by the score. The recording sheets were checked by a registered nurse at the end of the shift or when concerns around the patient's condition were raised. We saw that on occasions the check by the registered nurse had not taken place. However, on these occasions there had been no deterioration in the observations which required escalation.
- At the last inspection it was noted that risk assessments were not consistently and/or appropriately completed by staff. Individual patient risk assessments were monitored as part of the Fundamentals of Care audits. The Fundamentals of Care are based around 12 topics of care and the audit checked the compliance of meeting these areas. Data produced by the trust, from the Fundamentals of Care audits, showed that from June 2015 to June 2016 the compliance rate was from 95% to 98% each month.
- An assessment was completed for patients on admission regarding potential risks from venous thromboembolism (VTE). Compliance on the completion of VTE assessments was part of the Fundamentals of Care audits but also monitored by the VTE clinical nurse specialist. The audits found that the trust achieved the national standard of conducting VTE risks assessments for 95% of eligible patients.
- A staff survey conducted in February 2016 identified a knowledge gap among the doctors regarding the emergency management of diabetes in patients who are unwell and their diabetes unstable. Concerns were raised regarding when patients presented with high or low blood sugars and the action to take in an emergency. There had been a programme of education put in place for junior medical staff and support available at all times from the on-call diabetes consultant and specialist nurses.
- The trust undertook audits of patient care documentation including risk assessments for individual patients. The trust target for compliance with maintaining records was 95% and the overall trust compliance remained above this.
- The trust had appointed additional staff to the tissue viability team in order for them to provide advice and guidance to the wards to proactively manage and reduce the numbers of patients experiencing pressure damage. The tissue viability team had identified wards where higher number of patients had experienced pressure damage.
- The trusts electronic whiteboard system which was in use on each ward provided a system to alert staff to the risks for individual patients. The information was provided by the use of icons against the name of each patient which alerted staff to a specific need or risk. For example, the risk of falls, to identify a patient with diabetes or those living with dementia. The system also highlighted when a referral had been made to a specialist team, for example cardiology, specialist respiratory nurse or to the therapy team. The icon remained highlighted until physically turned off once the referral had been fulfilled. Senior managers and clinicians in the medical care group were alerted by the electronic system if the referral was not actioned within two days.
- The trust also used a system of placing stickers in patient notes to alert staff to specific patient risks. For example, the risk from falls or allergies.

- One ward had developed a system of having a picture of a small peach at their bedside to indicate that additional care was needed regarding the patients risk of pressure damage.
- The acute stroke ward ensured that all patients admitted to the hospital following a stroke had a swallowing screen carried out by the stroke nurses and a full swallowing assessment by the speech and language therapist if necessary. This ensured that patients at risk of choking were not provided with diet but kept hydrated by an intravenous infusion until a full assessment and if necessary enteral nutrition commenced. Enteral nutrition is given via different types of tubes such as a nasogastric tube (a feeding tube which is passed through the nose into the stomach).
- The World Health Organisation (WHO) checklist was carried out to reduce the risks to patients attending the catheter laboratories for certain procedures. The WHO Surgical Safety checklist was developed to decrease errors and adverse events during procedures. We observed that a radiographer carried out the initial check when patients arrived in the catheter laboratory. However, this member of staff was often replaced by another radiographer. This did not ensure that staff involved in the procedure could be confident that the correct patient was in attendance for the correct procedure. The trust informed us that when a radiographer was relieved by a colleague during a procedure there was a handover between the two members of staff. This was not observed during our inspection. The trust stated this was to protect the staff members from the impact on their health from wearing personal protective equipment in the form of 'lead' coats which were heavy. The trust also stated the changing of radiographer reduced the occupational exposure to radiation for staff.
- The acute medical unit had introduced a triage system which provided a framework to ensure patients were assessed promptly and appropriately. Timescales had been set for the patient to be assessed by clinicians. Initial assessments was by a doctor's assistant within 15 minutes of arrival on the ward. Within half an hour the patient was to be seen by a registered nurse, within one hour a junior doctor and review by a senior doctor or consultant within four hours. This system had been recently implemented but we were provided with positive feedback that the target times were being met by all grades of staff.
- The stroke pathway had been developed to ensure that patients who had suffered a stroke were seen immediately by appropriate staff, and that treatment commenced promptly after arriving at the hospital. A multi-disciplinary team were involved in this pathway including acute physicians working in ED, a stroke specialist registrar and stroke coordinator specialist nurses working across the hospital.

Nursing staffing

- At the last inspection there was a requirement made to ensure that the trust provided sufficient numbers of suitable qualified, competent, skilled and experienced persons to provide adequate levels of nursing staff to ensure the safety of patients at all times. Some progress had been made with a number of student nurses who were due to complete their training in August 2016 who had been recruited and offered employment from September 2016. We spoke to two student nurses who had been offered permanent positions. They were pleased to have been offered their preferred place of work and were looking forward to taking up their new positions. There had also been a work stream to recruit nurses from overseas which had aspired to recruit 50 nurses. However, to date only five nurses from this scheme had passed all the recruitment checks and these people were due to commence employment in August. While these initiatives had had some success further recruitment was on going.
- In July 2016 the medical care group employed 460 full time equivalent (FTE) registered nurses. There were 84 FTE nursing vacancies which meant the vacancy rate was 15.4% across the medical care group.
- The skill mix on wards had been reviewed and a number of health care assistants at band 3 level had been recruited to help address the shortfall of trained nurses.
- Between January 2016 and April 2016, the medical wards had an average fill rate (including Day and Night shifts) of registered nurses of 95%.
- The trust reviewed the staffing levels throughout the medical care group a minimum of twice a day at an operational meeting which took place immediately after the site management meeting. This meant that senior staff in the hospital were made aware of the numbers and placements of patients within the hospital. Staff carried out assessments of the levels and skill mixes of

staff on all wards using a safe staffing tool and acuity of patient tool. This enabled staff to assess the dependency and care needs of groups of patients on individual wards, reflected against the allocated staff.

- We attended one of the site management and operational meetings during our inspection. We observed that the number of patients and their care and treatment needs were discussed for each ward. The matron or ward manager for each ward or department attended the meeting. Decisions were made at the meeting regarding the allocation of staff, including available agency and bank staff, to ensure that each ward was provided with safe cover. Staff were moved between wards and departments when necessary to ensure priority areas were provided with additional staff. Whenever possible the senior bed management team tried to avoid this by using agency and bank staff. We were told that this process ensured the wards were safely staffed, although not always staffed to optimum levels.
- Where it had been identified wards and departments were significantly short of staff a red flag alert was put onto the electronic staffing system. This resulted in a text being sent to the mobile phone of the director of nursing and the head of nursing for the medical care group to ensure they were aware of the situation. Alerts were also sent to the computers of senior staff to make them instantly aware. Once action had been taken to resolve the issue, the electronic staffing system identified this by a change in colour. Each day a report was sent to the trust board of directors so they were kept up to date with the staffing levels and / or concerns around the hospital.
- Staff confirmed to us that if the staffing levels were deemed unsafe due to acuity of patients and their identified care and treatment needs, the head of nursingchief nurse for medicine would make the decision to close beds on the ward. This then enabled staff to provide safe care on the ward.
- Staff told us that on occasions they had requested additional staff to cover gaps in the rotas but there had been no staff available to fill the shift.
- Military nurses fulfilled some shifts in the hospital. In the acute medical unit (AMU) one whole time equivalent post was filled by military personnel and often additional staff were available to work in the department. On one day of our inspection there were two additional military staff on duty.
- A number of the wards and departments we visited during our inspection were working under the agreed establishment level. Staff told us this often happened as sometimes agency or bank staff were not available. They confirmed that if they were at establishment other wards in the hospital would be prioritised as needing additional staff and they would be moved. Staff understood the need to prioritise where they were needed the most based on patient need but found this dispiriting at times.
- We saw agency staff working on a number of the wards we visited. We spoke with three agency registered nurses. They told us they had been given an induction to the layout of the ward and we observed one being given a detailed patient handover.
- We reviewed the off duty rotas for a number of the wards and found that often staff were working under establishment. For example, one rota showed four duties each week had not been filled. Another ward's duty rota identified staffing to establishment was achieved on only two shifts out of two weeks. On occasions the staff were reduced by two on a shift. Student nurses and registered nurses told us that on occasions the students were used as part of the team and included in the staffing numbers rather than being supernumerary. The students stated this did not cause them concern and they felt supported by the registered general nurses and the health care assistants on the ward.
- Nursing staff had a daily team safety briefing and then a detailed patient handover. We saw this either took place at the whiteboard or in each bay at the end of the patient's bed. Staff who came on duty at lunchtime were provided with a handover to ensure they were aware of the patient's care needs and any associated risks. A printed handover sheet was used which provided an overview of each patient and their identified care and treatment needs. One ward had redesigned the handover sheet to provide additional information about their patient group.

Medical staffing

- At the last inspection there was a requirement made to ensure that the trust provided sufficient numbers of suitable qualified, competent, skilled and experienced persons to provide adequate levels of medical staff to

ensure the safety of patients at all times. During this inspection, we found there had been improvements to the level and skill mix of the medical staff working across the medical care group.

- Data provided by the trust identified that the medical staffing skill mix was similar to the England average. In February 2016 there was a similar proportion of consultant, middle career doctors, registrars and junior doctor grades when compared to the England average.
- Improvements had been made to the medical staffing cover in some areas within the medical care group. For example, there were now three consultants on duty in the mornings to assess and plan patient care and treatment through the acute medical unit (AMU). This had been extended to the afternoons where there were two consultants who carried out this role. This meant that patients were seen by consultants in a timely way on admission to the hospital and reviewed each day they remained in the AMU. Consultants were not resident on AMU but operate on an on call basis. The trust had liaised with the deanery and as a result the numbers of registrars working in the medical care group had increased from one to two. This enabled two registrars to be on duty overnight, additional cover was available at peak times such as between 5pm and 10pm and during the day. The number of training registrars on the on call rota had also increased from 15 whole time equivalent to 20 whole time equivalent.
- In response to this increased establishment, we have been successful in providing double cover of registrars between 08:00-22:00 to support the medical on call and medical cover streams, as well as providing additional cover between 17:00-22:00 on Mondays and Fridays as predictably busy days.
- Since the last inspection the trust had introduced a new role known as the Doctors' assistant (DA). The DAs were band three health care assistants who had completed additional skills and competencies. The DA worked from 8am to 6pm and covered the medical wards and departments providing support to the junior doctors. Their role included taking blood, performing ECGs, escorting patients to tests and performing catheterisations. This enabled the junior doctors to focus on caring for sick or deteriorating patients and managing medicines. Staff we spoke with made positive comments about the impact the DAs have had on the service provided. Nursing staff were pleased to receive prompt responses from the DAs when called. The junior doctors we spoke with said the presence of the DAs had reduced the pressures on their time and ability to provide care and treatment in a prompt way.
- The acute care team worked across the hospital and was comprised of registered and unregistered nursing staff who supported doctors in carrying out specific procedures such as cannulation (placing a tube into a vein for fluids or medicines to be administered), taking blood for specific tests, electrocardiograms (ECG which is a simple test that can be used to check your heart's rhythm and electrical activity) or urinary catheterisation.
- Medical cover arrangements for the outlying patients had been stabilised since the last inspection. An outlying patient is one who is not on a medical ward, usually due to a lack of medical beds. Three outlier teams had been established who looked after patients who were not on medical wards. The teams rotated on a weekly basis so that continuity of care was provided for patients and staff had a clear understanding of which team had responsibility at any given time. Nursing and medical staff confirmed these arrangements were an improvement and provided consistency and prompt care and treatment for patients when required.
- Medical cover across the wards was provided by consultants and their teams during weekdays. We saw consultants on the wards we visited and staff confirmed their presence was reliable and they were accessible when needed.
- A daily medical handover took place at 5pm which provided an opportunity for all patients to be handed over to the out of hours medical teams. Overnight the medical cover was provided by a consultant on call for AMU. There was one registrar on duty for AMU and another allocated to cover the medical wards and departments. In the evenings and overnight there were six or seven junior doctors on duty who were allocated to specific wards. All of the junior doctors we spoke with said the registrars were helpful to them. The registrars confirmed consultants provided on call advice and support when needed.
- There was a consultant presence at weekends in the hospital with ward rounds carried out on one or both days over the weekend. All of the staff we spoke with were clear that if there were concerns about any of the

patients the consultant would be telephoned for advice or guidance. Staff said that on occasions they attended the hospital to provide care and treatment to patients out of hours and when requested.

- The acute care team triaged requests for medical staff to see patients overnight. They allocated the requests in order of priority and to the appropriate staff. For example, either to the junior doctors, registrars or acute care team. In the case of a medical emergency the staff fast bleeped the doctors without going through the triage process.
- Seven consultants were in post to provide acute inpatient neurology and acute and chronic stroke care. The consultants in this speciality worked across seven days and provided a 24 hour, on-call service.
- The AMU held a safety briefing at 8am each day which included medical staff and nursing staff. Following this briefing a detailed handover was carried out regarding each patient.
- The cardiology consultants were allocated to individual patients on the cardiology wards. From information staff shared with us not all of the consultants had routine days or times to attend the wards and sometimes they were only on the ward once a week due to their additional commitments. However, this made it difficult for staff to plan their staffing to support the patients ward round. Positive comments were made about two cardiology consultants who had regular ward rounds with their team. The cardiology registrars were on the wards each day and readily available when staff required assistance. The cardiology wards reported that junior doctor posts were not always filled and there were no foundation level 1 doctors allocated to the wards. The numbers of senior house officer had reduced from three to two on the two cardiology wards.
- The cardiology consultants operated a rota to provide cover on the emergency acute coronary syndrome (ACS) team and this rotated each week. The ACS consultant led a daily board round attended by nursing and medical staff and provided a detailed patient discussion.
- A team of ten diabetes consultants were in post and an on call rota operated to provide support and guidance across the hospital for inpatients with diabetes. The on call rota was in operation from 9am to 5pm on weekdays and the consultants were also on site between 8am and 2pm at the weekend. The diabetes consultants also provided consultant cover to general medical patients admitted to the short stay ward.
- The renal consultants carried out a ward round each day. The duty consultant also carried out an afternoon round of any sick patients and any patients admitted after a renal transplantation. A multidisciplinary team (MDT) meeting took place every week attended by all of the medical staff, surgeons, specialist nurses, and the senior ward sister. There was also a daily lunchtime MDT involving the medical team, nurses, occupational therapist and dietician. The renal speciality provided an out of hours on call team consisting of a consultant, registrar and senior house officer all of who could be in the hospital within 20 minutes of being called. Staff reported this worked well.
- The gastroenterology and hepatology speciality provided a consultant led seven day service which included an out of hours on call system which also covered the weekends. Staff reported that they often attended the ward at weekends when on call to see patients. Daily ward rounds took place providing a detailed review of all patients on the ward. The consultants also considered patients admitted to other wards and prioritised beds for those who would benefit from being on the specialist ward.
- A 27 bedded reablement ward had been opened which also had 11 escalation beds open at the time of our inspection. The medical cover establishment was for four consultants and a registrar. The medical cover for the ward was provided by two rheumatology consultants and two senior house officers. We were told that one of the senior house officers was leaving at the end of the month. Staff were concerned that this member of staff would not be replaced as they had not been advised of any formalised plan in place to replace this doctor. The trust advised us a recruitment process was due to start the week following our inspection. Full whiteboard rounds were held by the senior house officer twice a week. Any concerns identified were escalated to the consultant.
- The medical cover on the respiratory wards was by a team of service specific consultants. The out of hours cover was, at times, provided by general physicians. If there were no respiratory consultants on call, the

respiratory consultants were prepared to be consulted or called into the hospital to see their patients when necessary. They also provided a respiratory ward round on a Saturday and Sunday to review acutely ill and new patients when general physicians were providing the on call support. Full and detailed ward rounds took place and prior to the weekend a definitive care and treatment plan was put into place for each patient for the on call staff to follow.

- The acute stroke unit had appropriate medical cover in place during the weekdays with ward rounds taking place. Out of hours a consultant was on call and could attend the hospital within a short period of time when requested. A registrar and senior house officer were on call for the stroke unit and for any stroke patients admitted to other wards.

Major incident awareness and training

- Staff had access to a major incident policy and procedure which was available on the trust intranet.
- The hospital had an incident room which would be used during a major incident. This was also used for the daily site management and operational meetings. Electronic access to the hospital's intranet, and patient, staff and ward information was accessible from this room.
- A senior nurse on duty was allocated responsibility for planning and coordinating should a major incident occur.

Are medical care services effective?

Good

Are medical care services caring?

Good

Are medical care services responsive?

Good

We rated responsive services in the hospital as good. This was because:

- The numbers of medical outliers had reduced since our last inspection as the trust had provided additional medical beds. This meant that patients received a responsive service and their access to medical staff had improved.
- The trust had developed services to be more accessible to local people and reduce waiting list times.
- The numbers of patients experiencing multiple moves between wards had reduced since our last inspection. Patients did not experience moves late at night as frequently as at our last inspection.
- The acute stroke pathway was responsive to the needs of patients and staff provided a proactive service to ensure patients were assessed and treated promptly on arrival at the hospital.

However:

- There was not a clear pathway for patients attending the hospital for care and treatment from the cardiac catheter laboratories. The medical care group were in the process of increasing the services available to patients by the provision of a third mobile cardiac catheter laboratory.

Service planning and delivery to meet the needs of local people

- The medical care group had reviewed their services since the last inspection. We met with the senior clinical and management staff for the medical care group who demonstrated their accountability and responsibilities for medical services within the hospital. The care group provided a link between the wards, departments and the executive team of the trust and had taken forward plans to develop the services to meet the needs of local people. We saw the medical care group had implemented changes to the services provided since the last inspection, which better reflected the needs of the local population, provided more choice and increased flexibility.
- At the previous inspection, patients requiring medical care and treatment had not always been able to be admitted to a medical ward due to the pressures on beds across the hospital. The service had been reviewed and additional medical wards formed to provide 60 more medical beds together with dedicated medical staff to provide care and treatment. This was a significant improvement on the quality and consistency of care and treatment to patients.

- A monthly nurse-led chronic kidney disease clinic had been developed in four off site locations to take the service to the patient. The trust had received positive feedback from patients regarding this service and there had been a positive impact on the reduction of waiting lists.
- The acute neurology service provided a facility for patients to attend the ambulatory care unit for assessment rather than routinely admit them to hospital. The trust had monitored the access times for patients with epilepsy through this clinic and found they exceeded the NICE guidelines around access times to treatment for patients with epilepsy.
- The trust had worked with an external company regarding funding to establish a mobile infusion unit. This enabled clinically appropriate patients with multiple sclerosis to be able to receive their infusion in a bespoke facility and improved their access to services.
- Following an increase in the number of specialist stroke coordinators appointed, a weekend service had been introduced to support patients who had experienced a stroke. Previously this support had only been available on weekdays.
- Additional endoscopy theatre lists had been introduced on weekdays running between 8.30 am to 6.30pm and on Saturdays from 8.30am to 4.30pm. This enabled patients access at times convenient to them and reduced the waiting lists. An on call endoscopy consultant carried out emergency investigations and treatment at night and at the weekends.
- Gastroenterology clinics had been expanded to provide services in the evenings and at weekends.
- Hepatology evening clinics had been introduced to enable patients to attend at times convenient to them. A hepatology pathway had been developed and led by a nurse and consultant to provide patients with care and treatment as a day case. The pathway provided an alternative to a previous two day inpatient stay.
- Further work was being undertaken within the medical care group to redesign services and locations to ensure the optimum environments and care were made available to specific patient groups. For example, patients requiring cardiology care and treatment.
- The patient pathways for the cardiac catheter laboratories were complex. There was not a designated area in the catheter laboratories for patients on arrival. Patients were admitted to one area and then following the procedure were transferred to one or two other wards depending on their condition. Patients recovered in the nearby theatre recovery area after investigation. The pacing theatre was in a different part of the hospital from the catheter laboratories. There was no day case facility within the catheter laboratory area, and post-procedure wards were all at some distance away on different floors in different parts of the hospital. The medical care group was in the process of planning a third cardiac catheter laboratory which would be a mobile service and would be located elsewhere in the hospital. This did not ensure a seamless pathway for patients.

Access and flow

- The trust electronic database of all patients provided a reference point for senior staff to review the location of all patients and the stage of their treatment and care. The site management meetings used this system a minimum of twice a day, but generally at three points in the day, to review the flow of patients through the hospital. The system enabled staff to quickly identify where patients were waiting for admission to a ward or discharge out of the hospital. This provided an up to date picture of the pressures on beds and where and what the key concerns were.
- On Bickleigh ward, a ward specialising in cardiology care and treatment, the average length of stay was between 2 and 7 days but patients with some conditions, for example bacterial endocarditis, percutaneous aortic valve replacement and end-stage heart failure may stay for a lot longer.
- The renal ward had made changes to the environment of the ward and had transformed what was previously a storage area into a clinical day case assessment area. This was used for patients attending the hospital for a renal biopsy as a day case. Positive feedback had been received on the effectiveness of this system as patients were provided with care and treatment from specialist staff. This had also reduced the need for an overnight stay.
- The bed occupancy rates at the hospital from July 2015 to July 2016 were similar to the England average.
- The average length of stay for elective and non-elective patients is generally lower than average at the trust and Derriford Hospital level, except Clinical oncology which is higher compared to the England average.
- Medical patients were admitted by referral from their GP to the acute medical unit (AMU) or the ambulatory care

unit (ACU) or via the emergency department of the hospital. Some of the specialist medical wards had direct access for known patients and the consultant would arrange their admission where necessary.

- The ambulatory care unit provided short term care and treatment for patients as a day case service. However, on the day of our inspection we saw two patients had required further treatment and had been admitted to the hospital to stay overnight.
- The medical care group worked cohesively with the emergency department (ED). There was an acute physician on duty each day from 11am to 7pm who was available to assess all patients who potentially required admission to a medical ward. They supported the ED staff to plan the patient's pathway. For example, to AMU, speciality ward or to the ambulatory care unit. Staff we spoke with in ED were positive about this process who found that it enhanced patient flow and experience.
- At trust level, between March 2015 and February 2016 all of the medical specialties were performing below the England average for the referral to treatment times (RTT) within 18 weeks. Data showed that in March 2015 only 70% of all patients had a referral to treatment within 18 weeks but this had improved to 90% by January 2016. The trust position in July 2016 was 87% overall compared to the position of 92% for England.
- The worst performing specialities were Cardiology, at an average of 75.9% versus an England average of 88.1% and General Medicine with an average of 87.5% versus an England average of 96.9%. This meant that patients attending Derriford hospital generally waited longer for a referral to treatment than patients in other parts of England.
- Further data provided by the trust identified that the number of patients waiting more than 18 weeks on an incomplete pathway of care had reduced at the end of April. The trust had worked together with NHSI to develop an improvement trajectory to reduce the number of patients waiting and in April this trajectory target had been met. However, the national standard of 92% of patients referred to treatment within 18 weeks was not met.
- The inspection carried out in 2015 at the hospital had identified concerns regarding the cardiology referral to treatment times and the recovery environment within the cardiac catheterisation laboratories as these did not meet the needs of the patients and department fully. We were shown an internal business plan which was being developed to install a third cardiac catheterisation laboratory in order to ensure more patients accessed care and treatment in a more timely way.
- In the cardiology clinic, the provision of clinics had increased, had been changed and additional sessions were put in place to enable more patients to be treated. A new recovery pathway had been implemented in November 2015 to enable cardiology day case patients to attend the hospital and recover within a specific area. However, the waiting lists for elective catheter laboratory procedures were long with some patients waiting for up to a year.T
- The trust reported to the Myocardial Ischaemia National Audit Project (MINAP) regarding the care and treatment of patients following a heart attack. We saw that the patients attending the hospital experienced longer delays for treatment, such as primary percutaneous intervention (pPCI) when compared to the England average during 2013 to 2014. The target for patients to receive this treatment, including getting to the hospital, was 150 minutes. The trust achieved 70.9% of this target against a national average of 87.5% during 2013 to 2014. However this had improved by June 2016 to 81% of patients receiving treatment within the target.The trust reported to the **Myocardial Ischaemia National Audit Project (MINAP) regarding the care and treatment of patients following a heart attack. We saw that the patients attending the hospital experienced longer delays for treatment, such as primary percutaneous intervention (pPCI) when compared to the England average during 2013 to 2014. The target for patients to receive this treatment, including getting to the hospital, was 150 minutes. The trust achieved 70.9% of this target against a national average of 87.5% during 2013 to 2014. However this had improved by June 2016 to 81% of patients receiving treatment within the target.**
- The referral to treatment times in endoscopy had improved through the introduction of Saturday endoscopy lists to enable increased sessions for patients on the waiting list to attend. Information from the trust demonstrated that the endoscopy waiting list targets were now being met. This included the two week

cancer waiting times, four week waits for urgent patients and six weeks for routine patients. Follow-up patients had previously experienced long delays of up to six months but this had now reduced to four weeks.

- Patients identified as suffering a stroke followed a pathway to speed up the effective treatment including thrombolysis. The stroke pathway in the hospital had been developed and three additional stroke nurse coordinators had been appointed to provide a seamless stroke service to patients.
- Since our last inspection the number of medical beds available in the hospital had risen by 60. This had been achieved by the forming of new medical wards. This meant that the numbers of patients admitted to wards outside of the medical care group had reduced. These patients were known as medical outliers. During our inspection there were limited numbers of medical outliers in the hospital. Systems were in place to ensure the arrangements for medical care and treatment for medical outliers were planned and that nursing staff knew who to contact each day.
- Data provided by the trust identified that 23% of all patients moved wards two or more times during their stay at the hospital. Out of these patients, 8% moved wards three or more times during their admission. The numbers of patients moving wards had reduced in the past year and close monitoring took place to establish the reasons for this happening.
- The trust had developed a standard operating procedure regarding the movement of patients around the hospital. It had been agreed that patients would only move wards when the following criteria was met; to create a speciality bed, for isolation purposes or a higher level of care was needed. For any other reason permission was required from the site manager on duty.
- A protocol was in place regarding the times of bed moves and staff confirmed that unless there was no other option, patients were not moved to other wards between 10pm and 9am. However, during our inspection we were told about a patient who had been moved wards at midnight. The explanation was that a bed was required as a priority on the patient's original ward.
- The trust was working with their information technology department to create an icon to appear on the interactive whiteboard system which would identify any patient who had moved wards twice. This would reduce the numbers of patients being moved three or more times unless it was justified based on clinical need.
- Patients attending for elective catheter laboratory procedures were pre-assessed by the staff approximately a week prior to the procedure. Once provided with an admission date, the patient attended Fal ward to prepare for the procedure. After the procedure the day case patients return to Postbridge ward. Arrangements were made with Bickleigh ward for any patients requiring admission or closer observation. This potentially meant that patients could have up to three ward moves on the first day of their stay.
- The site management team prepared a monthly briefing which was presented to the patient experience committee regarding the number and times of ward moves that patients experienced. The monthly reports demonstrated that the number of ward moves and later times of moves had reduced considerably.
- At the last inspection we identified there were medical outlying patients on a number of different wards and that medical cover was not consistent or established. The trust had followed guidance from the Royal College of Physicians to increase the number of medical wards to reduce the average number of medical patients on non-medical wards. Staff were positive in their comments about this and stated the medical cover and continuity of care for patients had improved.
- The site management team and operational staff focussed on patients' discharges each day. For example, we attended a site management meeting and saw that there were a number of patients planned for discharge the following day. A member of the site management team was tasked to ensure that attention was focused on the prescribing and preparation of their medication so that it was ready for the point of discharge. We were also told that should patients be waiting on transport to take them home or to community care, a member of the senior team would be actioned to visit the transport office to prompt a review of the reasons for the delay.
- A scheme had been introduced within the hospital known as the 'golden bed'. This focussed ward staff on reviewing all of the patients who could potentially be discharged that day, before 10am, thus making a bed

available early in the day to plan admissions. Staff we spoke with were positive about this process and the impact it had had on ensuring attention was paid to discharging patients earlier in the day.
- There was a complex discharge team working within the hospital who liaised with ward staff and external providers to make arrangements for patients who had complex care needs. This was an integrated team which included social care staff, who worked for the local council, together with health staff. The team provided a single point of contact for wards when planning patient discharges. We observed a social worker on one medical ward supporting a patient and their family with their discharge planning.
- 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.
- The hepatology service had developed an early ward discharge scheme which enabled patients to be discharged home earlier. Following their discharge the consultant followed the patient up to ensure they continued to be well. The patient was also provided with information on how to directly access the service if needed.

Meeting people's individual needs

- All of the wards had accessible information leaflets for patients to access regarding a variety of medical conditions. All of the leaflets we saw were in English. We did see information posters were displayed in public areas in languages other than English.
- Translation and interpretation services were available and staff we spoke with were knowledgeable on how to access these services.
- 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 hospital had a dementia care lead nurse and consultant who provided support to staff and patients. The Alzheimer's Society's Dementia Friends Scheme was in operation. This is a national programme for people to learn more about dementia and the ways in which people can help others living with dementia.
- The number of specialist stroke coordinators had increased over the past year from one whole time equivalent post to three. This enabled a seven day service to be developed and ensure consistency of care to patients who had experienced a stroke at the weekends.
- Two specialist Parkinson's nurses had been appointed to provide a service for patients admitted to the medical wards with Parkinson's disease.
- A headache nurse specialist had been appointed to improve access to services for patients suffering with headaches.
- These specialist nurses had been recruited internally which had led to a reduction in experienced nurses on the acute stroke and neurology ward.
- The hospital environment had been refurbished to reflect the care and support needs for people living with dementia. We saw thought had been given to the colour of the walls and bays and rooms on the wards, and were painted in different colours and had different pictures to enable patients to find their bed. Signage throughout the hospital assisted patients and visitors living with dementia by the use of pictures and colours.
- Patients living with dementia were identified by discreet identification on the staff whiteboard and in their notes to ensure staff were all fully aware of their additional needs. We saw staff were responsive and showed empathy and understanding to one patient who lived with dementia who was unsettled on the ward.
- Learning disability resources were available on the wards for staff and provided contact details for specialist staff, communication tools and learning material for staff.
- Staff had access to a psychiatric liaison nurse within the trust for support when providing care and treatment to patients who were also experiencing mental illness.
- We saw that an external organisation was available to source staff to provide one to one support to patients who were at risk of self-harming or living with a mental illness. Agency and bank staff were also requested to provide additional support for patients when needed on a one to one basis.
- The care of the elderly wards had refurbished their day rooms to provide a more homely atmosphere and the furnishings and décor were in the style of a 'front room'. Activities were available on the care of the elderly wards for patients to access. For example, memory boxes, reminiscence tools, colouring books, jigsaws, board

games, television and music provision. Twiddle muffs had been introduced onto the wards. These are knitted muffs for patients to put their hands inside and have different textures or attachments to distract them.

- The wards had not reported any mixed sex breaches. This is where patients of different gender have to share a bay or toilet or bathing facilities. Staff told us that should they have any transgender patients, they would ask the patient their choice of bed space and try to meet their requests.
- The trust provided free WIFI access for patients in the hospital and we saw signs advising of this within wards and departments. One person we spoke with was grateful for this facility when spending time waiting for their relative to return from tests and investigations.
- Call bell audits were carried out by wards and departments and showed positive outcomes. The audits were carried out by colleagues from another ward. Some wards had changed bays from six to five beds to make space for a desk to be placed in the bay. This had enabled staff to work and complete their paperwork in the bay. Positive comments were made about this system including that the number of falls had reduced, as staff were on hand to closely monitor patients who perhaps would not use the call bell for assistance.
- During our inspection we observed four wards for the accessibility of call bells for patients. We saw that all call bells, with the exception of those for five patients, were within reach of the patient. Of the five patients who did not have a call bell, one was sat away from their bed space while it was being cleaned. The other four patients were either very poorly or living with dementia and staff said they did not use the call bell. These patients were located in an observation bay close to the nurse's station and there was also a desk in the bay so that nurses could observe and monitor the patients.
- Patients who were admitted with a stroke and had swallowing difficulties were assessed by a speech and language therapist (SALT) prior to being provided with diet and nutrition. Experienced stroke nurses worked on the acute stroke unit and could carry out a basic screening assessment of a patient's swallowing. At the weekends there was no SALT on duty. This meant that if the nurses screening assessment indicated that the patients swallowing was compromised, the patient would remain nil by mouth until the SALT was available. A patient could therefore be nil by mouth for two to three days waiting for a full assessment. In these circumstances, patients were hydrated with an intravenous infusion or subcutaneous infusion (these are non-oral methods for hydrating patients).
- The stroke team was proactive in monitoring the acute stroke pathway each week to review the access to treatment experienced by patients. This included the admission routes, the time to have a CT scan, the time to thrombolysis and the time to receive a swallowing assessment. The staff team reviewed patient treatment pathways with a view to looking at where time could be saved and where any marginal gains could improve patient outcome.

Learning from complaints and concerns

- The trust told us prior to the inspection that information regarding how to make a complaint was provided to each patient in a 'welcome to Derriford Hospital' pack, which was placed at each bedside. We saw information displayed on posters in wards and departments and leaflets were available on how to make a complaint. However, we asked staff on six wards if they provided patients with these leaflets and were told that this did not happen but they were available if patients requested them.
- Staff were clear that leaflets and information on how to make a complaint could be provided to patients in other languages and formats. For example, in large print.
- We attended the nursing handover on one medical ward. We observed that a patient had been transferred to the ward at midnight and that this had upset them. They wished to make a complaint and had been informed how to do this. The ward sister went to see the patient immediately after handover to discuss their complaint.

Are medical care services well-led?

Good

Surgery

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

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 oesophagogastric, 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 nine surgery wards, a day surgery admissions unit (Fal), a day case recovery unit (Postbridge) and a surgical assessment unit (Meavy).

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 Infirmary Theatres: day of surgery admission unit, two theatres and recovery area

We visited all the surgery wards, the preadmission clinic, the day surgical admission unit and the day case recovery unit. We spoke with 35 staff, including theatre managers, the head of nursing, matrons, ward sisters, consultants, senior doctors, junior doctors and nurses. We also talked with healthcare assistants, operating department practitioners and occupational therapists. We spoke with 10 patients and one relative. We observed care and looked at 10 sets of patients' records. We reviewed data provided in advance of the inspection.

Interventional radiology is mentioned in this report; however, they are not managed under the surgical care group. The management arrangements are via a different care group to surgery.

Derriford Hospital had 35,757 surgical admissions from 1 January 2015 to 31 December 2015. Of these approximately 50% were day case admissions, 20% were elective admissions and 30% were emergency admissions.

Surgery

Summary of findings

We rated surgery services as good overall and requires improvement for responsive because

- The trust encouraged openness and transparency about incident reporting and incidents were viewed as a learning opportunity. Staff felt confident in raising concerns and reporting incidents. At this inspection we found there had been an improvement in the reporting of incidents by junior doctors.
- The trust had introduced doctors' assistants since our last inspection to help reduce the junior doctors' workloads. The feedback we received was that this was working well and junior doctors felt they had more time to diagnose and treat patients.
- At our last inspection patient records were not being stored securely meaning there was a potential risk of access by unauthorised people. This had been addressed at this inspection and all patient notes were stored in locked cupboards.
- At our previous inspection we identified concerns with how insulin was being prescribed by junior doctors. The trust had set up a 'Safer Insulin Group' to review their policies and procedures, which was on going. We had no reports of errors from staff at this inspection.
- The environment in the interventional radiology department was highlighted at our last inspection due to lack of space, privacy and dignity for patients pre and post-procedure. Since then staff told us that patients who had a general anaesthetic were recovered in theatres main recovery. A curtained area had been provided to screen patients from the corridor. The trust had plans in place for a major refurbishment but these were several years away from completion.
- Leadership of the surgical care group was good and a cohesive clinical governance structure showed learning, change and improvement took place. Managers regularly reviewed the approach to risk management in their specialities. A number of specialty meetings fed into the overall clinical governance systems and provided board assurance.

However:

- The trust breached the 18-week referral to treatment target operational standard across all surgical specialties, apart from plastic surgery, from March 2015 to June 2015, when the target was abolished by the government (the operational standard is still used by the majority of trusts to monitor their performance). By February 2016, only one surgical speciality was meeting the abolished operational standard and that was plastic surgery. Performance had deteriorated to under 50% for neurosurgery. Over the entire period, all specialties except for plastic surgery performed below the England average.
- Since our last inspection in April 2015 the number of cancelled operations had risen. The percentage of patients not treated within 28 days of a cancelled operation had also risen. The trust told us they had 67 patients who were waiting 52 weeks or more for some surgery. Of these, 37 had not been given a date for their operation.
- There were periods of understaffing on the surgical wards and theatres where the trust's safer staffing numbers of qualified nurses were not met. Additional non-qualified staff were used at times to cover any gaps in the rota. However, the trust was working hard to address these shortfalls.
- Mandatory training for all staff was not meeting the trust's target.
- Due to pressure for their beds and the demand for their services, some patients had to use facilities and premises not appropriate for the services being provided.
- We found at our last inspection the theatre scheduling system for operating lists were not being managed to make sure they were being utilised effectively, for example, late starts and lists were under or over-populated. The trust had started to implement a new computer system but work was still needed on this. Theatre lists were being reviewed seven days in advance and a daily meeting was taking place within theatres to review lists for the next day. However, not all of the operations lists were finalised and patients were often added after these meetings, which caused issues with staffing and equipment.

Surgery

Are surgery services safe?

Good

We rated the safety of surgery services as good because:

- Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Incidents were used as a learning tool.
- Patient records were now being stored securely on the wards and units so there was no risk of access by unauthorised people.
- Following concerns raised at our last inspection in relation to insulin prescribing the trust had set up a working group to review their policies and procedures.
- The environment in interventional radiology had been reviewed and changes made to improve it until the planned refurbishment takes place.
- The introduction of doctors' assistants had reduced the burden on junior doctors.

However:

- The trust did not always achieve its planned qualified nurse staffing numbers.
- Mandatory training, including some safeguarding training, was not meeting the trust target.

Incidents

- The trust encouraged openness and transparency about incident reporting and incidents were viewed as a learning opportunity.
- The trust had reported one never event in surgery services since our last inspection in April 2015. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by healthcare providers. The investigation had been completed. We were told the patient had been informed of the incident and was kept up to date with the investigation and its outcome. The surgical care group management team told us they were reviewing a number of areas to make sure this type of incident would not happen again. They were also looking at how patients were marked pre-operation. We spoke with staff in one of the theatre units who told us about the changes that had been implemented following this incident. An audit of pre-operative marking was on going during our inspection so no results were yet available.
- Staff were encouraged to report incidents using the trust's electronic recording system. The appropriate ward manager and matron saw all incident reports. Staff told us there was a 'no blame' culture and incidents were viewed as an opportunity for learning by the trust.
- At the last inspection we were told junior doctors were not reporting incidents. However, at this inspection junior doctors told us they knew how to use the incident reporting system and were reporting incidents.
- We were told about an incident where staff had identified a concern with a nasogastric tube (these are tubes passed through the nose into the stomach). We saw printed information sheets about this in theatres and on some of the wards providing details to staff about the issue and to use an alternative nasogastric tube.
- On the majority of surgery wards, they were having a 'team review' and safety briefing at handovers where feedback from incidents was discussed. We saw minutes of some of these meetings.
- From data provided by the trust for the period between June 2015 and May 2016, we saw there had been 17 serious incidents reported under the Strategic Executive Information System (STEIS). These included slips/trips and falls, pressure ulcers, and surgical invasive procedures.
- In 2014/15 the inpatient and re-admission surgical site infection (SSI) rates for patients undergoing hip replacements was higher than the England average. Repair of neck of femur saw no infections.
- Infection rates for both hip replacement and repair of neck of femur had fallen from 2013/14 to 2014/15. Knee replacement infection rates had slightly increased.
- Mortality and morbidity meetings occurred within surgical specialities either monthly or every two months. We saw meeting minutes for ear, nose and throat, general surgery, plastic and urology; they showed discussion of individual cases and opportunity for teaching and learning for staff .

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This Regulation requires the trust to

notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. We saw evidence in the root cause analysis investigation report into the never event that the requirement of this regulation had been met.

- Staff we spoke with understood the principles of Duty of Candour. One senior member of staff gave us an example of where they followed the regulation. They told us how they explained the situation to the patient and wrote to them with a written explanation and apology. They also contacted the patient a week later to ask if they needed further explanation of the outcome or support.
- The screen savers on the wards' computers all had a message for staff about Duty of Candour.

Safety thermometer

- We saw the surgery wards had information about harm-free care on display. There was evidence of the monitoring of harm-free care on all surgery wards and this was clearly signed with displays showing the number of days since the last patient harm event.
- Safety crosses were developed from the Productive Ward Programme. This programme, devised by the NHS Institute Worldwide, looked at improving ward processes and the environment for better patient care. It provided tools for nurses to make changes to their physical environment. Safety crosses were one of these tools. This visual tool used a 'green cross' for no harm and 'red cross' to indicate harm. It monitored, for example, the rates of falls and pressure ulcers. These were completed daily and displayed on the ward noticeboards. On Shaugh ward (trauma and orthopaedics) they had no falls for 206 days. Sharp ward (orthopaedics) had no falls resulting in harm for 350 days.
- Each ward completed safety thermometer monitoring every month but the results were not on display for patients or the public to view as the trust chose to use the safety cross system. On a set day each month staff recorded the required data on avoidable patient harm to the NHS Health and Social Care Information Centre. This is nationally collected data providing a snapshot of avoidable patient harm on one specific day each month. This included all pressure ulcers and patient falls with harm. The report also included catheter and urinary tract infections (UTIs). Wards had a grid on display indicating for that month if they had a fall or pressure ulcer. Between March 2015 and March 2016 the surgery wards had reported to the safety thermometer 21 pressure ulcers, with a peak showing in October 2015. The prevalence rate appeared to show a worsening trend more recently. There were 26 falls resulting in harm in total. There were 10 catheter urinary tract infections. We spoke with the Head of Nursing for Surgery who told us the peak in pressure ulcers was due to the increase in pressure ulcers found under plaster casts. A system had been introduced to identify and monitor patients deemed as high risk. An on going review was taking place involving the tissue viability nurse and meetings chaired by the Director of Nursing for Surgery.
- We saw evidence of techniques to help patients avoid harm. This included air mattresses, comfort or intentional rounds and identification labels on the patient board to identify them to staff as having specific risks, such as falls and vulnerable pressure areas.

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, theatres and units green 'I am clean stickers'. These clearly displayed the date the equipment was last cleaned.
- On Stonehouse ward they told us how they had achieved major reduction in the number of infections caused by intravenous lines (IV). This had been since the introduction of an antiseptic soaked cap used on the end of the IV line. The estimated savings to the trust were about £40,000 from the reduction in the use of treatments, for example antibiotics, following an infection.
- We observed staff in theatres maintaining strict infection control procedures. We observed scrub staff and surgeons 'scrubbing' (this was where staff washed their hands up to their elbows using specialist soap and single use scrubbing brushes) and wearing sterile gloves and theatre gowns. All staff in the theatre made sure they did not touch these members of staff so they were as sterile as possible to prevent the risk of cross-infection.
- We observed staff following the infection control policy. This included being bare below the elbow and ensuring long hair was tied back.

- Patients who were known to be cross-infection risks were placed in rooms with clear labelling to indicate that appropriate cross-infection procedures should be carried out prior to entering. We saw all staff wearing aprons and washing their hands before entering the room. This was in line with infection control policy.
- We observed porters cleaning wheelchairs in between transporting patients around the hospital.
- Clinical waste was managed in line with the trust's policy. Single-use items of equipment were disposed of appropriately, either in clinical waste bins or sharp-instrument containers. Staff in theatres told us how they managed all their waste. We saw different coloured bags used for waste. Staff transported these around on trolleys. A procedure was in place for the disposal of radioactive material. A senior member of staff from procurement told us they had made savings and changes to the way theatre waste was managed. This included recycling everything not contaminated by body waste. This had reduced clinical waste by 50%, increased recycling by 50% and reduced household waste by 90%. This was going to be implemented across the hospital.
- On the surgery risk register we noted a risk about a decontamination system and risks it posed to staff using it. Staff in theatre told us about a new decontamination system that had just been introduced to replace the old one and they felt it was much better.
- Between April 2015 and March 2016 the surgical care group had no hospital apportioned bacteraemia cases of methicillin-resistant Staphylococcus aureus (MRSA). There had been 17 hospital–acquired cases of MRSA. For Clostridium difficile in the same period, there were eight reported cases. This was an improvement from our last inspection.
- Each ward had their hand hygiene audit results on display. For example, Moorgate ward displayed 94% compliance for June 2016 and interventional radiology displayed 100%.

Environment and equipment

- There was safe provision of resuscitation equipment.
- There was a requirement for trolleys and equipment, including defibrillators, in all areas to be checked daily. However, we found not all wards and units were doing this. For example, on Fal unit we found missing entries for every month from January this year up to the time of our inspection. In main recovery we also found missing entries in February to July this year. We found between four to 10 missing entries for each month on the above units. There was no evidence that this had been identified by other staff on the units and action taken.
- In main theatres, by theatres 17 and 18, we found a resuscitation trolley that was due for servicing in April 2016, along with the defibrillator and oxygen regulator. Staff told us they had reported this on a number of occasions but the medical engineering department in the hospital had not yet serviced it.
- The trolleys were well-located within wards, units and theatre areas so they stood out and were easily accessible. All the resuscitation trolleys were secured with a tamper evident seal. This was to make sure all the trolleys had not been opened or equipment used since they were last used. In main theatres we saw resuscitation equipment for children. We also saw a number of trolleys set up for difficult intubations. These were easily accessible to staff. When a trolley was moved it was recorded on a noticeboard detailing where it had been taken and the date.
- The environment in the Royal Eye Infirmary Theatres for patients in the admission section was limited. They had three bays for admission and recovery of patients. Due to the limited space, patients' relatives were not able to be with them. They had three rooms where patients were taken post-operation if they needed more time to recovery.
- On Sharp ward (orthopaedics) there had been changes to the environment since our last inspection. Five new beds had been set up especially for the care of patients with fractured neck of femur. Staff said an audit had shown that if all patients were cared for in the same bay the outcomes were better for them. They had also removed a bed from each bay reducing them down to five and each had a nurse's desk. This meant nurses were able to observe patients more closely.
- In the main theatres (theatres one to eight) new doors had been fitted to prevent staff from walking in whilst the laser was being used. When the laser was being used the doors automatically locked.
- Theatres and recovery areas were supplied and fitted with the appropriate equipment. Recovery areas had oxygen and suction at each bed space and a selection of equipment that staff required when caring for a patient. Emergency call systems were in place, which we were told were tested regularly but we did not see any records to prove this.

- At our last inspection we identified issues with the environment in interventional radiology, as it was not fit for purpose. Patients did not have a waiting area and they were recovered in a corridor post-procedure. This meant their privacy and dignity was compromised. The trust told us they have plans in progress to refurbish this area, but work was still outstanding. However, some changes had been made. A curtain had been fitted to screen off the area where patients waited for procedures, and consultants told us they tried to obtain consent from patients on the wards, although this was not always possible due to demands on beds. Patients who had a general anaesthetic were now transferred to main theatre recovery post-procedure.
- The trust sent us details of equipment logs for surgery. This listed all medical equipment in theatres, wards and units and who serviced and maintained them in line with manufacturer's guidance. The manufacturer or the hospital's medical engineering department maintained equipment. We found that not all equipment on this equipment log had evidence of recent servicing, for example, Pro thermoscans had no date of servicing, a single flow meter was last serviced in February 2011 and a body charger 545 last recorded repair was 2009 and no record of any servicing. On the wards and in theatres we saw equipment with stickers indicating when it was last serviced.
- We reviewed the daily safety checks of anaesthetic machines in some of the theatres. These were undertaken by theatre staff prior to the start of operating lists. We saw these had been completed. This was also recorded on the anaesthetic practioners' daily capture form.
- Theatres and the Central Sterile Stores Department (CSSD) had clear procedures in place for the management of dirty and clean equipment to make sure patients were not at risk of cross-infection. There was a procedure in place to manage equipment that may have been used on patients known to have the rare and fatal brain condition, **Creutzfeldt-Jakob disease (CJD**).
- Equipment provided by CSSD was traceable. We saw tracking stickers from CSSD equipment in patient notes. This enabled the hospital to trace patients who had been treated with CSSD equipment if any issues were identified in the future.
- Similarly, patients' notes had records of the surgical equipment or prosthesis used to enable them to be tracked and traced.
- A new operating table with a higher weight limit had been purchased for use in one of the orthopaedic theatres. This table was also easier to clean. Staff told us the table was also easier to move about, and if the table proved successful they would be rolled out across the unit.
- We found chemicals covered by the Control of S**ubstances Hazardous to Health (**COSHH) Regulations left in an unlocked sluice. For example, chlorine cleaning tablets and a mixed solution were left on the sink in the sluice on Fal unit. This was unsafe practice because the sluice rooms were unlocked which meant patients, visitors and staff could be exposed to these chemicals.
- We saw stock rooms on the wards were all tidy and staff told us they had deliveries of stock/equipment twice a week.
- The Department of Health and NHS England recommend that all hospitals, hospices and independent treatment centres providing NHS-funded care undertake an annual assessment of the quality of non-clinical services and the condition of their buildings. Patient-led assessments of the care environment (PLACE) were completed after our last inspection and towards the end of 2015. Areas included Lyhner, Clearbrook and Crownhill wards. Some areas had been identified as needing repair/improvement. The trust sent us copies of their action plans addressing these areas.

Medicines

- Medicines were safely and securely stored and managed on both the surgery wards and theatres.
- However, in the Royal Eye Infirmary Theatres department we found eye drops were stored in an open box in an unlocked room. Staff told us this was because they were in use so frequently during the day they were always monitored
- We found medicine refrigerators were locked and their temperatures monitored to make sure they were in the correct range for storing medicines.
- Stocks of intravenous fluids were stored securely.
- Daily checks on controlled drugs were taking place.
- In theatres, all medicines were stored securely and at the end of each operation list a medicine count took

place. All cupboards were then checked to make sure they were locked. We were shown a copy of the checklist that had to be completed each day for each theatre being used. A section on this included the checking of medicines and refrigerator temperatures.

- At our last inspection nurses and pharmacists raised concerns about junior doctors making insulin prescribing errors. These surrounded the wrong type of insulin (long versus short acting) being prescribed, and in another case insulin had been omitted incorrectly. The trust told us a 'Safer Insulin Group' had been set up to review the trust's policies and procedures to prevent this from happening. The review was on going at the time of our inspection.
- Medicine management training for the surgery care group was 76% against a trust target of 100%.
- Between 1 March and 30 April 2016 an audit of medicines in the surgical care group had taken place. Findings showed that 89% of patients had received all the medicines correctly as prescribed on their medicine chart within the last 24 hours. Seventy percent of all medication allergies had been documented in the appropriate place on the medicines chart, while for 28% of patients this had not been applicable. Missed doses of medication were also audited, including whether a reason had been documented. However, a compliance score was not recorded for this question. The medicines charts we examined were all completed in full.

Records

- Patient records were stored securely and were in line with the patient's nursing needs and medical reviews.
- At the last inspection we identified issues with patients' records not being held securely, meaning unauthorised people potentially had access to them. At this inspection we found all patients' records were being stored securely, including computer records. On Crownhill ward, the patient information board was stored behind a locked door where only staff had access.
- The trust had a standardised care pathway for elective surgery, which was started at the pre-admission clinic if the patient had attended. This documented the patient's journey from admission to discharge. In the patient records we examined we found all areas had been completed, including risk assessments. Anaesthetic records and details of the operations were also included. We saw venous thromboembolism (VTE) assessments were included as part of the care pathway and were completed as required.
- We reviewed the medical and nursing notes of 10 patients on the majority of the surgery wards. The records were up-to-date and had clear information regarding the patients' medical care and treatment plan. All records had clear signatures and dates indicating when medical staff had reviewed the patient. We saw evidence of appropriate and timely assessments.
- An audit of patient records in the surgery care group took place between 1 March and 30 April 2016. Results showed that in 85% of the records there was an individualised care plan. In 98% of the records risk assessments had been completed (for example for pressure ulcers), and in 96% of records manual handling assessments had been completed.

Safeguarding

- Staff were aware of their responsibilities to investigate and report any safeguarding concerns about children or adults.
- All staff we spoke with had a good insight into safeguarding and knew how to escalate concerns to the trust's safeguarding team. Staff commented on how helpful the team were. There were posters displayed detailing who the safeguarding team were and how they could be contacted.
- On Sharp ward (orthopaedics) there was a dedicated orthogeriatrics team who reviewed the medical needs of patients over the age of 70 years, especially those with fractured neck of femur. This was to safeguard these patients.
- The trust provided us with training figures for the surgical care group. These showed safeguarding level one was 98%, safeguarding level two was 89%, safeguarding level three was 79% and child protection level three was 79%. The trust target for mandatory training was 100%.

Mandatory training

- Staff were mostly up to date with training in safe practice, processes and systems but were not, however, meeting the trust target of 100%.

- On Crownhill ward, we were told that mandatory training was block-booked to enable all staff to attend. This was built into the staff rotas. This was also the same for Clearbrook ward. Clinical educators on each ward monitored compliance with mandatory training.
- In theatres, time was put aside for all staff to complete their mandatory training.
- We were told most mandatory training was completed via e-learning but some required practical sessions, for example moving and handling and resuscitation.
- Sepsis training was included in the trust's mandatory training and staff we spoke with told us they were aware of the protocol.
- The trust target for mandatory training was 100%. Within the surgical care group compliance with the trust update was 83%, resuscitation was 82% and moving and handling was 89%.

Assessing and responding to patient risk

- Risks to patients who were undergoing surgery procedures had been assessed and patient safety was monitored and maintained.
- Patients for some elective surgery attended a pre-operative assessment clinic where all required tests were undertaken. This included MRSA screening, venous thromboembolism assessments and any blood tests. If required, patients could be reviewed by an anaesthetist. A junior doctor attended the clinics to undertake a background history of the patient and complete any further medical tests. At the Erme unit, they reviewed the majority of patients for surgery, except orthopaedics and some thoracic patients.
- Patients who attended for day surgery at the Freedom unit also attended a pre-operative assessment and underwent any tests required to make sure they were fit for day surgery.
- Patients undergoing thoracic surgery who were from out of the area were admitted to the ward and pre-assessed the day before surgery on Crownhill ward. This was to identify any possible risks that may prevent the surgery from going ahead.
- Patients admitted to Hound ward (surgical admissions unit) were all assessed by a nurse, doctors' assistant and a doctor on arrival and then a decision made on whether they needed to be admitted.
- The hospital was using the five steps to safer surgery guidance, which included the World Health Organisation (WHO) surgical safety checklist in all surgical procedures (this is a tool for clinical teams to improve the safety of surgery by reducing deaths and complications). As recommended by the NHS National Patient Safety Agency (NPSA) the tool had been adapted for more specific use in areas such as ophthalmology and interventional radiology. The hospital adopted the use of the checklist as part of the introduction of the NPSA Five Steps to Safer Surgery 2010 guidance.
- We observed patients' identities being checked when they were collected from the wards, day unit or admissions units prior to their operations and procedures. This was to make sure staff had the correct patient.
- We observed all parts of the WHO checklist being completed in full in theatres, and all staff in the theatre were present.
- Outside each theatre, in the main theatre department, compliance with the WHO checklist was recorded. Theatre 11 had a compliance rate of 99% for June 2016 and theatre 12 was at 90%. A senior member of staff told us they investigated why each theatre was below 100% and put actions in place to address this. The trust sent us details of their audits for this, which documented what was missing from each checklist. Where areas were missing on the WHO checklist these were followed up with the staff who were present in theatre at the time.
- The WHO audit for eye theatres in June 2016 showed 100% compliance.
- Eye theatres and interventional radiology used a modified WHO surgical safety checklist pertinent to the operations and procedures they undertook. We observed the first part of the WHO checklist being completed in interventional radiology but we were not present to witness all of this being completed. Staff told us the WHO checklist was embedded into their procedures.
- At the end of operations we observed the final count of instruments and swabs used to make sure they all tallied with the number at the beginning of the operation. This was to make sure no instruments or swabs were left inside a patient. This count was recorded.
- The hospital had a policy for monitoring acutely ill patients. The hospital used their own modified version of the national early warning score for the monitoring of

adult patients on wards. This used a system of raising alerts through numerical scoring of patient observations. The system was in use on wards and in recovery rooms.

- An audit of patient records in the surgical care group took place between 1 March and 30 April 2016.This showed that in 99% of cases all observations had been performed at the required frequency.
- The 'sepsis 6' policy was in place and patients were escalated and reviewed by doctors as required.
- The Acute Care Team supported staff when caring for patients with complex needs. Staff on Crownhill ward told us the team were included in their daily ward rounds.
- There was an on-call rota for out-of-hours interventional radiology and neuro-interventional radiology. However, there were not enough consultants to cover the on-call for neuro and often consultants covered this as a 'gesture of good will'. An additional member of staff had been appointed and was due to start in October 2016 which would increase the number of staff able to undertake on call.

Nursing staffing

- There were vacancies for nursing staff in some of the surgery wards and theatres, which resulted in some shifts being under their safer staffing numbers. Staff told us at times this impacted on the standard of care patients received.
- Staff told us about the 'Safe Care System' they used three-times-a-day. Senior nurses on each ward entered how many staff they had on duty, their level of experience and patient acuity. Matrons reviewed this and re-deployed staff as required. A red flag system had recently been introduced to the Safe Care System, which allowed the escalation of situations, for example where staff were behind on observations, medicines and intentional rounding. This was then escalated to the matrons to review staffing levels to re-deploy staff to this area.
- On Crownhill ward there were nine whole time equivalent vacancies for qualified nurses and one to two bank staff were being used on average every day. The senior management team for the surgical care group told us they had closed four beds on this ward due to staffing issues and this was on the risk register. Eight new members of qualified staff were due to start in August. However, they were all newly-qualified and would require supervision and support. On this ward staff cared for oesophogastrectomy patients immediately post–operation. These patients had complex and high needs following this major surgery. Due to staffing issues on the ward, staff were concerned about meeting the needs of these patients.
- Across five surgery wards there were a total of 13.5 whole time equivalent vacancies for qualified staff. Some wards were supported by military qualified nurses. Recruitment to fill these vacancies was on going.
- The risk register recorded that Shaugh ward had five escalation beds but staffing had not been agreed to staff these if, or when, they were opened.
- All wards told us that at times they worked below their safer staffing levels. Fill rates from January to April 2016 demonstrated this. On day shifts the fill rate for qualified nurses was between 84% and 87%. For unregistered staff it was between 90% and 92%. On night shifts fill rates for qualified nurses were between 87% and 92%.For unregistered staff an average fill rate of 104% was achieved.
- Freedom day surgery unit had recruited to all their vacancies and new staff were due to start shortly.
- In theatres there were 13.58 whole time equivalent vacancies, which included qualified and unqualified staff. A senior member of staff told us they were currently going through the recruitment process to fill some of these posts. There were 11 staff on long-term sickness and six on maternity leave. We saw safer staffing numbers displayed outside each theatre and some were not meeting these numbers. For example, theatre 10 was under-staffed and staff we spoke with told us they often worked under their required numbers.
- Bank and agency staff were used on the wards and in theatres to cover gaps in the rotas. To maintain continuity of care the same staff were often booked. A documented induction was provided to all bank and agency staff.
- **Allied health professional** staff, which included physiotherapists and occupational therapists had a total of 29 whole time equivalent vacancies.

Surgical staffing

- Surgical staffing numbers meant patients received safe care and had access to consultant-led care and treatment. However, out of hours this was not always by a consultant for that speciality.

Surgery

- The trust employed slightly more consultants than the England average. Consultants made up 43% of the medical workforce, compared to 41% nationally. Middle grade doctors made up 6% compared to 11% nationally, registrars 43% compared to 37% nationally and junior doctors 7% compared to 12%. To assist junior doctors due to the reduced numbers, five doctors' assistants on Hound ward covered 24-hours-a–day, seven-days-per week. Their role was to undertake some of the junior doctors tasks, for example blood taking, and to allow junior doctors time to diagnosis and treat patients. Wolf and Stonehouse wards and the orthopaedic unit also had doctors' assistants in place. The trust told us they were working with the local university on implementing physician assistants to further support junior doctors in their role.
- Staff on the wards told us they felt well supported by the doctors. They said all disciplines of doctors were approachable and responded to their telephone calls for advice, support and to visit patients as required.
- Most surgery specialities had at least daily ward rounds; some had twice-daily with additional ward rounds at weekends. On Clearbrook ward they had an assigned junior doctor each weekday to review patients and complete other tasks as required.
- The senior management team for the surgical care group told us they had an on-call consultant who was in emergency theatre all day and had no other roles so they could purely concentrate on operations. Consultants were on-call out of hours but some covered for other specialities. A handover took place between consultants on-call.
- Junior doctors told us they felt supported by their senior doctors.

Major incident awareness and training

- Staff told us they knew the procedure to follow if a major incident took place and they had access to the policy to help them
- In the event of a major incident all elective surgery would be stopped**.**
- There was a designated incident room which would be used during a major incident. This room was also used for the daily site management and operational meetings. Access to the hospital's intranet, patient, staff and ward information was accessible from this room.
- A senior nurse on duty was allocated the responsibility for planning and coordinating should a major incident occur.

Are surgery services effective?

Good

Are surgery services caring?

Good

Are surgery services responsive?

Requires improvement

We rated the responsiveness of surgery services as requires improvement because:

- The trust breached the 18-week referral to treatment operational standard across all surgical specialties, apart from plastic surgery, from March 2015 to June 2015, when the target was abolished by the government (the operational standard is still used by the majority of trusts to monitor their performance). By February 2016, only one surgical speciality was meeting the abolished operational standard and that was plastic surgery. Performance had deteriorated to under 50% for neurosurgery. Over the entire period, all specialties except for plastic surgery performed below the England average.
- Since our last inspection in April 2015 the number of cancelled operations had risen. The percentage of patients not treated within 28 days of a cancelled operation had also risen. Due to pressure for their beds and the demand for their services, some patients had to use facilities and premises not appropriate for the services being provided.
- The trust had 67 patients waiting over 52 weeks for their operations, and of these 37 had not been given a date. However, the trust was working hard to reduce these and had action plans in place.

However:

- The theatre booking system had been reviewed and changes had been implemented to reduce the risk of operations being cancelled and/or delayed. However, staff told us that there were on going issues with the revised theatre list system, as the lists were not always finalised at 3pm the day before surgery.
- The trust had a number of initiatives to reduce the number of cancelled operations. For example, the 'golden bed' identified patients who could be discharged earlier to free up beds for elective operations.

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, for example routine spinal surgery, some patients had been transferred to other health care providers.
- The surgical care group were also working with the commissioners to address their referral to treatment times for all surgery specialities.
- Staff within the interventional radiology department told us they did not have enough space in the department and this had an effect on their capacity and opportunities for meeting the needs of local patients. One staff member said there were four general interventional radiologists sharing one room and there were no hybrid theatres (a hybrid theatre is a combined operating theatre and interventional radiology suite). They also said they were unable to offer services that were available at other hospitals, such as lung ablations under a general anaesthetic. Lung ablation is a minimally invasive treatment of lung tumours, carried out by radiologists, through the use of catheters. They felt this was important, as they were a major cancer centre. The surgical care group and the staff in interventional radiology told us they were currently in a planning phase to expand the interventional radiology department but were still some years away from being able to deliver this.

Access and flow

- The trust breached the 18-week referral to treatment target operational standard across all surgical specialties, apart from plastic surgery, from March 2015 to June 2015, when the target was abolished by the government (the operational standard is still used by the majority of trusts to monitor their performance). By February 2016, only one surgical speciality was meeting the abolished operational standard and that was plastic surgery. Performance had deteriorated to under 50% for neurosurgery. Over the entire period, all specialties except for plastic surgery performed below the England average.
- Since our inspection in April and May 2015 the number of cancelled operations had risen. Between July and September 2015, 664 operations were cancelled. and 563 of these were re-booked within 28 days, but 101 were not. Between October and December 2015 409 operations were cancelled, with 341 being re-booked within 28 days, but the remaining 68 were not. Between January and March 2016 the number of cancelled operations was 618 and 122 were not re-booked within 28 days. The number of cancelled operations between April and June 2016 had reduced to 394, with 87 operations not being re-booked within 28 days.
- The surgical care group management team told us they were receiving more referrals and patient acuity was increasing which was having an impact on their treatment times and cancelled operations. They were in the process of increasing their collaboration with primary care. They told us this would reduce the number of unnecessary referrals and would assist in setting up efficient pathways and assessments for patients. This was a new initiative which needed time to become embedded.
- They also spoke about issues with discharging patients into the community. The bed occupancy level was running at 90% capacity, which was above the England average. Following a review by the Royal College of Physicians, the number of surgery wards had been reduced by two and these had been transferred to the medical directorate to reduce the number of medical outliers in surgery. This had an impact on their number of beds available for elective surgery. The trust was looking at other ways to improve access to surgery services. These included working with other hospitals regionally to improve access to services as a whole, reviewing theatre lists daily and weekly, asking surgeons to prioritise patients dependent on need and looking to increase the number of beds on wards where patients with more complex needs post-surgery could be cared for, rather than being admitted to the critical care unit.
- The trust had closed their neurosurgery list to routine spinal surgery with the agreement of the local Clinical Commissioning Group and another provider was being

used to accommodate these patients. Urgent referrals and patients with high co-morbidities were still being accepted by the trust and managed in line with their policy.

- At our last inspection we raised concerns about the theatre scheduling system, as operating lists were not being managed to make sure they were being utilised effectively. For example there were late starts and lists were being under or over-populated. At this inspection the surgical care group told us that a new computer system had been obtained to address these issues, however it had not been as successful as they had hoped. Work was continuing on this at the time of our inspection. A daily 3pm meeting took place in theatres and all senior theatre staff from all specialities attended. They discussed the theatre lists for the next day. Staffing numbers and skill mix was also discussed at this meeting. We were told that not all theatre lists were finalised at the time of the meeting for the next day and often new patients were added. This had a knock-on effect as staff were not always aware of what equipment was needed or if they had enough for all operations.
- We attended one of the 3pm meetings and noted the display board confirmed that from 1 April 2016 to the time of our inspection, 382 theatre lists had been finalised, 18 had not been finalised and 135 lists had changed after the 3pm meeting. We were told that this had, on occasions, led to operations being cancelled because equipment had not been available and additional patients had been added to the list resulting in lists over-running. All staff worked very hard to make sure all operating lists were covered to prevent cancelling a list due to staffing issues.
- Staff told us the reason theatre lists could change after the 3pm meeting was because consultant's secretaries added additional patients to them. If this happened, the theatre lists were reprinted in pink so staff were aware that changes had been made. Staff told us that finalised theatre lists should be in by 2pm ready for the 3pm meeting and were flagged if they were not. The policy was that if the lists were not in by 2pm then the theatre list would not take place. However, staff confirmed that this was difficult to enforce.
- Staff told us that theatres were usually prepped the day before so if another operation was added to the theatre lists there was a possibility that the theatre would not have the appropriate staff and/or equipment available for the additional surgery. Staff told us it could also mean that theatre staff were unable to prioritise equipment cleaning or sterilisation.
- The trust told us they had 67 patients who were waiting 52 weeks or more for some surgery. Of these, 37 had not been given a date for their surgery. There were eight patients who had cancelled their own surgery, and of these one patient needed to be reviewed by their consultant. The trust had highlighted a number of areas why they had patients waiting 52 weeks or more. For example, demand on their services and theatre list cancellations due to staffing issues. They told us they were looking at ways of reducing this, for example, using other providers where possible and putting on additional theatre lists at weekends and out of hours. We saw patients who had been waiting for 52 weeks or longer were highlighted on operation lists to alert staff and minimise the risk of their surgery being cancelled. However, it is not acceptable for patients to wait this long for treatment. A patient contacted us prior to our inspection and told us they had been waiting over a year for their operation and it had been cancelled three times. During our inspection we spoke with patients who told us they had their operations cancelled more than once and one patient had been waiting for nearly a year.
- The recovery area in the main theatre was able to pre-book extended stays for patients with complex needs, mostly neurosurgery patients. They generally stayed in recovery for between four and six hours before being admitted to a ward. This helped to reduce the number of critical care beds needed and reduced the workload for the surgery wards.
- The surgery services had introduced some new initiatives to start operating lists on time. One of these was the 'golden bed'. This initiative identified patients on the wards who could be discharged earlier. Preparations, for example organising medicines, were made in advance to facilitate an earlier discharge. This made sure beds were available earlier for new patients and allowed surgery to start when it was scheduled.
- The trust was looking to implement and embed a repatriation policy, which would transfer patients to their referring hospitals within 48 hours after their surgery to reduce pressure on bed occupancy. It was

thought that this would result in fewer cancelled operation for other patients. Although the leadership group confirmed that the system had not yet been embedded.

- The day room on Lynher ward was in the process of being converted into a discharge lounge. Some minor works were needed to complete this. A leaflet had been devised by the ward to give to patients about this. The purpose of this was to enable them to free up beds earlier and admit patients for surgery.
- Since our last inspection Hound ward (surgical admission unit) had been moved from level 10 to level seven. This had meant it was next to two surgery wards. Staff felt this had improved patient flow.
- Average lengths of stay for all elective patients in 2015 were slightly longer compared to the England average of 3.3 days, averaging out at 3.8 days. Cardiac surgery was below the England average with 6.9 days compared to 8.8 days nationally. Neurosurgery was 2.9 days, which was below the England average of 4.5 days. For trauma and orthopaedics, it was the same as the England average about 3.4 days.
- For all non-elective surgery in 2015 the average length of stay was very slightly lower than the England average at five days compared to 5.2 days. Colorectal surgery was 3.7 days compared to the England average of 4.7 days. For upper gastrointestinal surgery the average length of stay was lower than the England average at 3.8 days compared to 4.6 days. Trauma and orthopaedics was slightly higher than the England average at 9.4 days compared to 8.7 days.
- Some patients were being cared for on an inappropriate unit. Postbridge unit, a day case unit, was being used as the escalation ward when the hospital was extremely busy and had no beds. Staff told us they requested beds to replace the trolleys used. There were separate toilet facilities for male and female patients, but no washing facilities for patients. The only shower was further down the corridor on another ward. Staff had to accompany patients to the shower, which meant they were off the unit.

Meeting patients' individual needs

- Services were planned to take into account the individual needs of patients.
- Facilities were in place throughout the hospital for patients and visitors with physical disabilities. These included, for example, disabled access to all areas, patient lifts and disabled toilets.
- The trust used a system of electronic boards on each ward where up to date information was stored. This system was able to identify patients with specific needs, for example, patients living with a learning disability or dementia. This enabled staff to be aware that more observation and specialist input may be required to meet the needs of these patients. The hospital had a dementia care lead nurse and consultant who provided support to staff and patients.
- Staff had access to learning disability resources on the wards, including contact details for specialist staff, communication tools and learning material for staff.
- Specialist diets could be provided for patients. Diabetic, soft and Halal foods were all available. Staff told us they needed some notice to obtain Halal meals, but they were able to provide other food in the meantime.
- Translation and interpretation services were available and staff we spoke with were knowledgeable about how to access these services.
- Staff had access to a psychiatric liaison nurse within the trust for support when providing care and treatment to patients who were also experiencing mental illness.
- The trust had devised a number of information leaflets for patients to complement verbal information that was discussed as part of the care pathway. These included explanations about the different types of surgery.
- All surgery wards were, on 1 August 2016, going to introduce the 'Let's be open' strategy to implement open visiting on the surgery wards. It is thought that this can help with patient recovery.

Learning from complaints and concerns

- Patients' concerns and complaints were used to help improve the quality of care.
- Complaint themes were discussed at governance meetings and learning from these was shared with staff at their meetings.
- At our last inspection information about the Patient Advice and Liaison Service (PALS) was not available on all wards and units. This had since been addressed and we saw leaflets on each ward and unit advising how to access PALS. PALS provided support to patients and relatives who wished to make a complaint.

- Senior staff on wards told us they tried to resolve complaints locally on the wards with the complainant.
- Since our last inspection in April 2015, surgery services had received the highest number of complaints within the trust. The three most complained about areas for surgery based on the classifications by the trust were; safe and quality care, access and waiting, and information, communication and consent.

Are surgery services well-led?

Good

We have rated surgery services as good for well-led because:

- The leadership, governance and culture promoted the delivery of high-quality person-centred care.
- There was a clear statement of vision and values, driven by quality and safety. Staff were aware of the trust's vision, values and strategy.
- The thoughts and ideas from staff on how the surgical care group could be improved were being listened to and the culture around incident reporting and learning outcomes had changed positively.
- Staff felt that senior managers were visible, approachable and accessible.

However:

- Within the interventional radiology department, staff told us there were issues with working relationships as the roles and responsibilities of the nursing and radiology staff were not clearly defined.
- Not all staff within interventional radiology felt their ideas were being listened to and acted upon in relation to developing the department.

Vision and strategy for this service

- The surgical care group management team had a clear vision and strategy in place to deliver quality services and care to patients. The immediate strategy for the service was to reduce waiting times for treatment and cancelled operations. One new strategy which had been implemented was for each service line (surgical speciality) to review their theatre lists seven-days in advance to identify any surgical issues, potential cancellation of operations and to implement plans for re-bookings. The surgical care group lead told us this practice had allowed the service lines to prioritise patients and reduce the amount of cancelled operations. The strategy going forward was to build on what they were currently doing and improve the success of their service.
- At our last inspection in April 2015 the surgical care group management team wanted to look at reducing the number of beds in some of the bays on the wards due to the cramped conditions. At this inspection we saw this had taken place on some wards.
- Staff within the theatre department and wards were aware of the visions and values of the surgical care group. The information had been passed down through the surgical board meetings, team reviews and at handovers.

Governance, risk management and quality measurement

- A governance framework was in place to monitor performance and risk and to ensure the executive board were routinely updated.
- Changes to the governance system had been made, which included the introduction of a surgical board who met twice a month. The attendees included the service line managers, matrons, consultants and physiotherapists. Prior to the meetings, the surgical care group management produced an agenda along with data packs containing the current risks and trends within the surgery department. The risks within each surgery speciality and the strategic direction of the surgery department were discussed and then communicated to the service lines and at executive board level. During each meeting an action log was produced and then provided to the service lines. This had resulted in increased efficiency in the monitoring of the performance and faster identification of any serious risks within the surgical care group and governance framework. We were sent minutes of a number of service line meetings prior to the inspection and we saw these discussed issues within each speciality to include medical and nursing for example, incidents, staffing levels and friends and family responses.
- A governance group met once a month, with each service line invited to feed into the group every six months. During the governance meetings serious incidents within the surgical care group were discussed and learning was shared. The governance policies and procedures were reviewed and discussed to identify any

issues. The surgical care group management team informed us that any governance changes and learning was shared at team review meetings, during handovers on the wards and in theatres, and at senior sister monthly meetings. We were sent minutes of these meetings prior to the our inspection.

- Senior and department managers recognised there were still a high number of operations cancelled. They believed once their plans were implemented fully the numbers would decrease.
- We saw the surgical care groups risk register prior to our inspection and found it was reviewed regularly and updated actions added. This included a number of risks we have mentioned in this report, for example, staffing levels on a number of wards and the use of escalation beds on Sharp ward without the agreed staffing. The use of Postbridge unit and other units as an escalation wards was included, but it did not mention about Postbridge unit not having any showering or bathing facilities for patients to use.
- Junior doctors told us meetings between the junior doctors and senior management took place once a month. During these meetings they discussed governance and risk management. Junior doctors said they were unable to recall any formalised daily meetings on the surgery wards.

Leadership of service

- The leadership within the surgical care group reflected the visions and values of the trust to promote good quality care. Within this care group there were 13 service lines (surgical specialities) and the surgical care group oversaw them all. The surgical care group lead told us the care group members had a good relationship with all of them and they felt all relevant information was being shared upwards and downwards.
- At the time of inspection the leadership of the surgical care group was in a transition period. The previous lead was moving into a new role and was being replaced by a new clinical lead. We met with members of the critical care group and they told us their focus was on the ways in which they could manage the demand. They also focused on improvements to the systems they had implemented to reduce referral to treatment times and the number of cancelled operations.
- Theatre, and ward staff told us their senior colleagues and management teams were approachable. Staff felt listened to when issues were raised or escalated. However, not all staff in interventional radiology felt listened to by senior management.
- Staff on all the wards said the ward manager and matron were visible, accessible and supportive. They also said the Head of Nursing for Surgery and Director of Nursing were regularly seen on the wards.
- A junior doctors we spoke with told us they had good working relationships with the registrars, senior house officers and most of the consultants.
- Staff told us briefings from the Chief Executive were received every two to four weeks and were regularly shared in their ward or unit meetings.
- Junior doctors and staff within the interventional radiology department were able to identify the Chief Executive and stated they regularly visited the departments and listened to the thoughts and feelings from staff about how the service could be improved.
- There were a number of staff within the interventional radiology team who felt there were issues with roles not being clearly defined. They felt there was a blurring of the roles and responsibilities of the nursing staff and radiographers, which had caused confusion. Although this had not caused any safety concerns, it had affected working relationships.

Culture within the service

- Staff on the wards were all enthusiastic about working for the trust and how they were treated.
- Staff told us they felt “valued”, “respected” and “trusted” by their line managers and wider hospital management teams.
- Staff were told of compliments and feedback about their care and treatment. We saw thank you cards on wards for staff to read.
- Staff told us they were understaffed within theatres and they regularly worked beyond their hours in order to ensure patients were safe and well cared for. A senior operating department practitioner informed us they had stayed on after their shift had ended in order to attend the 3pm theatre list meeting. They told us this was to ensure cover had been arranged for their theatres as they did not want to leave the responsibility with anyone else.

- A staff member within the interventional radiology department said the Chief Executive had changed the culture within the trust and that everyone now had a voice.

Public engagement

- Patients were encouraged to give their views on the services provided to help improvement and with the planning and shaping future services.
- Patients and relatives were able to feed back their views on the ward via the NHS Friends and Family Test.
- To encourage feedback from patients the department had continued with the 'tea with matron' initiative. These sessions were taking place once a month.

Staff engagement

- Staff were encouraged to give their views on the services provided to help improvement and with the planning and shaping of future services.
- Staff told us they received email bulletins daily and weekly which provided them with information on safety alerts, changes within the hospital and social activities. Junior doctors told us it could be difficult to filter out the useful emails because they were sent a lot of information and did not always have the time to read it.
- Staff told us they knew how to raise concerns. This could be done at team review meetings, directly with senior staff or through the staff survey. We were told by senior staff that information from staff was shared at senior sister meetings, surgical board meetings and at governance meetings.

Innovation, improvement and sustainability

- All staff were encouraged to help with the continuous improvement and sustainability of the trust. However, some staff in the interventional radiology department and theatres didn't feel their ideas for improvement had been listened to.
- The trust was looking at ways of saving money but improving patient care. For example, money had been saved by reducing the administration of antibiotics through the introduction of specialist caps for intravenous lines. A waste management review and process change had seen financial and environmental improvements, and this was going to be rolled out across the hospital.
- Junior doctors told us they were encouraged and supported to develop audits and projects to enhance patient care and monitor performance. They said there were regular opportunities to present their ideas at medical education meetings.
- The trust awarded certificates to teams who performed well in respect of safety targets. The certificates were recognition of the effort the staff made to keep patients safe and well cared for.
- The surgical care group told us they were currently in a planning phase to expand the interventional radiology department but were still some years from being able to deliver the project.
- Staff told us they were in favour of an electronic theatre booking system within the theatre department to replace the current system. The surgical care group informed us they were currently part way through a testing phase and there was still a long way to go until the system could be implemented. They told us the new system would help to reduce the issues they currently faced as previously mentioned, but it was taking a lot of time and effort to ensure the system was ready to install.

Critical care

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

Information about the service

At Derriford Hospital there are two units providing critical care: the department of critical care (referred to as general/neurosurgical in this report) across Penrose and Pencarrow wards, and cardiac critical care in Torrington ward.

The general/neurosurgical department was opened in its current configuration in September 2009. It provides a service to patients who need intensive care (described as level three care) or high dependency care (described as level two care). Patients are admitted following complex and serious operations and in the event of medical and surgical emergencies. The department provides support for all inpatient specialities and tertiary services within the acute hospital, and to the emergency department (including major trauma patients). The two ward areas are linked together. Penrose ward is for patients needing general intensive and high dependency care and Pencarrow ward specialises in patients having neurosurgical advanced care. The department treats around 1,600 patients per year. The acute care team is also part of the general/neurosurgical critical care unit. Services include the outreach team, vascular access team, resuscitation team, the hospital-at-night service, and the pain team. The acute care team supports around 600 patients each year in other parts of the hospital, including patients discharged from critical care.

Pencarrow ward has 10 beds and Penrose, 16 beds. The nursing teams work mostly in one of the two wards, although they are flexible in ensuring the department is safely staffed. The medical team work across the whole combined department. The service is led by a consultant intensivist (a consultant specialising in intensive care medicine) who is part of the medical physician team at the trust.

In 2015, the department of critical care admitted around 47% of patients from elective (planned) and emergency surgical procedures. The remaining 53% were non-surgical patients. Of the surgical procedures, around 19% were high-risk elective surgery, and 23% were following emergency or urgent surgery. Twenty-seven percent of patients were admitted through the emergency department, and 23% came from one of the hospital wards.

The cardiac critical care service provides advanced care for cardiac surgery patients. The service is part of the Southwest Cardiothoracic Unit located at Derriford Hospital, and was established in 1997. The critical care unit is part of the purpose-built cardiothoracic centre, opened in its current configuration in 2008. Torrington ward is an intensive care and high dependency unit for patients following cardiac surgery. The unit was funded to admit patients to 16 beds: eight beds and two side-rooms located in the level three (intensive care) area, and six beds located in the level two (high dependency) area.

During this inspection, we visited the cardiac critical care ward and general/neurosurgical department on Wednesday 20 and Thursday 21 July 2016. The purpose of this follow-up inspection was to look at how the critical care teams had addressed our previous concerns in relation to their responsiveness. At our last inspection in April 2015, we rated this area as 'requires improvement': the other four questions asking if the unit was safe, effective, caring and well-led were rated as 'good'. During

this inspection, we spoke with a range of staff, including consultants and nurses. We met with the clinical leads for both services, the director and matron of the cardiothoracic surgery service, and the matron for critical care and the neurosurgical service. We spoke with patients who were able to talk with us, and their relatives and friends. We checked the clinical environment, observed care, and looked at records and data.

Summary of findings

We went back to the critical care services on this follow-up inspection to review how the units had acted upon findings from our April 2015 inspection. At that time, we had concerns relating to the responsiveness of critical care services. Our concerns were primarily around patient flow and meeting the needs of patients through timely discharge. This was predominantly in the general/neurosurgical unit, which was heavily reliant upon the bed-state in the rest of the hospital and its ability to respond to the need to discharge a patient. On this follow-up inspection, we found the trust had made good progress in addressing the main areas of concern within the general/neurosurgical unit. There had been good progress in reducing the number of patients who had delayed discharges and those discharged to another ward bed at night. This had come from positive consultation, and improved teamwork with all those parts of the hospital affecting patients in critical care.

The cardiac critical care unit provided care for patients undergoing elective or emergency surgery. Due to the nature of the service, and how it was established as an integral part of the cardiothoracic pathway, it was more in control of patient flow. It therefore had less reliance upon the bed-state in the rest of the hospital when discharging patients. Nevertheless, it had made good progress in reviewing patient pathways and reconfiguring bed spaces to improve responsiveness, delays, and patient flow. The cardiac unit was, however, yet to contribute data to the Intensive Care National Audit and Research Centre (there were plans for this to happen shortly) so the unit did not have regular data to benchmark itself in terms of its responsiveness against other services.

We have rated the responsiveness of the service as good because:

- The services were planned and delivered to meet people's needs and co-existing conditions. The services met with local clinical commissioning groups to plan, evolve and improve their services.
- There were arrangements for relatives to stay close to the hospital in purpose-provided accommodation.

Critical care

They had access to facilities, including food and drink, and extensive information in bedside folders about all services within the hospital and the wider community.

- In accordance with specialist guidance, a consultant reviewed patients in both the critical care units within 12 hours of their admission.
- A productive and efficient working relationship had been established between the general/neurosurgical critical care team and the bed management team. This had brought the issues affecting critical care more to the fore and improved access and flow for patients. Cardiac services had been reconfigured to improve delays, access and flow.
- The general/neurosurgical unit had made good progress to reducing the number of patients discharged at night. This was continuing to improve.
- There had been significant progress in reducing the delays in discharging patients from the general/ neurosurgical unit. The results showed the unit was now below (better than) the average for similar units for delayed discharges.
- There had been productive consultations between medical teams, and improvements and adaptations to operating theatre lists to help with access and flow in the general/neurosurgical unit. This had led to new efficiencies and reduced the number of operations cancelled due to lack of a critical care bed. There had also been work undertaken to adapt clinical pathways in cardiac services, and find alternatives to admission to critical care.
- There were almost no patients transferred to another hospital due to lack of a critical care bed. There had been a high level of flexibility and response from the critical care teams to enable almost all patients to be admitted to the units when they needed urgent and emergency care.
- The individual needs of patients were taken into account and patients were well supported. Care was tailored to the needs of patients, and their preferences and circumstances were understood and acknowledged.
- There were follow-up meetings, reviews or conversations to support patients discharged from the general/neurosurgical unit. These were being reviewed to look to provide an optimal service taking account of patient and relative need, and the best use of resources.
- Complaints were listened and responded to, and used to improve patient care and support.
- Patients and their relatives were included in feedback and investigations of complaints, and told when practice had changed because of their input.

However:

- The critical care services had yet to establish the dedicated psychology service in accordance with the guidelines of the Faculty of Intensive Care Medicine core standards and NICE guidance, although had made good progress with commissioners, and already obtained partial funding for the new services.
- The cardiac critical care unit had yet to contribute to the Intensive Care National Audit and Research Centre in order to obtain and learn from valuable benchmarking against other similar units. This had been recognised, and work towards producing data was underway.

Critical care

Are critical care services safe?

Good

Are critical care services effective?

Good

Are critical care services caring?

Good

Are critical care services responsive?

Good

We have rated the responsiveness of the service as good because:

- The services were planned and delivered to meet people's needs and co-existing conditions. The services met with local clinical commissioning groups to plan, develop and improve their services.
- There were arrangements for relatives to stay close to the hospital in purpose-provided accommodation. They had access to facilities, including food and drink, and extensive information in bedside folders about all services within the hospital and the wider community.
- In accordance with specialist guidance, a consultant reviewed patients in both the critical care units within 12 hours of their admission.
- A productive and efficient working relationship had been established between the general/neurosurgical critical care team and the bed management team. This had brought the issues affecting critical care more to the fore and improved access and flow for patients. Cardiac services had been reconfigured to improve access and flow, which was more in the control of this service.
- There had been significant improvements in the general/neurosurgical unit, which was discharging fewer patients at night, and this was continuing to improve.
- The trust had made significant progress in reducing the delays in discharging patients from the general/neurosurgical unit. The results showed the unit was now below (better than) the average for similar units.
- There had been productive consultations between the trust's consultants and doctors to look for improvements and adaptations to operating theatre lists to help with access and flow in the general/neurosurgical unit. This had provided efficiencies and reduced operations cancelled due to lack of a critical care bed. There had also been work undertaken to adapt clinical pathways in cardiac services, and find alternatives to admission to critical care.
- There were almost no patients transferred to another hospital due to lack of a critical care bed. There was a high level of flexibility and response from the teams, and patients were admitted to the units when they needed urgent and emergency care.
- The individual needs of patients were taken into account and patients were well supported. Care was tailored to the needs of patients, and their preferences and circumstances were understood and acknowledged.
- There were follow-up meetings, reviews or conversations to support patients discharged from the general/neurosurgical unit. These were being reviewed to look to provide an optimal service taking account of patient and relative need, and the best use of resources.
- The service listened to complaints, responded to them, and used them to improve patient care and support.
- Patients and their relatives were included in feedback and investigations of complaints, and told when practice had changed because of their input.

However:

- The critical care services had yet to establish the dedicated psychology service in accordance with the guidelines of the Faculty of Intensive Care Medicine core standards and NICE guidance, although had made good progress with commissioners, and already obtained partial funding for the new services.
- The cardiac critical care unit had yet to contribute to the Intensive Care National Audit and Research Centre in order to obtain and learn from valuable benchmarking against other similar units. This had been recognised, and work towards supplying data was underway.

Critical care

Service planning and delivery to meet the needs of local people

- Commissioners and other stakeholders were involved in service provision and development. The general/neurosurgical unit had met with commissioners in the last year to discuss funding to increase the provision of allied health professionals. Our previous inspection had highlighted that, although the service provided by the pharmacists and physiotherapists was safe, it did not meet the guidance of the Faculty of Intensive Care Medicine core standards for critical care units. The input and support provided by of these staff groups to patients and the rest of the multidisciplinary team was insufficient. A funding request for both this, and the provision of a dedicated psychologist to provide support for patients and relatives (another part of the core standards which was not being provided by the services) had been presented by the general/neurosurgical team to local commissioners. The bid had been partially funded so far, further discussions were ongoing, and the management team was working with commissioners to prioritise how it was to be implemented.
- The facilities and premises were appropriate for the services delivered. Both the cardiac unit and the general/neurosurgical unit were built just prior to the issue of guidance from the Department of Health for building modern critical care units. They were, nonetheless, built and equipped to a high standard. In terms of meeting the needs of people using critical care services, the performance against the Department of Health standard (HBN 04-02) was as follows:
  - In both units, there were dimmable artificial lights. Patients said the lights were dimmed at night and they were able to sleep.
  - Both units had secure intercom-controlled entry with CCTV. The units had different entrances for patients and visitors. This supported both the privacy and dignity of patients.
  - There were quiet rooms and visitors' rooms for people to be able to meet and talk away from the unit. All bed spaces were capable of giving reasonable visual and auditory privacy for patients and their visitors. There were side rooms on both units, giving additional privacy. Staff used these sensitively when additional privacy was seen as particularly important.
  - There were good bathroom facilities for patients in the general/neurosurgical unit, but less so for patients in the cardiac unit. Patients had access to a shower and three toilets in the general/neurosurgical unit, and this helped the patients who were well enough to be able to use them. However, there were no toilet or shower facilities for patients in the cardiac unit. Staff said most patients who were able to use these should have already been discharged to a ward, or they would be able to use the facilities on the adjacent ward.
  - There were high-backed chairs with footrests to enable patients to sit out away from their bed when they were well enough to do so.
  - Both units had natural daylight, although not all patients in the cardiac unit were able to see a clock. The guidance for critical care units emphasised the importance for patients to be able to know the time. All the bed spaces in the general/neurosurgical unit had a clock within either the space or visible close by. However, one was not visible for all the cardiac patients.
  - The temperature on the units was comfortable. We visited the units on one of the hottest days of the year so far in 2016, and, although the corridors had heated up from the outside air temperatures, the units were comfortable.
  - There were facilities within the hospital for visitors to get something to eat and drink. All the facilities were described and mapped out in the trust's excellent bedside folder, which contained a wide range of information.
- Work had been done in the units to keep noise/disturbance to a minimum. In our previous report, we wrote about there being some excess noise at times from everyday activities in the general/neurosurgical unit. The acute care team (part of the general/neurosurgery department) had undertaken an externally recognised project. This looked at how to reduce noise/disturbance in the units and throughout the rest of the hospital. One of the senior nurses in the acute care team was proud to tell us about their work in noise reduction across the hospital. It had also achieved international recognition, and the nurses were shortly to visit the USA to present their findings to an international conference. The recommendations included both no-cost and low-cost improvements. These included:
  - Lights to be turned down on the wards by 11pm.

- The phone and call-bell volume to be turned down, so it could be heard but not at shrill levels as it might be in the daytime.
- Have conversations in offices at night where possible.
- Ensure doors were closed before using noisy equipment such as macerators.
- Thinking before switching lights on in the unit or bay when the bedside light was perfectly adequate. Make sure all bedside lights were therefore in working order.
- Consider eye masks and earplugs for patients.
- Noise-monitoring equipment.

The purchase of noise-monitoring equipment had been approved. The acute care team were going to obtain portable monitoring units. These would be moved between wards and units to enable staff to evaluate the sort of noise they were making, and take steps to minimise it.

- The units had equipment to meet patients' health needs that could be unrelated to their critical illness or condition. This included haemodialysis machines to provide kidney dialysis treatment. These machines were dual purpose, in also providing haemofiltration for patients needing renal replacement therapy for acute kidney injury. These patients could therefore be treated on the unit, and not transferred elsewhere for this specialist therapy.
- There were facilities for relatives to stay overnight. The general/neurosurgical unit was able to provide short-term overnight accommodation in a visitors' room. There was also a room in the cardiac unit for an unplanned overnight stay for a relative. The trust also had links with a charitable organisation providing accommodation (The Lodge) for relatives and carers. If they were well enough, patients were also able to stay at The Lodge with their family before an operation. The Lodge was a few minutes' drive or short walk from the hospital. It opened in 2001, and was advertised in literature and a booklet produced by the same charitable organisation, specifically for cardiac patients. Staff, particularly in the cardiac unit, commented upon how The Lodge enabled families to get support from other people in the same or similar position. Staff said they had recognised they could provide a certain level of support, but there was a significant benefit from being able to get support from those in similar circumstances. Otherwise, the units provided information for people about hotels, B&Bs and local services in the area, including transport links.
- Patients and visitors to critical care were given information they could read in their own time, but there was almost no information on the trust website. The information to take away included a specific booklet for cardiac patients, produced in association with a local charity linked to cardiac care. The booklet was also made available to referring hospitals, consultants, and GPs to give to their own patients. The booklet had been reviewed and approved by a patient group and one of the 'tea with matron' sessions. There was a booklet for general/neurosurgical intensive care patients which was about to be reprinted, so that it was kept up-to-date. Both booklets contained helpful information for patients and their relatives, including equipment, visiting, what to bring or not to bring, and how to contact the units. There was other information on noticeboards and in leaflet stands. There was, however, almost no information about either the general/neurosurgical unit or the cardiac unit on the trust website, which is one area where some patients and relatives would look for information. There was information published about visiting times and telephone numbers, but nothing about the units themselves.
- The trust was responsive to the needs of long-stay patients in critical care. There were arrangements to enable the relatives of patients experiencing a long-stay in hospital to get a discounted car-parking rate. Staff in the critical care units were aware of this scheme and helped visitors. Staff were also aware of charitable funding opportunities for long-stay relatives at The Lodge, and how to direct visitors to other services, such as expenses for people receiving benefits.
- The general/neurosurgical critical care service followed-up patients discharged from critical care. Providing a follow-up service for patients was part of the National Institute for Health and Care Excellence (NICE) guidance 83: Rehabilitation after critical illness, recommendation 1.1.25, and the Faculty of Intensive Care Medicine (FICM) core standard 2.16. The FICM stated, "Critically ill patients have been shown to have complex physical and psychological problems that can last for a long time. These patients benefit from the multi-modal approach that an ICU follow-up clinic can

deliver." The general/neurosurgical unit, which was where these standards and guidance were directed, had established a follow-up service, as opposed to a regular clinic. The unit contacted all patients following discharge and sent them a questionnaire to complete and return. The questionnaire included screening for post-traumatic stress disorder, and possible physical or medical problems. A returned questionnaire might lead to a consultant arranging a follow-up meeting with a patient, or the consultant writing to a patient's GP and recommending further therapy or treatment. A GP might then refer a patient to, for example, physiotherapy, or another allied health professional to support or treat the patient. The consultant might also refer the patient to the trust's psychology service. We saw letters to patients' GPs to this effect, one after review of a questionnaire, and another from a face-to-face follow-up meeting.

- The general/neurosurgical unit and the cardiac critical care unit were both proactive in looking to improve or adapt their services. Noise-reduction, seven-day working, and adapting care pathways were recent examples. The general/neurosurgical unit was also researching follow-up clinics with a view to providing a telephone-based service to improve the response rate to follow-up questionnaires. It was hoped this would provide improved follow-up support to patients, but have in mind those patients who could not complete a questionnaire. These patients might be among the more vulnerable people in society. One of the senior nurses was undertaking a research project on the optimal follow-up service for the unit to pursue.

Access and flow

- There had been a significant improvement in access and flow for patients. This was particularly the case, as was needed, in the general/neurosurgical unit, which, as described in our last report, had problems with discharging patients. At that time, this was due to the lack of available beds in the wider hospital to move patients to when they were fit for discharge from critical care, and high levels of demand in the healthcare system. One of the main contributing factors leading to improvements was a changed and much-improved relationship with the hospital's bed management team. The general/neurosurgical team were now considered as a key part of bed management and attended the 8:10am bed meeting each day. This meeting was preceded by conversations on the unit with the nurses and doctors to ensure a clear picture of the unit's pressures/capabilities was taken to the bed meeting. The conversation at the bed meeting now took much more account of prioritising the discharge of patients from the general/neurosurgical unit, rather than, as previously, looking mostly at whether the unit was able to admit patients. Prior to this reprioritisation, if the unit had a vacant bed, it was presumed to be not under pressure, and the focus moved away to other areas. The focus had now shifted to understand and acknowledge the importance of discharging patients in a timely and appropriate way.
- Staff had been proactive and successful at improving access and flow in the general/neurosurgical unit. There had been progress made to achieve a more efficient operating theatre programme to align with the work and pressures upon the general/neurosurgical unit. Consultants had a good multidisciplinary approach to each other's pressures. Theatre lists and bookings for elective operations were now better organised to take into account the pressure in the unit, and this was helping to increase the access and flow for patients. Consultants discussed cases with one another to consider the different options available to ensure surgery went ahead, and looked for collective solutions.
- There had been changes in the cardiac critical care unit, which had led to improved access and flow for patients. This had included a recent consultation and move to seven-day working; ring-fencing of beds on surgical wards; and changes to bed management within the service to improve patient flow. There had also been alterations to clinical pathways. This included adjustment to anaesthesia, where it had been researched and recognised that local rather than general anaesthesia was safe and preferable in some procedures. This reduced the need to bring post-operative patients through intensive or high-dependency care. The cardiac team were also leading on a southwest programme looking at the process of referrals for transcatheter aortic valve implantation (known as TAVI procedures). The aim of the programme was to increase the number of appropriate patients who would be suitable for this less invasive procedure and avoid the need for open-heart surgery, which is carried out under prolonged deep anaesthesia. A higher take-up among patients, who

could otherwise be too frail for a conventional valve replacement, would reduce length of stay and add to improvements to access and flow through cardiothoracic services.

- The general/neurosurgical unit and the trust had taken action to reduce the number of patient discharges delayed due to a lack of available beds elsewhere in the hospital. There had also been action from the cardiac unit to improve delays and patient access. Although patients remained well cared for in critical care settings, when they were medically fit for discharge, the unit was not the best place for them. Failed discharge could delay patients who needed to be admitted, or meant a unit had higher occupancy levels than recommended. There were improvements in three different measures of delay:
  - Data from the Intensive Care National Audit and Research Centre (ICNARC) reported a fall in the level of delayed discharges from the general/ neurosurgical critical care unit (the cardiac unit was not a contributor to ICNARC, but was hoping to submit to the programme if a funding bid being prepared was successful). In the last five years, the general/neurosurgical unit had been above (worse than) similar units (combined general and neuroscience units) for delayed discharges (now measured as delays of more than eight hours). In the first nine months of 2015/16 (April to December 2015), delays had fallen to 2.2% of patients, from a high point in the last five years of around 5% in 2014/ 15. The 2015/16 result was better than similar units, who were on average discharging 4.8% of patients with more than an eight-hour delay.
  - The general/neurosurgical unit's own data provided an up-to-date picture. This showed there had also been a significant drop in the number of patients who were delayed in the unit for more than 24 hours. At the peak of the problem, in June 2014, there were 35 patients delayed for more than 24 hours. In April 2016 (the latest available data), this was just one patient. The peak in the six months from November 2015 to April 2016 was eight patients in March 2016, and the average was 4.8 patients.
  - There was a similar pattern for delays measured at over six hours and over four hours. Both of these had dropped in the last year to April 2016, and were back to below average levels and those last seen in 2013.
- The discharging of medically fit patients from general/ neurosurgical critical care to a ward in the same hospital was not always achieved at the right time for the patient (happening at night), but this had improved in the last year. This information was not available for the cardiac unit, although there was no evidence to suggest it was an issue for a unit with a more planned patient flow (as most patients had planned elective surgery). Studies have shown discharge of patients at night can increase the risk of mortality; disorientate patients and cause stress; and be detrimental to the handover of the patient. Data from ICNARC for the first nine months of 2015/16 (April to December 2015), for discharges made out-of-hours (between 10pm and 7am), showed the unit was slightly above (worse than) similar units for this measure. In these nine months, the average number of patients discharged out of hours was 3.2%, against a similar unit average of 2.2%. This had, however, steadily fallen each year for the last five years, and was on target to fall further when the latest data was added. The unit had gathered data beyond December 2015 (yet to be reported by ICNARC). Whereas there was an average of around nine patients discharged at night each month in the nine-month ICNARC period, and much the same for the next three months, this had fallen to an average of seven each month in April to June 2016. Data from the unit showed the vast majority of the night-time discharges were at the start and end of the period, so mostly before midnight, and around 7am.
- Staff on the general/neurosurgical unit had been proactive with anticipated patient discharges. Paperwork for patients who were approaching fitness to discharge was started as soon as possible, and particularly on the quieter night shift. This was enabling discharges to be more efficient, as planned better in advance, and was saving time when the discharge was ready to happen.
- Occupancy levels had reduced and enabled an improved access and flow to and from the general/ neurosurgical unit. The cardiac unit mostly had 100% occupancy, which was planned, as this was a unit admitting post-operative patients from elective or urgent surgery. It was therefore expected to have high levels of occupancy in order to meet the needs of an optimal number of patients. Where occupancy had been below 100%, this had been due, most of the time, to reducing open beds to respond to insufficient staff on duty, rather than any other inefficiencies. For general

critical care units, the Royal College of Anaesthetists recommended maximum critical care bed occupancy of 70%. Persistent bed occupancy of more than 70% suggested a unit was too small, and 80% or more was likely to result in non-clinical transfers that carried associated risks. Detailed occupancy figures for the general/neurosurgical critical care unit, as published by NHS England, showed an average occupancy of 68% for the six months from December 2015 to May 2016. The peak was 81% in January 2016. In reality, the occupancy was higher than this figure. This figure took into account all beds, when, in practice, some beds had been closed to ensure others were safely staffed at all times. The unit's own data showed occupancy of around 75% on average for the six-month period. This was better than the England average of 85%. Nevertheless, occupancy had reduced since our last inspection. In January 2016, it was 90.5% and in February was 88.1%. Both of these were above (worse than) the England average at the time of 88%.

- Patients were rarely transferred from the general/neurosurgical unit or cardiac unit to other critical care units for non-clinical reasons. Non-clinical transfers occur when a patient is moved to another acute hospital, mostly due to the lack of an available bed. Non-clinical transfers for the general/neurosurgical unit had been almost zero for the last five years, with the last occurrence reported by ICNARC in 2012/13. The unit was, consequently, better than similar units for non-clinical transfers, as similar units transferred 0.3% of patients in April to December 2015, when ICNARC reported there were none moved from Derriford hospital. This was, however, slightly different to information provided by the unit, which reported one non-clinical transfer took place in November 2015. Despite this anomaly in data, the occurrence remained rare.
- There were some essential clinical transfers or those arranged to bring patients closer to home. Clinical transfers were arranged when specialist treatment was needed elsewhere. The general/neurosurgical unit had transferred five patients for this purpose in the 12 months from June 2015 to May 2016. Both the general/neurosurgical and cardiac unit would repatriate patients for a number of reasons. The cardiac unit, for example, had repatriated patients, who had come to this regional centre for specialist cardiac surgery, back to their 'home' hospital when they were well enough to be moved. This had enabled them to be closer to their family and friends as they continued their recovery. The general/neurosurgical unit had also repatriated patients who, for example, had been on holiday in the area, and were moved back to their 'home' hospital for the same reasons.
- There was timely review in person by a consultant in intensive care medicine within 12 hours of admission to the general/neuro unit, and the appropriate consultant surgeon or consultant cardiothoracic anaesthetist or intensivist in the cardiac unit. There was seven-day working in both units, and the medical rotas ensured there was a consultant either on duty or on call at all times.
- Some, although few, operations were cancelled due to lack of a critical care bed and when there was no other option, to optimise patient care and safety. This happened in both the general/neurosurgical unit and the cardiac unit. Data from the cardiac team for the 12-month period from July 2015 to June 2016, reported there were 253 operations cancelled. Of these, 111 were due to a critical care bed not being available post-operatively. This represented two operations a week on average. Another 43 were cancelled due to an emergency operation taking priority. This information was not being benchmarked against other units in England and we were therefore not able to report if this was better or worse than average. However, in a 2014 report from the National Cardiac Benchmarking Collaborative (a group made up of 28 UK specialist cardiac centres), the Plymouth team were in the middle of the range of cancelled elective operations. The median average was 11% and Plymouth cancelled 12% in the 2013/14 year, which represented 289 operations. However, this number had fallen in the period reported above, to 253 in 12 months. Although there was no data provided to demonstrate this, staff said the cancellations were generally very short-term and most operations took place the following day or shortly afterwards.
- There were low numbers of operations cancelled due to the lack of an available bed in general/neurosurgical critical care. In the 12 months from July 2015 to June 2016 there had been 182 elective operations cancelled due to no critical care bed available post-operatively. This represented just 0.3% of patient admissions to surgery.

- Staff were proactive to avoid cancelling elective surgery, when it was otherwise too late to make alternative arrangements. This helped maintain good patient access and flow and limit the inevitable disappointment to patients and relatives. We observed staff on the cardiac unit, for example, making sure all staff were aware if they had a patient due for surgery who had experienced a previous cancellation or long waiting period. Staff were aware of how any further changes would affect the patient or family, and made sure they were given a specific priority, while assuring the safety for all other patients. Patients were also assessed on the day before their cardiac surgery. This was to make sure they were still fit for surgery, had understood and acted upon the various things they needed to do, such as stopping certain medicines, were free of any other illnesses (such as the common cold), and had fasted appropriately. Timely cancellation of operations for unplanned reasons (such as any of the above not having been achieved) enabled other surgery to be brought forward if a patient was found to be unsuitable at that time and needed their operation rearranged.

Meeting people's individual needs

- Communication aids were available to help patients who could not use speech. This was something more relevant to the general/neurosurgical unit and patients being helped to breathe with a tracheostomy. The unit had high and low level communication boards (where patients could write or point to words and letters), and computer tablets, which could be used for communication and feedback to the staff from relatives and patients. There were speaking valves for use with patients with a tracheostomy, and input from a speech and language therapist. The Guidelines for the Provision of Intensive Care Services (issued in 2015 by a multi-professional joint working group under the Faculty of Intensive Care Medicine and Intensive Care Society) recommended all patients with critical care needs who have communication difficulties should have access to an early, timely, responsive and appropriately skilled speech and language service, which can provide quality care.
- Dedicated psychological support for patients or their families was not yet established, but the units understood the significance of this. It was now a high priority for the units' consultants. Following our previous concerns in relation to this gap in their service, the general/neurosurgical unit had applied to the clinical commissioning group for funding. This bid had made advanced progress. As we highlighted in our last report, 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. Acute stress has been shown as one of the strongest risk factors for poor psychological outcomes after intensive care. The National Institute for Health and Care 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 significant role supporting distressed families. Some patients were referred to the local psychological service, but there was limited capacity in this service. There were, therefore, some delays in this process, and no ability to predict patients or families that might need help and provide timely therapeutic intervention.
- The services reflected the needs of the local population. There were no apparent barriers to admission due to a patient's age or gender. Intensive Care National Audit and Research Centre data reported the average age for patients admitted to general/neurosurgical critical care was 60 years, which was similar to the national average. Typically, the majority of patients admitted were male (around 56%) which was also similar to the national average.
- There were services and care designed to take account of people's different needs. This included a translation service; help for people with hearing or vision impairment; support for different diets linked with preference, clinical need, or cultural values; support for people living with dementia; screening for patients to manage delirium or withdrawal from drugs and alcohol dependency; and tailored support for patients with a learning disability or learning difficulty. Patients were identified in a sensitive way to ensure staff were aware of any specific needs. This included the use of symbols and codes to identify patients' needs, while not breaching the patients' rights to confidentiality. In meeting dietary needs, we heard staff in the cardiac unit arranging to provide certain food for a patient who was used to a different diet (a lot more fruit in this case).
- Care was tailored to meet the needs of the patients and those close to them. The cardiac team told us about

admitting a patient with a learning disability, and how they had introduced a package of care to enable their family to stay with them on the unit (in a side room) 24 hours a day. They arranged, with advanced planning, to transfer this patient back to their 'home' hospital as soon as it was clinically safe. This was to ensure the person had the support of the rest of their family and carers. Another patient had been able to have toys around them as they wished. One of the senior nurses from the acute care team (the service including the critical care outreach service, the pain team, hospital and night, resuscitation, and vascular access) told us how a patient who was recognised as having additional needs from living with dementia or a learning disability would be identified. This would be to avoid moving them at night, or moving them multiple times. The general/neurosurgical unit had designated staff champions (or link nurses), who were enabled to give more specialist advice on a specific need, or knew how to get information to help support a patient. These included, but were not limited to rehabilitation, patient diaries, learning disabilities, elderly care, and palliative care.

- Staff were responsive to patients needing to keep in touch with the world around them. This was more relevant to patients in the general/neurosurgical unit, but had been achieved on both units. Staff had taken patients outside for fresh air, including safely moving complex monitors and equipment. Patients had been taken to visit the atrium in the hospital on level six, and had been able to look out over the hospital and beyond. In the general/neurosurgical unit, rehabilitation plans were written up on the patient's own whiteboard in their bed space, so patients could see their own plans and progression. Since our last inspection, the general/neurosurgical unit had also introduced more proactive use of the patient diary. Research has shown how patients who are sedated and ventilated in critical care can suffer memory loss and often experience psychological disturbances after discharge. Patients' diaries had been introduced as the unit recognised they provided comfort to both patients and their relatives. The general/neurosurgical staff said this had been recognised as also helping patients come to terms with their illness and a member of the nursing staff had taken charge of this activity. The diaries were given to the patient to take home as their own property. There were also televisions available at all bed spaces in the general/neurosurgical unit. Staff on the cardiac unit had raised money (supported by a matching donation from the trust) to provide three televisions for patients in the cardiac critical care unit, so those who were well enough could use these.
- Patients or visitors with a disability were able to access the units on an equal basis with others. There was good physical access to the units. They were located close to stairs and lifts and accessible by flat access from the main and other entrances. They were well signposted, and the visitors' entrances, which were separate from patient entrances, were highlighted and welcoming. The doors into the units, the waiting room and clinical area were wide enough to allow wheelchair access and remained open long enough for people to safely enter and leave the units.

Learning from complaints and concerns

- There was information available to direct people who might want to make a complaint or raise a concern. Most concerns about critical care were discussed verbally between patients, their relatives/carers, and staff, and rarely escalated to a formal complaint. Staff said most concerns were resolved quickly by listening and acting to resolve problems. Information on the units was made available to people who wanted to complain or raise concerns other than verbally, such as by telephone, through a website link, or by letter. Leaflets were also available in waiting areas describing the complaint process. The matron for the cardiac unit talked with passion and enthusiasm about the 'tea with matron' sessions. These were held monthly for an hour. Patients and relatives were invited to take tea and cake with the matron for the unit they or their relative had been admitted to. This was another forum where patients and relatives could raise concerns, or make suggestions to make hospital life easier for them.
- Complaints and concerns were dealt with efficiently. There were very few complaints and concerns made to the critical care units from patients or their relatives. Nevertheless, the cardiac team told us about an incident and subsequent complaint from a family. We saw how this had been investigated promptly, and the family had been involved in a timely way in the process and outcome. The team had accepted how communication was an area that could be improved, and ensuring information given to families was

consistent, and considerate of its impact. Complaints were responded to quickly, and any delays or reasons to need to extend an investigation were explained to the people concerned.

- Changes were made when a complaint or concern demonstrated they were needed. The cardiac unit, for example, talked with us about how they had amended clinical practice and policy in one aspect of cardiac monitoring following a complaint investigation. Televisions had been provided in the cardiac unit when patients expressed concerns about boredom at times.
- People were involved with complaints and given feedback as they wished to receive it once an issue had been investigated. Staff demonstrated how they had involved patients and relatives with complaint feedback and the way the service planned to make or had made changes. Feedback had included holding meetings with those involved, or writing to the person concerned if this was how they preferred to hear back from the hospital.

Are critical care services well-led?

Good

Maternity and gynaecology

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

Information about the service

The maternity and gynaecology services were managed from within the trust's women and children's care group. The trust provided a range of antenatal, intrapartum and postnatal maternity services for women 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. Women assessed as having low risk had midwifery led care. Between April 2015 and March 2016 there were 4,572 births. Of these, 163 were planned home births.

At Derriford hospital there was a 13 bed delivery suite, two of which were high dependency and one room had a birthing pool. In addition, there was a four-room triage area, two 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 or additional 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 Meavy ward which had 12 beds. These included general and emergency gynaecology, urogynaecology, 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 Meavy 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. Any higher gestation period would require the patient to be referred to a specialist provider.

During this inspection we spoke with a range of staff working across the gynaecology and maternity services. These included; two consultants, the women and children service line manager, the head of midwifery, nine midwives, two gynaecology nurses, two midwifery support workers and one administrator. We held a number of focus groups. These were attended by a total of 10 midwives and two gynaecology nurses and two gynaecology support workers. We reviewed five patient records. Before, during, and after our inspection we reviewed the trust's performance information.

Maternity and gynaecology

Summary of findings

This was a follow up inspection to assess whether the trust had made sufficient progress to improve the 'Safety Domain' following a comprehensive inspection during April 2015.

The previous inspection identified the maternity services needed to make improvements to the safety of the service. This related to the environment, equipment and cleaning policies and procedures. Improvements were also required to patient discharge processes and the storage of some medicines. During this inspection we found the trust had made good progress in improving the main areas and issues identified as a concern within the maternity services.

We have rated the maternity and gynaecology services as safe because:

- The delivery suite was consultant led and able to support women with high risk pregnancies or complex health. Patients assessed as having low risks were appropriately supported by midwives.
- Staff were knowledgeable about incidents and learning from these was demonstrated.
- Patients had risk assessments completed and reviewed regularly.
- There were established and thorough safeguarding systems in place to protect vulnerable adults and children.
- The delivery suite had been partially refurbished and some faulty equipment had been replaced, which enabled more effective cleaning.
- Records and medicines were safely stored and equipment had been regularly checked.
- Discharge processes had not been reviewed but this was promptly amended during our inspection.

However:

- Processes in place were not clear for identifying the percentage of staff who were compliant with mandatory and other safety training. Related to this, we found staff training was urgently required for emergency procedures using the birthing pool.
- There were no plans in place to complete the refurbishments on the delivery suite.
- The cleaning policy and procedure for the birth pool required reviewing.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Good

On this follow up inspection we have judged safety as good because:

- Refurbishments had started on the delivery suite. This included: four of the 13 delivery rooms, one bathroom and walls in all rooms and corridors. This enabled more effective cleaning to prevent and limit the spread of infection.
- There was an identified cleaning process for the birth pool and all staff were clear who was responsible for this.
- Broken suture lamps on the delivery suite had been replaced.
- The supervisor of midwife to midwife ratio had increased to the recommended levels and additional midwives had completed supervisor training.
- Daily checks of emergency equipment had been completed.
- Whilst the discharge process from the maternity services had not been reviewed before this inspection, this was completed whilst we were on site.
- Medicines had been stored appropriately.

However:

- The birth pool cleaning policy required review to demonstrate compliance with any manufactures guidelines and recommendations and incorporates any further recommendations from the trusts infection control lead.
- Processes to identify and evidence, the percentage of staff who were compliant with mandatory and role specific training were not clear.
- There was some outstanding refurbishments required on the delivery suite. This includes the remaining nine birth rooms, and the bathrooms and toilets which were shared between patients.
- Not all areas such as the inside of windows in the delivery suite were included in the cleaning schedule.
- There was a lack of equipment to promote normalising birth and movement during labour and to aid pain relief.

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 and post-partum haemorrhages. A list of reportable incidents was included in the maternity risk management framework. Staff demonstrated an understanding of the processes they should follow.
- 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 limited in some areas.
- Staff told us feedback and learning from incidents was cascaded through handovers, emails, team and other meetings. We looked at the maternity newsletter (emailed to all staff) dated May 2016, and the gynaecology and maternity safety brief used during handovers. These included learning from investigations and incidents and practice points on how to improve communication to reduce patient incidents. In addition, we reviewed various meeting minutes, including from the women and children's business meetings (dated March, April and May 2016). These documented learning points from gynaecology and maternity serious incident investigations.
- There had been nine serious incidents reported between June 2015 and May 2016. We looked at the documentation for six of these and saw root cause analysis investigations had been completed. These included scrutiny of records, tests, policy, staff recollections and multidisciplinary discussions. Overall action plans had been completed. This included sharing any identified learning and additional actions required to minimise other patient risks with all departmental staff. The records documented who was responsible for completing actions and time scales. Action plans were kept under review during weekly service line managers' meetings and within monthly risk management and clinical effectiveness meetings.
- Obstetric and neonatal mortality and morbidity meetings were held every two months. We looked at meeting minutes (dated November 2015, January and March 2016) which detailed individual case reviews. Areas of good practice and service issues were identified for each one. Detailed discussions were recorded between the clinical staff attending the meeting to further embed learning and improve practice and procedures. For example, obstetricians and

neonatologists had been liaising with each other as and when required. Following one incident a process to ensure there was daily communication between obstetricians and neonatologists was formalised. This was done in order to for the consultants to maintain a more consistent and joint overview of actual or potential clinical issues.

Duty of candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires the trust to notify the relevant person when an unintended or unexpected incident had occurred. The trust should provide reasonable support to the relevant person in relation to the incident and offer an apology. Staff we met in the maternity and gynaecology services demonstrated an understanding of these regulations and their responsibilities.
- We saw evidence of duty of candour requirements documented in the six serious incident investigation reports we reviewed. This included confirmation that the principles of duty of candour had been followed with examples of details of conversations with patients. For example, when and who had provided an apology, the time spent with patients and their families discussing the circumstances of incidents, how incidents would be fully investigated and who would be responsible for maintaining contact and providing ongoing information and any other support required.

Safety thermometer

- The inpatient maternity and gynaecology wards (Argyll and Meavy) 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 displayed in some clinical areas for patients, visitors and staff to see.
- The maternity services had recently introduced an adapted NHS safety thermometer. This included monitoring infection rates and complications during and after birth as well as patients' perceptions of safety. For example, if the patient felt concerns had not been taken seriously. This information was being used with the more extensive maternity dashboard to monitor patient safety. These were analysed through monthly governance processes. If improvements were identified, actions were recorded as taken to improve patient safety.

Cleanliness, infection control and hygiene

- All ward areas appeared visibly clean. We observed stickers were used to indicate when equipment had been cleaned and were ready for use. Antibacterial hand cleaner was available throughout clinical areas and we observed staff and visitors using these. We reviewed hand hygiene audits for the maternity services dated June 2015 to May 2016. These reported 100% compliance with hand decontamination before and after patient contact.
- There was a low risk of patients contracting a hospital acquired infection. We looked at records for the gynaecology and maternity services between April 2015 and March 2016. There had been no reported incidences of Norovirus, Clostridium difficile (Cdiff), E. coli, methicillin-resistant Staphylococcus aureus (MRSA) or methicillin-susceptible Staphylococcus aureus (MSSA). There had been no cases of Cdiff or MRSA reported since May 2015. Records reported appropriate precautions and patient care were followed.
- During our previous inspection we were concerned the delivery suite could not adequately comply with the prevention and control of infections policy and guidance. This was due to damaged areas in rooms and corridors which consequently could not be effectively cleaned. During this inspection we observed four of the 13 delivery rooms had been completely refurbished. This included replacement flooring and sinks with elbow operated taps. Walls in all rooms and corridors which had previously shown damage, had been covered with toughened easy to clean material.
- During our previous inspection, we were concerned about arrangements to clean the birth pool. There had been confusion regarding whose responsibility this was and there was no cleaning schedule, records or audits. During this inspection staff understood cleaning staff had responsibility for decontaminating the pool after use. These duties were completed by midwifery care assistants when cleaning staff were not available.
- We saw cleaning guidance was kept near the birth pool and we were assured this was followed after each patient use. Staff confirmed the guidance had been based on trust guidance: 'Decontamination Guidelines

and Procedures', 2012. Senior staff were not able to confirm if the birth pool cleaning guidance had been developed to take account of the manufacturers' recommendations or with further advice from the trust's infection control lead.

- During our previous inspection, staff confirmed the inside of the windows on the delivery suite had not been fully cleaned for a long time. During this inspection, we saw the windows had still not been cleaned. Senior staff told us this was due to the high costs quoted for this work.
- On the gynaecology ward (Meavy) the environment and equipment appeared visibly clean. We observed the sluice room was visibly clean and organised with bleach tablets (used for cleaning) stored in a padlocked cupboard. Staff were observed using personal protective equipment such as aprons and washing their hands before and after providing patient care.
- On Meavy ward we saw there were effective and safe processes in place for the safe storage and sensitive disposal of the products of conception. All processes and procedures were marked with a discrete symbol. This was understood by all staff including the ward housekeeper, cleaning staff and porters.

Environment and equipment

- The maternity and gynaecology environment was organised, with equipment stored appropriately. 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 area.
- The gynaecology and maternity wards and delivery suite were accessible with a swipe card for staff and controlled by a buzzer for patients and visitors. CCTV was used in the maternity areas.
- During our previous inspection we identified improvements were required for the security and safe discharge of mothers and babies. Patients were requested to formally check-out at the maternity reception. We observed this was not always completed and the trust did not use baby tagging or have an abduction policy. During this inspection we spoke to senior staff about the discharge processes for patients and newborns. The processes had not changed, but senior staff subsequently promptly addressed this. The revised maternity discharge pathway showed patients were to be discharged directly from the ward or the delivery suite rather than the maternity reception. The trust told us these changes to procedure had been cascaded to staff through emails, as part of shift handover sheets, within the maternity newsletter and had been added to the message board on the delivery suite. The trust had also developed a standard operating procedure 'Infant/Neonate Abduction SOP', (December, 2015). The midwifery staff we spoke with were aware of this policy and how to access it.
- During our previous inspection, emergency resuscitation equipment was accessible in all clinical areas but daily safety checks had not been consistently completed. During this inspection, we saw records which documented equipment had been checked and reviewed as fit for purpose on a daily basis. This included adult emergency resuscitation equipment on the gynaecology and maternity wards and delivery suite, and for 12 baby resuscitaires.
- 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. Equipment in the two rooms used for high dependency patients and within the obstetric theatre and recovery area was fit for purpose.
- During our previous inspection we saw areas on the delivery suite which required updating due to poor décor and faulty equipment. During this inspection we observed some areas and rooms had been improved and some faulty equipment had been replaced. This included the purchase of six mobile angle poised lamps and some seating for birth partners. Renovations were due to begin on the main clinical work station and to one of the bathrooms. This included the installation of a double-sized bath for use by patients in labour.
- Whilst four of the 13 delivery rooms had been refurbished, these remained clinical in appearance as opposed to promoting a more 'home-like' environment. This has been shown to reduce stress and promote a normal birth process (Safer Childbirth, Royal College of Obstetricians and Gynaecologists, 2007). There were no further plans in place to renovate the remaining nine birth rooms or the en suite toilets which were shared between two rooms.

- Birthing equipment to facilitate mobility and ease pain and discomfort in labour was limited. Birthing balls were available plus one t**ranscutaneous electrical nerve stimulation** (**TENS)** machine; and one birthing pool.

Medicines

- During our last inspection controlled drugs were stored unlocked in the unoccupied obstetric anaesthetic room whilst the operating theatre was in use. This meant there was a risk medicines could have been removed or tampered with. During this inspection we saw all medicines were stored appropriately in locked rooms and/or locked cupboards. The senior nurse (gynaecology) and midwife on duty were responsible for the safe keeping of medicine cupboard keys.
- Oxygen and nitrous oxide used for pain relief were piped into delivery rooms. Records showed the maintenance of these gases were reviewed and monitored.
- Medicines that required storage at low temperatures were kept in a dedicated fridge, which was in a key pad locked room. Records documented the fridge temperature was checked and recorded daily.

Records

- During our last inspection we observed that not all records or patient information was stored safely or confidentially. During this inspection we saw records within the gynaecology and maternity wards, on the delivery suite 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.
- 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. The hand held records were reviewed and updated during each consultation.
- During our last inspection we saw some gynaecology records for emergency patient admissions were insecure. During this inspection we saw records for emergency admissions were stored together in sealable plastic wallets, which were kept in the records trolleys. These were transferred to the patient's main files when they delivered or when a new record was made for them.
- We reviewed five patient 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 and documented where necessary. For example; for venous thromboembolism (VTE) and obstetric early warning charts.

Safeguarding

- Staff we spoke with were knowledgeable about the trust's safeguarding processes and were clear about their responsibilities. We observed how staff responded to a patient identified as vulnerable. Staff were kind and supportive whilst repeatedly providing the patient with examples of risks and consequences to their circumstances.
- 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, the more advanced level 3 training. We saw records which showed 100% of gynaecology staff had in date safeguarding training. Compliance for the maternity staff was recorded as between 82% and 92%. The trust compliance target was 100%. Despite this, senior staff were confident the majority of staff were in date with safeguarding training.

Mandatory training

- The trusts mandatory training included: trust updates, resuscitation, manual handling, medicines management and safeguarding adults and vulnerable children. Maternity and gynaecology staff were required to attend different levels of training based on their roles. Information was provided by the trust for training completed up to the 1 July 2016. Records supplied by the trust showed maternity staff were between 81-93%

compliant with mandatory training against a trust target of 100%. Records showed all gynaecology nurses and support workers were 100% compliant with mandatory training.

- Maternity staff attended an additional annual day's mandatory skills and drills prompt training (practical obstetric multi-professional training; PROMPt). This included basic and intermediate life support and neonatal life support. The trust confirmed 99% of staff were in date with this and the remaining staff (2) not in date had been booked to attend.
- We reviewed mandatory and other training spreadsheets. Whilst information was recorded for each person (211), it was not easy to gain oversight of level of compliance and percentage rates for each type of mandatory training overall. This information was regularly required as part of the directorates clinical and governance processes, and to provide quality and safety assurance at trust board level.

Assessing and responding to patient risk

- The delivery suite was consultant led and able to support women with high risk pregnancies or complex health. Patients assessed as having low risks were supported by midwives. Patient information was colour coded to represent high or low risks and enable staff to prioritise care. Records showed risk assessments were completed at the initial booking and continually evaluated throughout the antenatal, intrapartum and postnatal periods.
- Management of high risk pregnancies included 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.
- The midwives delivered 1:1 care to women in established labour 98% of the time. Maternity staff used the incident reporting system to record any care issues that occurred during labour and delivery. The midwife lead for risk management monitored the levels of 1:1 care by reviewing reported incidents and patient records. We looked at an audit dated July 2016 which had reviewed the 1:1 care for 2165 births between 1 January 2016 and 30 June 2016. Reasons were established for each patient where a lack of 1:1 care had been identified. These included inaccurate data reporting (25), patients who delivered in theatre, and patients who delivered rapidly and/or unexpectedly at home, or on transit to the delivery suite (35). There had been six patients where other factors had been identified. For example, emergency transfer from another maternity service. For all six patients, records showed attempts had been made to provide 1:1 care but this had not been possible on two occasions.
- Every delivery room had cardiotochograph equipment for fetal heart monitoring. We observed 'fresh eyes' stickers had been used to confirm trace readings had been checked and these 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 reviewed audits for the completion of the World Health Organisation (WHO) surgical safety checklist. This prompted actions for safe clinical practice before anaesthesia, before incisions, and before the patient left the operating room. Between April 2015 to June 2016, most of the results showed between 95% and 100% compliance with WHO for both obstetric and gynaecology surgeries. Where the compliance levels had dipped below this range, subsequent audits showed an increase in compliance levels.
- We saw risk management guidance tools were available and used appropriately within the gynaecology and maternity services. For example; obstetric risk assessment for venous thromboembolism, adult neurological observations and newborn early warning observations. Records documented concerns were appropriately monitored and escalated when required.
- Processes were in place to respond to gynaecology patient risks. We saw the gynaecology inpatient care had been relocated to the 12 bedded Meavy ward. As the ward comprised of 12 single rooms, senior staff said they ensured appropriate patient observations and review of care plans were maintained at all times. We saw documentation which showed every day a staff safety briefing was completed during handovers. This included any relevant risk information regarding patient care, staffing, equipment and policy updates.

- Staff training and policy update was required to safely support patients in the event of an emergency when using the birthing pool. We asked maternity staff about the policy and procedures in the event of an obstetric emergency using the birth pool. Staff were not familiar with the use of the electronic hoist or other emergency evacuation procedures. We observed that whilst the 'Guidelines for Waterbirth' were in date, the indications for leaving the pool lacked detail and reference to current best practice. We reviewed records and spoke to maternity staff which identified the emergency skills and drills training using the birthing pool had not been completed during the last year.
- We spoke to senior staff about emergency procedures and the birthing pool at the time of our inspection. A programme of training and assessment was developed and prioritised for maternity staff. We were assured patients requesting to use the birthing pool would only be supported by midwives who had completed training and had been signed off as competent to do this. The training had been included in all new staff induction programmes and as part of the midwives rotational programme. The head of midwifery confirmed a standard operating procedure (SOP) for emergency evacuation from the birth pool had also been developed. We were not clear if this included procedures to cover any faults with the electronic hoist. The SOP was in the process of being prioritised for approval before being shared with all staff.

Midwifery and other staffing

- The midwifery establishment had been established following 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour' (RCOG, 2007). We looked at the last staffing audit dated June to November 2015. The funded establishment was 184.73 whole time equivalent (WTE) posts. Of these, 10. 2 WTE posts were managerial or specialist midwifery roles, leaving 174.73 WTE staff to provide direct clinical care. Most staff felt this was sufficient and the staffing levels also met the ratios established by the local clinical commissioning group (CCG).
- The staffing establishment was split with approximately a quarter of clinical care provided by maternity care assistants. The skill mix ratio and general staffing numbers was monitored by ongoing analysis of patients' clinical outcomes. Records showed between April 2015 and March 2016 patient outcomes and staffing levels were within expected (safe) ranges for the number of births.
- The daily coordination of the delivery suite and assessment of the midwife to patient ratio was reviewed each morning by the matrons. During busy periods the escalation policy was used to redeploy midwives from the community, transitional care ward, and the ante/post-natal ward (Argyll). Records showed between April 2015 and March 2016, the midwife to birth ratio was within an acceptable range of between 1:24 and 1:33.
- An experienced band seven labour ward coordinator midwife was rostered on duty on every shift to advise and support other staff. Staff confirmed the majority of time the labour ward coordinator was not allocated clinical work. The activity levels on the delivery suite and other clinical areas were kept under regular daily review by the matrons.
- There were appropriate numbers and skill mix of gynaecology staff to meet patient needs. There were four specialist gynaecology nurses who provided clinical advice, support and treatments during outpatient's clinics. On the gynaecology ward (Meavy) the funded establishment was a combination of registered nurses and healthcare support workers totalling 18.38 WTE who all had a specialist interest in gynaecology. There was a low vacancy rate (0.2).
- Therapy and diagnostic staff were available to gynaecology and maternity patients. Physiotherapy and occupational therapy staff were not based on Meavy ward but senior staff said they were available and responsive when required. Diagnostic staff were able to complete scans for emergency gynaecology patients up to 6pm, Monday to Friday. At other times diagnostic services were accessed through the emergency department.

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 37.4 whole time equivalent medical staff were employed. Of these 56% were employed at consultant and middle grade (at least three years at senior house officer or above) compared to the England average of 43%. Records confirmed 158 hours

of consultant care per week was available to the delivery suite. This exceeded (was better than) the consultant staffing levels recommended by the Royal College of Obstetricians and Gynaecologists (2007).

- There was 24 hour consultant obstetric clinical expertise available to support with complex and /or high risk patients. Between 8. 30am to 6. 30pm, Monday to Friday consultant care was dedicated (no other clinics) including for any emergency gynaecology patients.
- The resident consultants on the delivery suite were supported overnight by another on-call consultant and middle grade doctors. Specialist obstetric or gynaecology registrars also worked between 8am and 11pm.
- A consultant anaesthetist was available on the delivery suite Monday to Friday from 8am to 5pm. Out of hours support was provided by the general on call consultant anaesthetist.
- If patients from other specialties were placed on the gynaecology ward (Meavy), senior staff confirmed the operating consultant completed ward rounds every day their patient remained on the ward. During the weekends this was completed by the on call (medical) consultant.

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

Are maternity and gynaecology services caring?

Outstanding

Are maternity and gynaecology services responsive?

Good

Are maternity and gynaecology services well-led?

Good

Services for children and young people

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

Information about the service

We carried out this inspection as a follow up to the inspection in April 2015. This was to monitor the response and actions to the 'requires improvement' ratings for safety in the children and young people's services at that time.

Plymouth Hospital NHS Trust provides hospital and community services for children and young people in Plymouth and surrounding areas of West Devon and East Cornwall. Services at the Plymouth hospital (Derriford) site include inpatient, day case, outpatient, radiology and accident and emergency services. Outpatient paediatric services are also provided at various outreach sites using neighbouring community service locations and Derriford employed staff. The trust is a level three paediatric oncology shared care unit and a designated teen and young adult cancer hospital.

Paediatric services located at Derriford Hospital comprised of:

(On level 12)

- Children's assessment unit for 24 hour advice. Referrals are accepted from GPs, emergency departments and there is open access for children with longstanding and life limiting illnesses.
- High dependency unit of four beds for children up to 18 years of age.
- Woodcock ward – 14 beds for children under 10 years of age with a combination of bays and individual cubicles. A play centre is located on this ward.
- Wildgoose ward – 13 beds for young people between 10 and 16 years with a combination of bays and cubicles. A school room is located on this ward.
- Dedicated children's outpatient department also providing care for children receiving diagnostic tests.

(On level six)

- Dedicated children's operating theatre and recovery area.
- The dedicated paediatric emergency department (adjacent to the adult emergency department and reported on in the urgent care report).

(On level five)

- A neonatal intensive care unit (NICU) with 14 intensive high dependency cots and eight special care cots. NICU supported the 18 bed transitional care ward, where babies and mothers stayed together, and mums were cared for by postnatal ward staff.

The Child development centre and community paediatric services were inspected at the same time as the Derriford hospital site. Community services provided by the trust for children and young people comprise of a child development centre which is based at Scott Business Park to the West of the City. The child development centre provides assessment and intervention to children whose development is of concern. Children's community nursing provides clinical support in the child's home, school or outpatient clinic.

At the time of this inspection we spoke with staff including nurses, consultants, medical staff and support staff. We met

and talked with three parents and their children. We observed care and looked at 29 care records and documents. We visited each of the paediatric areas in the hospital and community services.

Summary of findings

We have rated the safety of the service as good because:

- There were processes to report incidents with details of full investigations having been completed where appropriate. Learning points were shared with staff. Staff were confident in reporting incidents and always received feedback on progress of the investigations. Staff described being open and honest with patients and their relatives when anything went wrong.
- Standards of hygiene were monitored by staff with specific roles in infection control and areas we visited were visibly clean. Where incidences of infection were found, appropriate action was taken to control it.
- Medicine storage, prescribing and administration was managed to ensure children and young people received the correct medicines at the correct time. Pharmacy staff worked with staff on the paediatric wards to ensure staff were aware of safe protocols and any errors were highlighted as soon as possible.
- Children's weights were available in most cases for staff to prescribe appropriately.
- Safety audits were viewed by the management team to identify areas where practice needed to be improved with actions for monitoring progress.
- Records were kept securely to maintain confidentiality for the patient but were available for staff to view when required.
- Staff were aware of safeguarding processes and knew how and when to ask for supervision or support.
- Risks to patient safety were identified and reported to senior managers and actions were taken where possible. The last inspection had highlighted concerns over observations of oncology patients following cancer treatment procedures. Delivery of care to these patients had been reorganised and observations were now happening. Risks for children and young people who may harm themselves had been assessed and reduced by adapting the facilities and environment. For example, a room had been identified that was safe for young people to stay in and calm down and ligature risks had been removed. This room also protected children from witnessing disturbing behaviour.

Services for children and young people

- Emergency equipment appropriate for all ages of children and young people was available for use.
- Numbers of appropriately qualified staff on the ward areas we visited met the levels set out in national guidance. Managers achieved this by using staff flexibly across the paediatric areas. Staffing levels were monitored using a tool to assess how many staff were required to provide care for the number of patients and the level of care they needed.
- Medical staff ensured there were enough senior staff to provide expertise and advice for paediatric care. Medical staff were also providing specialist safeguarding clinics five days a week.
- The community paediatrics team provided a safe 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 workforce at the Child Development Centre and by the children's community nursing service. When clinically required, a visit was carried out at a child's home, nursery, school or other locality setting. This minimised the need for multiple appointments, and duplication of history-taking and documentation.
- Following the last inspection there were concerns with regard to the insufficient number of child assessments and care plans that had been completed in the children's community nursing team. During this follow up inspection we found the issues had been resolved and patient records were maintained and monitored.

However:

- Safeguarding update training for staff was at 91% which was not compliant with the 100% trust target. There were plans to enable staff to attend this training.
- Mandatory training for staff in one subject area was 80% which was below the trust target level of 100% compliance, although staff we spoke with were aware of when and how to update their training.
- Two pieces of equipment we saw indicated they had not been serviced within recommended timescales.
- In one area we visited there was an out of date Children's British National Formulary alongside the current version creating a risk of staff using outdated prescribing information.
- Patient details were displayed on an electronic board where visitors could view it which could compromise a child's privacy.
- Children and young people needing more intensive support from child and adolescent mental health services were cared for on the ward until a bed became available.
- An oxygen cylinder for emergency use in a community setting was not easily portable.

Services for children and young people

Are services for children and young people safe?

Good

We have rated the safety of the service as good because:

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- Standards of hygiene were monitored by staff with specific roles in infection control and areas we visited were visibly clean. Where incidences of infection were found, appropriate action was taken to control it.
- Medicine storage, prescribing and administration was managed to ensure children and young people received the correct medicines at the correct time. Pharmacy staff worked with staff on the paediatric wards to ensure staff were aware of safe protocols and any errors were highlighted as soon as possible.
- Children's weights were available in most cases for staff to prescribe appropriately.
- Safety audits were viewed by the management team to identify areas where practice needed to be improved with actions for monitoring progress.
- Records were kept securely to maintain confidentiality for the patient but were available for staff to view when required.
- Staff were aware of safeguarding processes and knew how and when to ask for supervision or support.
- Risks to patient safety were identified and reported to senior managers and actions were taken where possible. The last inspection had highlighted concerns over observations of oncology patients following cancer treatment procedures. Delivery of care to these patients had been reorganised and observations were now happening. Risks for children and young people who may harm themselves had been assessed and reduced by adapting the facilities and environment. For example, a room had been identified that was safe for young people to stay in and calm down and ligature risks had been removed. This room also protected children from witnessing disturbing behaviour.
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- Children and young people needing more intensive support from child and adolescent mental health services were cared for on the ward until a bed became available.
- An oxygen cylinder for emergency use in a community setting was not easily portable.

Incidents

- The system of reporting and monitoring incidents helped to protect patients, visitors and staff from avoidable harm.
- There were systems to ensure incidents involving children and young people were reported and investigated. Staff told us the reporting system was easy to use and they always received feedback about any incident they had reported. We saw documents of reported incidents where there was any slight risk of potential harm to patients. These were all investigated and learning points identified. Learning from one incident had prompted changes in how staff communicated information over the telephone when escalating a child's deteriorating condition. Guidelines for staff to use the SBAR (situation, background, assessment and recommendations) were introduced as a result. Staff we spoke with were familiar with this system and told us they applied it in other areas of their work as it helped them to analyse a situation.
- There were no never events reported for this service between March 2015 and May 2016. 'Never events' are serious patient safety incidents that are wholly preventable if healthcare providers follow national guidance and implement recommendations on how to prevent them. Each 'never event' incident type has the potential to cause serious patient harm or death and must be reported to CQC as a serious incident even if it did not result in harm to the patient. Any 'never event' indicates a failure in measures to keep people safe from harm.
- Mortality and morbidity of children and young people was discussed at clinical governance meetings. Neonatal intensive care consultants attended mortality and morbidity meetings, which were held on alternate months to review obstetric and neonatal morbidity. The named doctor for safeguarding attended the multiagency child death overview panel meetings. Learning from these meetings was reviewed and shared at clinical governance meetings and included whether alternative treatment may have prevented serious illnesses or death. Further cascade of learning points was through team meetings and in the safeguarding newsletter.
- Any information from national patient safety alerts was circulated to staff at safety briefings to ensure staff were aware of correct responses.
- Staff told us they used the same electronic system to report any safeguarding concerns in addition to contacting the safeguarding team. Between July 2015 and June 2016 there were 4,684 referrals to the safeguarding team from paediatric services. This included any slight concerns staff may have had, and for example, if there had been more than three attendances at the emergency department for a child or young person within a 12month period. The safeguarding team told us referral numbers to their team had increased since using the electronic system for reporting concerns.
- Staff in the Child Development Centre and the community children's nursing service used the trust's electronic reporting system to record accidents, incidents or near misses. A staff member we spoke with said they knew how to report and record incidents and that they always got feedback. For example, there was an incident report about the possible use of a wrong sized urinary catheter. This resulted in the management of indwelling urinary catheters in children across the area now being centrally managed. This was undertaken in conjunction with the bowel and bladder service. Alongside this, there had been networking with specialist bladder services in Exeter and Bristol and staff were involved in regional network groups. The community paediatric lead nurse said they encouraged staff to report incidents and always provided support and feedback. They added how staff having seen their reports taken seriously and investigated had encouraged staff to report more often. Incident reports were reviewed monthly by the Child Development Centre manager to identify any trends and to share the learning across community teams.
- We saw documents of incidents that had been investigated and feedback given to individuals. Learning was shared with staff using emails, newsletters and staff meetings.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. Staff attended training at induction to inform them of their duties regarding duty of candour and told us they offered immediate apologies to parents for any errors made not just the most serious.
- Child Development Centre and community children's nursing staff were aware of the term duty of candour. The community paediatric lead nurse said as they worked with children and their parents all the time it was often parents that reported concerns. As a result the parents were always kept informed of any investigations. Apologies were offered when it was found something had gone wrong.

Cleanliness, infection control and hygiene

- Systems for monitoring infection control and hygiene helped to keep children, young people and their families free from avoidable harm. This included observation of the environment and incidence of infection.
- All areas we visited were visibly clean and equipment had 'I am clean' stickers attached to indicate it had been cleaned. The stickers we saw on our inspection had the date of the cleaning written on them. These were current dates, and indicated the equipment had recently been cleaned. Staff told us that if the equipment was not used for a while, the date would indicate it should be cleaned again. In this way equipment was always prepared for use.
- The neonatal intensive care unit (NICU) had a system to ensure complex clinical equipment was decontaminated between patient use. Staff would attach a label indicating the type of cleaning required and technicians would ensure this was completed in a decontamination room. Once cleaned, equipment was returned to a clean storage area.
- Housekeeping staff completed cleaning audits of paediatric areas. They ensured the audits were viewed and countersigned by the nurse in charge. This gave staff immediate feedback on areas that may be of concern. Audit results were reported to senior managers at clinical governance meetings. NICU nursing staff were responsible for ensuring cot spaces were clean. The unit manager had completed an audit of the areas which showed lower levels of the cots were dusty. This had been shared with staff at team meetings and safety briefings to remind staff to check cot spaces at each change of shift. These areas were visibly clean at the time of our visit.
- Incidents of infection such as methicillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile were monitored for each area and reported to the infection prevention and control committee. Between October 2015 and March 2016 there had been one episode of Clostridium difficile on the children's high dependency unit and one on Wildgoose ward. In the same six month period there had been 10 incidents of MRSA identified in NICU in three separate outbreaks. We saw reports of how each incident had been investigated and brought under control with actions taken to protect other patients from the infection. This included nursing the affected patients in side rooms and staff using personal protective equipment such as aprons and gloves. Staff and patients on NICU had been tested, and a potential carrier of the infection been treated. There were extra measures in the form of washing hands and using sanitising gel on entry to each NICU area. We observed staff requesting visitors to follow the procedure.
- Play facilities such as small toys, electronic games and large toys were documented as having been cleaned according to a cleaning rota and between patient use where appropriate.
- There were good results from hand-washing observations. Hand hygiene audits were carried out monthly to monitor staff compliance with trust policy. Results were presented to the infection control committee. Between November 2015 and March 2016, results for paediatric areas were between 91% and 100%. Wildgoose ward was below the 100% target in November and December 2015. NICU were below the target in February 2016. On investigation it was identified that some staff were not washing hands after removing gloves. Education on hand hygiene had improved compliance.
- Hand sanitiser was available at the entrance to all paediatric areas with instructions for use. We saw staff using hand sanitiser between patient contact and washing hands according to the trust policy.

- There were systems to reduce the risk and spread of infection in the Child Development Centre (CDC).
- The week following the inspection some building works to further improve the unit were taking place; this included removing carpets in some multiple use rooms and changing some handwashing sinks to ensure compliance with the latest guidance from the department of health (HBN 00-09: Infection control in the built environment document).
- Toys we saw were clean and washable. However, the wall mounted suction machine had got an 'I am clean sticker' dated April 2016. We were told it had not been used since that date and that a cleaning schedule for the suction machine would be put into place meaning if it needed to be used it would have been cleaned at regular intervals and would also always be cleaned after it had been used.
- We observed staff in the children's community nursing service using good hand cleansing techniques when caring for children in their own homes. They were aware of the infection control policies and guidance.

Safety Thermometer

- The children and young people's service monitored and reported the incidence of commonly occurring harms using the safety thermometer. This is a national tool which includes escalation of a deteriorating condition and recording vital signs such as temperature, blood pressure and heart rate on the paediatric early warning score (PEWS). It also assesses pain and skin condition. Best practice would be to display these results for patients and visitors to wards. The neonatal intensive care unit did not display their results, but all the paediatric wards we visited displayed their results where patients and visitors could see them. Meeting notes discussed results of this monthly audit and improvement actions that were needed. As an example, the safety thermometer showed a rise in children experiencing pain in May 2016. Managers had asked staff to undertake a comprehensive audit of how they were using the pain assessment tool for children and young people. Other results showed that for May 2016, 90-100% of paediatric early warning scores were completed with deviations from normal escalated appropriately across the paediatric wards. These were records showing vital signs of a patient and when to seek further clinical advice.

Environment and equipment

- There were processes to ensure equipment and premises were maintained and appropriate for use in paediatric areas and staff were aware of them. Two pieces of equipment had passed their service date by four months but all other equipment we saw had been labelled as checked and due dates for maintenance checks were for a date in the future.
- Equipment was stored safely out of the reach of children and visitors. Waste was segregated and disposed of appropriately and any clinical equipment was stored in rooms inaccessible to children or their parents.
- Resuscitation equipment was available in all paediatric areas with age appropriate equipment including oxygen, suction and defibrillators. Emergency resuscitation trolleys had a number coded seal so they were tamper-evident. They were checked daily with a more detailed check completed monthly. On Wildgoose and Woodcock wards we saw three dates for the previous month where no check had been recorded. All the monthly checks we saw had been signed and dated by staff as having been completed and any medicines or equipment past its use-by date had been replaced.
- Areas that could be unsafe for children, such as kitchen areas, were secured with locks, high door handles and gates where appropriate to prevent young children accessing these areas. Security within the milk kitchen, which was used by high dependency unit and Woodcock ward, had been a concern at the last inspection. Action had been taken and the fridges were now locked, with a member of staff holding the key. This prevented the risk of baby milk being tampered with.
- There were policies and guidance to keep children safe. Areas we visited followed the trust child-abduction policy which had been available since December 2015. Ward areas had locked doors which would be opened to authorised visitors by ward staff. Visitors could let themselves out of the areas using door release buttons which were placed out of reach of small children. Closed-circuit television recorded any activity of people entering or leaving the neonatal intensive care unit and the transitional care ward. The recordings were not constantly monitored, but could be reviewed if a concern over safety of a child was raised. Staff did not constantly monitor people leaving the unit using the

main door. Staff told us there was always a member of staff present in any room where babies were cared for and they monitored parents and visitors entering and leaving the rooms.

- Electronic touch screens presented a risk of patient information being shared with unauthorised personnel. The purpose of the screens was for staff to have speedy access to patient numbers, surnames and discharge plans with treatment needs indicated by means of icons. This screen was on display near the nurse's station and information could be accessed without using a secure log in. The issue had been discussed at the Caldicott and information governance group 11 May 2016. Their decision at that time was that the risk of breaching personal information would be recorded on the risk register as acceptable and it would be reviewed at the next Caldicott and Information governance group meeting in October 2016.
- Space was available for children to use if they had sensory, behavioural or mental health needs. There was a sensory room on Woodcock ward. Wildgoose ward had a room that was being refurbished and was nearing completion. It was designed to support adolescents with emotional issues who needed a calm space away from other patients. Having this space helped protect younger children from witnessing extreme behaviours.
- Wards had been assessed for safety. This included risk assessments around self-harm. Ligature risks had been assessed and there were restrictors on windows to prevent accidents.
- The operating theatre and recovery areas had waiting areas dedicated for children. Staff were on hand to constantly monitor children and young people before and after surgery or surgical procedures.
- The Child Development Centre had appropriate resuscitation equipment, although the oxygen was difficult to transport. This included a defibrillator, oxygen and suction. Daily checks of this equipment had been undertaken and documented. This demonstrated emergency equipment had been appropriately tested and was deemed fit for purpose. However, the bag containing the oxygen cylinder was particularly heavy. There was no trolley or cage for this cylinder to be transported around the building when it was needed. Recently the equipment, including the oxygen, was needed when an adult was unwell in the waiting room some distance from where the cylinder was stored. Staff commented on how heavy it was to carry. The issue had not been added to the local risk register at the time of the inspection.
- There was equipment available for the community teams. 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 staff could pick it up and deliver it to the child's home. If more specialist equipment was needed, staff made a request to the equipment library, and we were told the response was prompt and equipment arrived quickly.

Medicines

- Medicines were stored safely and securely according to the trust policy. The wards stored medicines in locked cupboards near nursing stations and these were inaccessible to patients and visitors.
- There was support and guidance on medicines from trained staff. Pharmacy staff with experience in paediatric medicines management visited paediatric areas daily to monitor accurate and appropriate prescription of medicines, including antibiotics. Medicine charts we looked at had been checked for their accuracy and signed by pharmacy staff.
- There was safe management and administration of controlled drugs. Staff followed trust policy for administering and managing controlled drugs. This involved two staff checking and signing the controlled drug register at the time of administration. There were daily checks of stock levels, with a further weekly stock check carried out by pharmacy staff.
- Staff looked for ways to reduce minor errors and improve quality and safety in medicines management. For example, staff in the neonatal intensive care unit used a system of documenting minor medication errors such as timing of administration and which did not reach the incident reporting threshold. The findings were shared with staff at team meetings to highlight risks.
- There were suitable arrangements for documenting patient allergies or intolerances. All the medication records we viewed documented allergies to ensure staff were aware when writing prescriptions.
- There were accurate medicine charts, although we found a few with gaps around a child's weight. We looked at 17 prescription charts. All were signed and

dated appropriately with reasons given for omitted medications. All medicine charts had the child's age recorded but three had no weight of the child recorded. The weight of a child can be important in the correct prescribing of certain medicines.

- Staff had national guidance for medicines management. Current British National Formularies for Children (BNFC) were available for staff to use, although there were a few copies that were not the most up-to-date. In paediatric recovery we found two BNFCs from the previous two years. There was, therefore, a risk that staff may use out of date advice when prescribing medications.
- There were processes for calculating safe doses of medicine for children. For example, staff described how they calculated emergency drug treatment for each patient when they were admitted to the high dependency unit. They attached the information to their nursing record for staff to follow if an emergency situation arose. In line with national guidance, the calculation was based on height, weight and age of child.
- There was safe storage of medical gases. Those medical gases we saw were within their use by date and stored where staff could access them if needed.
- Community services were able to supply patients with prescriptions to obtain medicines. There were no medicines stored at the Child Development Centre. There was a secure system for holding prescription pads at the centre. These were used by doctors and nurse prescribers writing prescriptions for patients to take away to have supplied by their local pharmacy. The doctors and nurses had use of an up-to-date British National Formulary for Children), which provided guidance on prescribing, dispensing, and administering medicines specifically for children.

Records

- Staff followed trust protocols for storing confidential patient information. Medical records were stored in lockable cabinets which staff could open using a number code.
- Children and young people had individual care records which were kept near the patient in the neonatal intensive care unit and high dependency unit where staff were always present to monitor the child. Woodcock ward had individual care records such as paediatric early warning scores at the end of each patient's bed. Wildgoose ward were keeping patient care records with their medical records as a temporary measure because they were waiting for new storage that would hold the paperwork at the patient's bed space.
- Staff compliance in completing records was monitored by using audit processes. This included an audit of paediatric early warning score charts and The World Health Organisation checklist for 'five steps to safer surgery'. Audit results were monitored and fed back to staff at governance and team meetings. This included occasions where the surgical safety checklist had been used but not signed correctly. Staff were reminded of the need to sign each area of the checklist. Where compliance was found to be below the trust target, actions for improvement were identified and put into place and plans for re audit made.
- Children's records at the Child Development Centre were paper based and were completed by each member of the multidisciplinary team. This enabled appropriate sharing of information to ensure children were cared for safely and appropriately. We reviewed a set of patient records. Documentation was complete, legible and up to date. The record included individualised care plans, risk assessments covering nutrition and hydration, and a pain control assessment. There were detailed evaluation notes following each visit by a healthcare professional.
- There had been improvements to the care records produced in the community service. At the last inspection we reviewed eight sets of 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. Some patient information had not been recorded. Since the last inspection, community care plan documentation and the system for using it had been revised and relaunched. Two audits had been carried out since the relaunch. The most recent reported that only 6% of care plans were not fully completed. This was therefore a significant improvement, and work was ongoing to maintain and improve this record management.
- There had been a lapse in how a blood result was received and recorded. Blood results must be read back to the person reporting them over the telephone to ensure they are accurate. In one record we saw there was no evidence to demonstrate the results had been checked by repeating them back. There was also no record to say when the written results would be

available. The results had then been passed to a consultant for their review. When this was bought to the attention of the community paediatric lead nurse they immediately said staff would be reminded to document the conversation. This would include writing in the notes that results had been repeated back to the person giving them over the phone or that another person was listening into the call to verify the results. They said the issue would be taken forward to the August 2016 clinical governance group for consideration.

Safeguarding

- There were systems enabling staff to identify and report any safeguarding issues using current national guidelines. This included 'Working Together to Safeguard Children (2015)' and the intercollegiate document 'Safeguarding Children and Young People: Roles and competencies for health care staff (2014)'.
- There was appropriate seniority in the child safeguarding team. The team was made up of trained senior staff and included, as required, a named nurse and a named doctor. These 'named' staff had the responsibility for providing expert advice and guidance to fellow professionals. A trust director provided executive team leadership. The safeguarding team had recently been reorganised to incorporate adult and children safeguarding into one team. The named leads felt this was advantageous in ensuring safeguarding information was shared with all staff.
- Wards and children's teams had appropriate links to the safeguarding teams. Safeguarding champions were appointed from staff in each area. They attended safeguarding meetings each month, and cascaded information following serious case reviews and safeguarding updates to their colleagues. Trained supervisors provided staff supervision for safeguarding children on an informal basis as requested or required.
- Safeguarding referrals were monitored and improvements made where appropriate. As an example, the 'did not attend' (DNA) policy for children who missed outpatient appointments was revised. It now included reporting to safeguarding when appointments were cancelled by the parent. However, it did not capture incidences of a parent failing to book an appointment after being advised to do so by a health professional.
- Updating of safeguarding training by staff at Derriford hospital was below trust targets. Staff compliance with training was monitored by the named leads for safeguarding against a trust target of 100% staff attendance. At the time of our visit compliance with updating training was 97% for level one, 91% for level two, and 81% for level three. Training levels had been reported at the trust board meeting of 8 April 2016 as being below trust target due to not enough training sessions being offered by the local safeguarding children board (LSCB). There had been discussions between the trust and the LSCB and further session were being offered for Derriford staff to attend.
- Staff working in the children's services had relevant training on child exploitation. Admission paperwork included a checklist to highlight concerns about sexual exploitation and female genital mutilation. If there were any safeguarding concerns, an alert which highlighted the increased vulnerability of the child or young person, was placed on the patient records.
- Staff we spoke with were knowledgeable about safeguarding issues and support that was available. Staff described how they would make a safeguarding referral and named members of the safeguarding team they could approach.
- There was provision for children subject to abuse or neglect to get medical attention. Children and young people who needed medical review following safeguarding concerns were able to access a dedicated safeguarding clinic on Mondays to Fridays.
- Updating of safeguarding training by staff in the community met trust targets. Most (95%) of the care and support staff at the Child Development Centre and the children's community nursing service had attended safeguarding update training for children at Level two or Level three, dependent on their role. Staff demonstrated they knew, understood, and would recognise 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 paediatric lead nurse or the learning disabilities specialist nurse. Monthly safeguarding supervision sessions were held at the Child Development Centre to discuss any safeguarding cases, actions taken and learning from each case. Community staff were able to talk with staff on the paediatric ward at Derriford hospital for additional clinical advice and the safeguarding team for further safeguarding support.

- There were systems to follow up a child/family if they had not attended an appointment twice in a row. In order to ensure the appointments were not just forgotten, a reminder about an appointment would be sent two weeks prior to the appointment date.

Mandatory training

- All staff attended induction programmes including mandatory training when they started working at the trust. Mandatory training which was held on a yearly basis included duty of candour, resuscitation, safeguarding, manual handling and medicines management. Ward managers ensured their staff attended mandatory update training sessions when they were due to be completed. Attendance was monitored using the staff electronic records and any issues discussed at one to one meetings. The trust target was for all staff to be 100% compliant with mandatory training. Staff from the children and young people's service achieved between 80% (medicines management) and 92% (manual handling).
- The Child Development Centre line manager had a staff electronic record to ensure all staff from the service met their mandatory training requirements.

Assessing and responding to patient risk

- There had been improvements made to keep children safe. Our previous inspection had highlighted concerns about emotional and physical safety of children and young people. This related to young people who needed Child and Adolescent Mental Health Service (CAMHS) inpatient beds, and were admitted to Wildgoose ward. The children's services matron said that since our last inspection they had worked closely with the hospital security team on this concern. The matron was now part of the security strategy group and involved in security policy development. There had been some physical intervention (PI) training but a local provider had not been able to consistently provide the training due to their own staffing issues. Another local trust who had PI trainers had provided some training. As a result the practice educator for children's services had carried out a training needs analysis, and had help preparing a business case around provision of PI trainers within the Plymouth Hospitals NHS Trust.Nursing staff and security teams had clarified their roles in the event of similar incidents. They said the acute children's services worked better with the security team as a result.
- Timescales varied for children and young people with mental health needs being assessed by CAMHS depending on whether they lived in Plymouth, Devon or Cornwall. Each of these areas used a separate CAMHS provider who would assess children and young people at Derriford hospital. There was a six-day a week CAMHS service to review children and young people from Plymouth who were admitted for mental health needs (such as deliberate self-harm). Children and young people from areas in Devon or Cornwall would be reviewed at Derriford from Monday to Friday and were referred to the service provider from their home locality. If children already admitted to the hospital needed inpatient CAMHS beds, they were admitted to a CAMHS bed as soon as one was available.
- Wildgoose and Woodcock wards had risk-assessed their facilities to reduce the equipment that children and young people could use to harm themselves.
- There were facilities being finalised to allow children and young people to take time out from the ward. There was a newly designated de-escalation room identified, and furniture for the room was being ordered. This room was away from wards where other children were being cared for. The matron of the CAMHS service had provided advice for the design of this room, and with policies and procedures for management of risks for CAMHS patients.
- The community paediatric lead nurse said if they made a referral to CAMHS there was often a long period of time until the child or young person was seen. Until then, the community nursing service continued to hold the child or young person on their caseloads to provide what help and support they could. There were no figures held by the trust to show how long these patients had to wait.
- Staff used risk assessment tools for each patient to identify care that was needed to keep them safe. This included assessments for risk of sepsis, nutritional needs, and the risk of pressure damage to skin from being kept in one position too long. Care plans for any identified risk were written and updated at each nursing shift. Corresponding entries were made in the medical record. Each child and young person on Wildgoose and Woodcock wards had their condition monitored using a

paediatric early warning score (PEWS). This identified any increased risk or a deteriorating condition using vital signs of temperature, blood pressure, heart rate and respirations. These charts were colour coded according to increased risk and provided guidance for healthcare professionals on recommended action. The neonatal intensive care unit used specific charts for neonates which did not use the colour-coded system. However, staff told us any deviation in the recorded vital signs would be immediately escalated to more experienced professionals. These were audited annually with results fed back to staff at team meetings, and improvement actions identified. Following an audit, staff on Wildgoose and Woodcock wards were to have additional training on responding to trigger points when using the PEWS charts. We looked at 14 PEWS records, and all were completed appropriately.

- Staff were aware of procedures for recognising and escalating a patient's deteriorating condition and actions needed to gain further medical support for the child. Staff used the newly developed guidance to identify a child at risk of sepsis and followed the trust guidance for transferring unwell children to more specialist care.
- There was an appropriate system for responding to life-threatening emergencies. All staff on the wards and neonatal intensive care unit had completed paediatric intermediate life support training. The high dependency unit always had a member of staff on the duty roster with advanced paediatric life support training, and rotas showed there was always a member of the medical team available.
- The community paediatrics service was not an emergency service. Children's families were advised, if their child became acutely unwell, or their condition deteriorated, they contacted their GP, attended the nearest emergency department, or called for an ambulance.
- The concerns over lone-working arrangements had not been addressed. In the previous report we reported that 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. No security devices were in use across the trust, which put all lone workers at risk. A security device was being trialled by the community nursing team. During this follow up inspection we found the situation had not changed, and staff still did not have a security device. This issue remained on the women's and children's risk register. Staff described an application that could be downloaded to mobile telephones of staff working in the community. This could track their position and be accessed by relevant people in an emergency, but this had not been universally agreed.

Nursing staffing

- Paediatric staffing levels were reviewed in line with national guidance to ensure safe care and treatment was provided. Numbers of nursing staff had been reported as falling short of recommended guidelines in the previous inspection. This had been reviewed by the trust executive team and the establishment (planned levels) of nursing staff had been increased for NICU. Following previous difficulties in recruiting nursing staff, NICU managers were offering a relocation package. This had resulted in successful recruitment of nursing staff to NICU.
- Staffing numbers were planned to comply with the Royal College of Nursing document 'Defining staffing levels for children and young people's services'. The planned level of staffing on the wards for 14 patients was three trained staff and one healthcare assistant. Duty rotas showed these planned levels were met. Numbers of trained staff in the high dependency unit were compliant with Royal College of Nursing standards.
- Staffing levels in the neonatal intensive care unit met national guidelines with one nurse to each child being cared for. This was in accordance with guidance from the British Association of Perinatal Medicine (BAPM) guidelines and meant that each baby received one to one care from a registered nurse. Since the previous inspection there had been an increase in the number of registered nurses. These were nurses qualified within their specialty, and able to provide advice for staff on the safe care of neonates. The unit now had 68.9% of staff who had a post-registration qualification. This was just below the BAPM threshold of recommended levels of post-registration staff on duty being not below 70% of the registered nursing team.
- Numbers and skill mix of staff on duty were calculated according to the needs of the patients on the paediatric areas to ensure staff were able to provide safe care. A planning tool supported by the Bristol Royal Hospital for Children (part of University Hospitals of Bristol NHS Foundation Trust) was being trialled to determine numbers of staff needed for patients in all paediatric

areas. Each paediatric area reported their staff to patient ratio three times a day using an electronic reporting system. Managers reviewed this to assess how they could maintain safe staffing levels by moving appropriately trained staff to where they were needed. Staff we spoke with said they thought staffing numbers were better now than they had been a year ago.

- A senior nurse was available to provide advice for staff in all paediatric areas but the standard for a shift supervisor to be available in each area for each shift was not always met. Woodcock ward duty rota for the month of June 2016 showed four occasions when there was no supervisory role planned. All nursing staff on the rota were looking after patients rather than being supernumerary and providing support to staff. Wildgoose ward duty rota for the same period showed seven occasions where no supervisory role was planned.
- Staff were available to cover absences from an internal bank of nurses. There had been recent difficulties with using an external agency from the local area as it was not on the government approved framework to be used in hospitals. Managers had offered staff who were returning to work after maternity leave who wanted to reduce their hours, alternative terms of employment. This included joining an internal bank of suitably qualified nursing staff. Some staff preferred to be retained on zero-hours contracts and others were able to be paid on a weekly basis. The choice was given to the staff.
- Handovers between shift changes were carried out twice daily to ensure staff knew the care needs of their patients. A safety briefing was held in the morning which included medical and nursing staff. It included a review of planned staffing levels, patient discharges and admissions. Nursing handovers included a review of the paediatric early warning scores and actions that had been taken. The neonatal intensive care unit nursing staff ensured they reviewed each medicine chart as well as the recorded vital signs, and condition of the babies in their care.
- The community service managed planned and unplanned absence. The number of small specialist teams presented a risk to the service as just a small number of staff being absent had a big impact. This was managed through a series of short-term contracts to cover sickness and maternity leave, and ensure continuity of care for children and their families.
- Managers ensured safe staffing levels were maintained by calculating nursing numbers needed for the community nursing services using a 'caseload dependency score'. This calculated ratings based on whether the caseload was between low and complex. Each nurses' caseload was discussed at caseload supervision meetings and adjusted as necessary to ensure each team had a fair mix of low and high dependency cases.
- Caseloads for staff were of manageable size and visits were coordinated. The community paediatric lead nurse reviewed the caseloads of each community nurse to ensure children were receiving safe care and treatment at all times. There were concerns following the last inspection that the caseloads on the children's diabetes specialist team were too high. They were above the Royal College of Nursing (2013) recommendation of one nurse to a maximum of 70 patients. During this inspection we found that diabetes team in the children's community nursing service had a caseload of 193 children. Data showed that Nurse A had 66 patients, Nurse B had 69 patients and Nurse C had 58 patients. This was, therefore, now within the royal college recommended caseload numbers.

Medical staffing

- Medical staffing levels for paediatric services were reviewed and complied with national standards. Data for the paediatric service showed that consultants, middle career and junior doctors were higher in number than the England average. Numbers of registrar group doctors were proportionately lower than the England average. Rotas showed that consultants offered support for trainees and acted below their grade in order to ensure medical cover was provided in a safe way.
- Arrangements for support from a paediatrician complied standards from the Royal College of Paediatric and Child Health. Each paediatric area had access to medical support from paediatricians 24 hours of the day. Consultants were on call and senior trainees were available on the wards at all times. The neonatal intensive care unit had six advanced neonatal nurse practitioners who were able to offer support to junior doctors to ensure safe care was delivered.
- Most patients were seen by a consultant in accordance with standards of the Royal College of Paediatric and Child Health. Of the 12 records we viewed, one patient

with an acute medical need had not been seen by a consultant within the advised standard of 14 hours of admission. All other patients had been reviewed appropriately for their condition.

- Children and young people admitted for surgical procedures had their care overseen by the medical team specialising in their condition. If any medical concerns arose, a paediatrician would be contacted for their advice. Staff knew which consultant was in charge of a child's care and who to contact if the child needed to be seen.
- We were told handovers between medical staff were led by a consultant paediatrician. Details of the children's on going needs were discussed although we did not manage to view any handovers.
- We were told when locum medical staff were required they were staff who had previously worked within the paediatric departments to provide some consistency.

Major incident awareness and training

- Staff we spoke with were aware of major incident policies but not always aware of the procedures. They told us they would know what to do in event of a fire but anything more major would require instruction from their manager. Community paediatricians and nursing staff who also worked in the acute trust had received training in major incident awareness.
- The children's wards had a variety of cubicles and bays which staff told us were used flexibly in times of higher demand such as winter when children suffer more chest related problems.
- The Child Development Centre was not required to be part of the immediate response to the trust major incident plan.

Are services for children and young people effective?

Good

Are services for children and young people caring?

Outstanding

Are services for children and young people responsive?

Good

Are services for children and young people well-led?

Good

End of life care

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

Information about the service

End of life care at Derriford Hospital comes within the oncology department and sits under the clinical support services directorate. End of life care is provided by staff on all wards and departments. A standard operating procedure for the care of patients at the end of life has been written to inform all staff of their responsibilities to provide end of life care.

The hospital does not have specified acute oncology beds or wards but there is an acute oncology team working throughout the hospital.

The Specialist Palliative Care Team (SPCT) leads the specialist palliative care service in the hospital. The service is contracted by the trust from St Luke's Hospice, Plymouth. It is an integrated specialist palliative care team and has good coordination with community multi-disciplinary specialist palliative care teams as well as the inpatient unit at the local hospice.

St Luke's Hospital Specialist Palliative Care Team 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 SPCT provide a seven day service, available 8:30 am to 4:30pm, out of hour's advice was provided by St Luke's Hospice. The team consists of 2 part time Consultants in Palliative Medicine, 2 part time Associate Specialists in palliative medicine, three clinical nurse specialists, an End of Life Care Facilitator and one team administrator. 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. Of the referrals received 95% of urgent referrals are seen within 24 hours

Between April 2015 and March 2016 the hospital team received 1171 new referrals including 35 re-referrals. Of the referrals received 879 were for patients with a diagnosis of cancer and 327 were for a non-cancer diagnosis. Between March 2016 and June 2016 all new referrals were seen by the SPCT.

We visited 6 wards and specialist departments. We met two patients, spoke with two relatives and reviewed two Last Days of Life care plans.

In total we reviewed 25 patient records looking at end of life care when possible, but also specifically at Treatment Escalation Plan (TEP) records.

We talked to 24 staff about end of life care. These included the specialist palliative care team, ward nurses and doctors, the chaplaincy team, portering services 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

At this inspection we reviewed the effective domain only. This was because areas requiring improvement were noted at the previous inspection in April 2015. At this inspection the effective domain was rated as good because:

- All staff spoke positively about the support they received from the SPCT. Ward staff had sufficient training and the ongoing support and help from the Specialist Palliative Care Team to deliver effective care and treatment.
- Patient needs were assessed and they were treated in line with evidenced based guidance.
- End of life outcomes were monitored against national standards. Outcomes from previous audits had been used to make changes to patients care. There were some improvements seen from the 2016 National Care of the Dying Audit and an action plan put in place to focus on the areas which required further work.
- Ward staff had sufficient training and the ongoing support and help forfrom the Specialist Palliative Care Team to deliver effective care and treatment. There had been an increase to seven day access to the Specialist Palliative Care Team.
- Improvements were seen in the completion of the Treatment Escalation Plans (TEP) and development of the audit tool as part of the pilot project remained ongoing. Whilst the development continued paper audits were being maintained.
- The management of Deprivation of Liberty safeguards ensured the safety of patients.
- Pain management and the management of nutrition and hydration was assessed, managed and recorded to ensure patients at the end of life were comfortable.
- The multi-disciplinary working between the Specialist Palliative Care Team and the wider hospital and local community were outstanding. The integrated working supported a continuity of care and avoidable admissions to hospital.

However:

- Following the previous inspection a local 'quality improvements in environment' project had been undertaken. Areas of improvement were planned for example single rooms available for privacy for patients at the end of life, these changes were underway but not yet completed, with a timescale of two years for completion. The multi faith areas and ablutions facilities had been identified as requiring further development at the previous inspection in 2015 and have a date for completion within five years.End of life outcomes were monitored against national standards. Outcomes from previous audits had been used to make changes to patients carethese included completion of six out of the identified seven areas noted previously as not metareas in the National Care of the Dying Audit.

End of life care

Are end of life care services safe?

Good

Are end of life care services effective?

Good

The effectiveness of end of life care was rated as good because;

- Patient needs were assessed and treated in line with evidenced based guidance.
- The management of Deprivation of Liberty safeguards ensured the safety of patients.
- End of life outcomes were monitored against national standards. Outcomes from previous audits had been used to make changes to patients care these included completion of six out of the identified seven areas noted previously as not met areas in the National Care of the Dying Audit.
- Pain management and the management of nutrition and hydration was assessed, managed and recorded to ensure patients at the end of life were comfortable.
- Ward staff had sufficient training and the ongoing support and help for the Specialist Palliative Care Team to deliver effective care and treatment. Access to specialist Palliative Care Services had increased to seven day workingAccess to specialist Palliative Care Services had increased to seven day working.
- The multi-disciplinary working between the Specialist Palliative Care Team and the wider hospital and local community were outstanding. The integrated working supported continuity of care and avoidable admissions to hospital.
- Improvements were seen in the completion of the Treatment Escalation Plans (TEP) and development of the audit tool as part of the pilot project remained ongoing. Whilst the development continued paper audits were being maintained.

However:

- Following the previous inspection a local 'quality improvements in environment' project had been undertaken. Areas of improvement were planned for example single rooms available for privacy for patients at the end of life, but these changes hadbeen agreed not yet been started.There was a completion timescale of two years.The multi faith areas and ablutions facilities had been identified as requiring further development at the previous inspection in 2015 and have a date for completion within five years.End of life outcomes were monitored against national standards.Local audits were delayed in being completed in some areas. These included audits of the last days of life carwe plan.Outcomes from previous audits had been used to make changes to patients care these included completion of six out of the identified seven areas noted previously as not metareas in the National Care of the Dying AuditImprovements were seen in the completion of the Treatment Escalation Plans (TEP) but auditing of improvements was not yet fully completed.

Evidence-based care and treatment

- Patients' needs and treatment were delivered in line with evidence based guidance. The trust Clinical Effectiveness Group was responsible for reviewing the compliance status for all published NICE guidance. The trust gave consideration to the clinical guidelines, interventional procedures, quality standards and other best practice guidelines issued by NICE and implemented these where appropriate to end of life and palliative care patients.
- The SPCT had written the Standard Operating Procedure (SOP) for end of life care (May 2016). This drew upon,

- One chance to get it right (2014)
- Dying without dignity report (2015)
- Care of dying adults in the last days of life – NICE Guideline (2015)
- Every moment counts (2015)
- Ambitions for palliative and end of life care. (2016)

- A national 'Ambitions document' was published in September 2015, from this the end of life team wrote a comprehensive 'end of life' strategy, gap analysis and action plan which was completed July 2016 and was driving trust development for the next five years. This was being used as a live document and the Trust was currently developing a 5 year end of life strategy with short and long term plans. The actions required included addressing local areas for improvement, national recommendations and the "Ambitions for

palliative and end of life care" framework (2015). There was also an aim to work collaboratively with colleagues in primary care, charitable sectors, social and health care services. The End of Life Committee will review progress of end of life care actions and improvements across the Trust. Progress will be monitored and reported through the Quality Assurance Committee.

- The trust used end of life care quality assessment tools to monitor the quality of the service provided. These included the electronic Palliative Care Coordination Systems (EPaCCS), Bereavement Questionnaires and assessment of their current position using the "Ambitions for Palliative and End of Life Care, A national framework for local action 2015-2020". As a result the hospitals local End of Life Strategy and action plan was based on these outcomes
- The Specialist Palliative care team had developed their own audit programme 2016/2017. This included Last Days of Life (LDOL) completion audit, bereavement feedback, National End of Life Care Audit for Hospitals and the rapid discharge audit – achieving preferred place of care /death and Treatment Escalation Plan Audit.
- All hospitals should undertake local audit of care of the dying, including the assessment of the views of bereaved relatives, at least annually. The last days of life local audit from its initial implementation had identified that areas of the care plan needed to be amended, these included prompts for reference to the hospital chaplaincy. A further audit had not yet been undertaken and the audit tool to be used was currently under revision. The audit was due in October 2016 to establish if the changes put in place had been successful.

Pain relief

- Pain management was well assessed and recorded. Pain control and other symptoms in dying patients were seen to be assessed at least four hourly and medication given promptly as necessary. Pain management was discussed with the patient where possible and appropriate, and with family, carers or other advocates. We looked at records of discussion around pain and saw that regular pain relief had been administered when needed.
- The last days of life plan included a daily medical review which included support information for medical staff about analgesia used for end of life care and the options to consider. The last days of life nursing care plan included 2 hourly symptom assessment and evaluation. Other care plans being used for example the oncology care plan also included advice about pain management. Staff told us that on any ward and for any illness, if pain control was proving complex they could contact the SPCT for advice.
- The trust had used the Faculty of Pain Medicine's Core Standards for Pain Management (2015) as part of their pain management tools. They used the hospitals pain team to support their decisions and used the pain ladder and formulary to made decisions about pain relief.
- Palliative medicines (which can alleviate pain and symptoms associated with end of life) were available at all times. Medicines were prescribed for end of life patients in anticipation of changes in pain level. One member of the SPCT was a nurse prescriber. Staff told us that access to a prescriber was never an issue as medical staff were always available.
- Ward staff received training on syringe drivers used to manage pain control. We saw training records which showed 231 staff had received the appropriate training to cover 38 areas and specialities of the hospital. The SPCT provided support to staff to start a syringe driver and staff from Brent ward were happy to answer questions and provide ongoing support to staff on other wards
- The bereavement survey results for the time 01 January 2016 to 31 July 2016 noted that 57% of responses were strongly agreed and 27% agreed that hospital staff treated any discomfort including pain and agitation their relative had displayed. A further 65% were happy with the care they or their relative had received.

Equipment

- Some equipment shortage for syringe drivers had been identified and addressed. Some syringe drivers were noted to need repair/replacement. There were 25 syringe drivers currently available for use in the hospital. We saw that there was a planned agreed budget to meet some of the shortfall caused by equipment being at the end of its work life. Staff confirmed that the identified risk of not having a syringe driver available had been reviewed and further stock purchased with a reserve emergency stock now in place.

Facilities

End of life care

- Staff said the relocation of the Specialist Palliative Care Team office to near the oncology ward was a positive move. SPCT staff found they were more involved and accessible to the wards.
- Following the previous inspection a local quality improvements in environment project had been undertaken. This was to improve the rooms available for last days of life care and provide environments where bad news was delivered. The trust were in the process of identifying quiet rooms and single rooms on wards which would be used for patients in last days of life or for breaking bad news. These would be made more comfortable i.e. through art work, new furniture, adjustable chairs/beds, lighting and floor/wall and window redesign. We were advised that a steering group had been developed and a bid for funding had been approved in principle by the Trust Charitable Fund and local Cancer Fund.
- Staff told us ten rooms on wards with the highest amount of end of life care provided had been allocated and were awaiting redecoration and refurbishment. The final plan is to completely redesign and redecorate 18 side rooms as rooms for end of life care rooms throughout the Trust .The end of life action plan identified completion within two years.
- We saw a counselling room outside Brent ward which staff from the level 8 wards could all use for the delivery of bad news or to speak privately with patients and families. The room was comfortable and non-clinical. Staff told us that plans were in place to identify a room on each floor which could be used for this purpose. This project was ongoing and the Sisters office on each ward had been identified for these difficult conversations whilst the work continued.
- We looked at the multi faith area and saw that previous issues remained ongoing. The capacity issues had increased for patients and staff who wanted to attend Friday prayers and had to leave because there was no space. There remained insufficient space for males and females to pray separately. There were also ongoing issues about the facilities available for ablutions prior to prayers.
- The chaplaincy staff explained that the situation was managed to the best of their ability but no other space was available at this time with limited possibility of development in the future. The end of life action plan anticipated action to address this situation within five years.
- The previous inspection had identified some issues around the use of lifts to transport deceased patients to the mortuary still ensuring patient dignity was maintained. We spoke with portering services who confirmed this issue had been addressed. Porters now used theatre lifts to transport to the mortuary and also had access to a swipe card which would override the lift opening at each floor.
- The portering staff were now included in the end of life committee meetings to be informed of any relevant changes which may affect them. The lead nurse for cancer services had also attended porters meeting to see how the all of the services involved could work better together. As a result there had been an improvement in the delays being experience by portering staff when attending wards. This improvement had meant that the mortuary staff were also not delayed by ward delays.
- Facilities for relatives at the end of patients' lives had been clarified on ward areas. Staff were now aware that access to food and drink for relatives should be provided and some wards had access, for relatives of end of life patients, to kitchen facilities.

Nutrition and hydration

- All patients had been assessed using a Malnutrition Universal Screening Tool (MUST) which identified nutritional risks. We also saw that when needed specialist dietician support was included in the patients care. For those patients at the end of life, their nutrition and hydration needs were assessed regularly throughout the day and appropriate plans put in place to ensure their comfort.
- The end of life action plan identified the need for nutritional champions on wards to improve nutritional care in end of life patients. The action plan estimated achievement within three years.
- We saw that all patients had drinks nearby and when needed a food and fluid record chart. We saw these to be appropriately filled in. The SPCT advised that the nutrition and hydration part of the last days of life care plan required review. The tick box approach did not lend itself to detail food and drink taken and staff comments. This had since been updated. The most recent nutritional survey showed there was a slight improvement for accurately completed food charts at

84.5% for the last quarter October to December 2015. The preliminary results for the next survey 01January 2016 to 31 March 2016 showed a further improvement to 88%.

- The National Care of the Dying Audit (2015, published April 2016) showed that for nutrition and eating: documentation of the assessment of a patient's ability to eat in the last 24 hours of life, was documented in 28% of the notes reviewed (national average 61%) and the ability to drink was recorded in 37% of notes (national average 67%); The need for more frequent assessment and documentation of possible need for clinically assisted hydration and nutrition was also an area for improvement.
- The trust nutritional audit for 1st October – 31st December 2015 showed some improvements and some further areas for improvement. A preliminary report was available for the same nutritional audit for 1st January to 31 Match 2016. This showed there had been deterioration in the completion of MUST. In July and September of 2015, all wards were expected to send their nutritional link nurse to the nutritional study days. This was expected to improve the quality of the work around MUST completion. Of the records reviewed in the survey 82% had a MUST completed. There was a record that 66% of the MUST scores had been completed on a weekly basis. In the preliminary survey results for 1 January 2016 to 31 March 2016 there had been an improvement in the use of the MUST screening tool.
- There was an improvement in protected meal times. The last two quarters had shown a steady decline in this aspect of meal times, dropping to 80%, however in the preliminary survey results for 2016 there had been an increase to 88% of mealtimes being protected, with medics seeing patients being the main reason for disturbing the patient meal time.
- We saw that when needed, patients were assisted to eat and drink and were supported to remain as independent as possible. There had been an improvement in assistance given to patients seen in the most recent survey; last quarter the result was 93% and the current quarter was 95%.
- There was an improvement in nurses' awareness of what the red tray and red jug lid signified. This system was used to alert staff to patients who may need extra assistance. Only 51% of the notes viewed in the most recent audit included documented the use of red trays and red jug lids in the patients care plan. The specific assistance the patient required was only recorded in 60% of the records viewed.
- The bereavement survey results for the time 01 January 2016 to 31 July 2016 showed that 36% of the people completing the form felt that staff had supported their relative/friend to eat and drink if they wanted to or were able.
- The making mealtimes matter with nutrition and hydration week was held on the 14th to 18th March 2016 and was planned to raise awareness of requirements such as MUST assessment. This was considered by the trust to be a success, with many directors, Consultants and ancillary staff being involved in meal times. Meldon ward won the prize for the most original initiatives during the week. These included fresh fruit being offered throughout the day, a World War 2 tea party, music being played through lunch times and sugar free cordials being offered to all patients instead of plain water, as well as a variety of cakes and biscuits.

Patient outcomes

- Plymouth Hospitals had submitted data to the National Care of the Dying audit 2015 (published April 2016) and saw improvements from the previous audit.
- The trust board summary report 'Implications and actions following the Report of National End of Life Care Audit in Acute Trusts (2015) May' 2016 reported that Plymouth Hospitals performed well against the key indicators scoring positive results in 11 of 13 (with the implementation of 7 day service) including:

- Availability of trust-wide continuing education and training including communication skills.
- Trust-wide access to specialist palliative care support – 7 day service (Jan 16)
- Bereaved relatives' or friends' perspectives.
- Documented evidence that the patient would die in coming hours and days
- Documented evidence the patient was given an opportunity to have concerns listened to
- Documented evidence that where it had been recognised that the patient was likely to die, there was a discussion with those nominated as important to the dying person.

- The remaining area 'The decision that the patient is in the last hours or days of life should be made by the

multidisciplinary team and documented by the senior doctor responsible for the patient's care. This should be discussed with the patient where possible and appropriate, and with family, carers or other advocates' remained ongoing.

- Some areas of improved practice compared to national averages included, the recognition that the patient was thought to be dying was reviewed regularly in 85% (national average 91%) of patients and led by a senior doctor in 64% of cases. This is an improvement on 2013 audit (22%) but less than national average. At the time of death a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order was in place for 96% (national average 94%) of patients' notes. Discussion about the cardio-pulmonary resuscitation decision with the nominated person important to the patient was documented in 67% (national average 78%) of cases. It was recorded that the nominated person important to 77% (national average 80%) of patients had opportunities to discuss the patient's condition with a senior healthcare professional. In 80% (national average 84%) of cases the people important to the dying patient were notified of the imminent death.
- Key clinical indicators requiring improvement included documented evidence that assessment of needs of persons important to the patient was undertaken 28% (national average 56%). Of those assessed 33% (national average 62%) had needs identified and 86% had their needs addressed. Holistic assessment of the patient's needs 35% (national average 66%) of case records. Documented evidence of care and support of the patient's family at the time of and immediately after death in 29% (national average 65%) of cases. There was documented evidence of discussion regarding the patients spiritual/cultural/ religious/practical needs with 6% (national average 15%) of patients able to take part on discussions. This was a slight improvement on the 2013 audit results of 4%. In a further 6% (national average 27%) there had been discussion with a nominated person important to the patient.
- The local audit of last days of life was presented to the end of life committee in October 2015. However as the changes identified required significant work such as education to ward staff and re-ordering, the Trust waited for the publication of the National Care of the Dying Audit (early 2016) to ensure incorporation of any further changes in the Last Days of Life paperwork, thus the changes were made simultaneously. Staff explained that development of an action plan for end of life care was formulated to include both local and national audits. This action plan had now been completed to include the outcomes of the National Care of the Dying Audit, assessment against the Ambitions Framework and the outcomes of the CQC inspection. The action plan was detailed and included anticipated timescale for completion and review information. At the time of the CQC inspection the changes were under review and required final approval by the EOL committee in July 2016 and the trust have confirmed the audit was underway by October 2016.
- A new initiative and project group has been established with nurse specialist and nurse consultants to implement a Thinking Ahead document, a tool for initiating conversations and plans for end of life and advanced care planning. This was being implemented in clinics as a pilot with plans for wider hospital use in the future. The care plan would be flexible to each patient's changing needs and reviewed periodically to ensure it contained the patient's current wishes. The document would give patients the opportunity to think ahead and document their future wishes for their care are. Staff told us that Living Wills were managed on an individual basis for each patient with consideration given to the patients existing wishes.
- Patients at end of life are asked where their preferred place of care would be. The bereavement survey results for the time 01 January 2016 to 31 July 2016 showed that 30% of people completing the survey strongly agreed and 30% agreed that their relative was given the opportunity to discuss the setting in which they would prefer to spend the last days of their life.
- As a result rapid discharge planning was undertaken by the wards with the support of the SPCT or the hospital discharge team. This process could facilitate the transfer of patients on the same day if possible or the next day. All rapid discharges by both the Plymouth Integrated Discharge team and the Hospital Specialist Palliative Care Team were audited to identify any delays. Within that timescale January 2016 to June 2016, the integrated discharge team had facilitated 77 discharges and the SPCT had facilitated 35 discharges. Of the discharges 49 were discharges home with a package of care and 54 were discharges to a nursing/care home.
- Rapid discharge figures for January-June 2016 from the SPCT – from the date when the fast track assessment was completed to the date of discharge showed that

14.9% were discharged the same day. Discharge within one day were 2.9%, and 11.7% discharged within two days. There were 5.8% discharged within three days and 20.5% discharged within four days. A further 14.9% were transferred within five days and 20% died before discharge. The remaining 8.8% of patients were transferred to the local hospice.

- Occasionally oncology patients were admitted to wards that were not oncology speciality and staff confirmed would be moved back to the oncology ward on clinical priority. Patients in the last days of life would not automatically be moved back to their speciality as end of life was considered everyone's responsibility to be managed correctly in the hospital. We reviewed outliers on Brent ward and no patients with end of life or palliative care needs were currently being cared for on other wards.
- The trust had implemented a butterfly sign to discreetly inform all staff that a patient was at the end of life or receiving palliative care in that room or area. Staff training was underway to ensure all staff including portering and domestic staff understood the need to be quiet and adjust their activities to not impact on the patient and their relatives.
- There was no participation in the Gold Standards Framework accreditation scheme and no plans in place to begin accreditation.

Competent staff

- Education and training in care of the dying was provided as mandatory training for all staff caring for patients. This included communication skills training and skills for supporting families and those close to dying patients. The End of Life 3 R project had established a competency framework through champions on each ward.
- Each ward had one or two end of life link nurses who attended end of life meetings and then cascaded the information back to the ward based staff. The end of life facilitator provided planned sessions every four months for the end of life link nurses. We observed cascaded learning taking place on Burrator ward where learning was being planned for the use of the Butterfly Tool.
- The end of life facilitator worked alongside the Macmillan education team to deliver teaching on 'core cancer' days every three months. There has been an end of life facilitator within the hospital in post for nine years, this position was continued with a new staff member in January 2016 showing an ongoing commitment of this important role in staff education and training. The end of life facilitator had also introduced end of life link nurse study days called One Chance to Get It Right. So far one day had been facilitated, the study day topics had included communication, reflective practice and raising awareness of pastoral care and spirituality. We spoke with staff that had attended and found the content to be informative.
- Formal and Informal one to one teaching was provided by the SPCT to nursing and medical staff when required. Issue specific sessions could be arranged and staff confirmed that the teaching provided by the SPCT was of the correct standard and content to help them. The SPCT also provided nurse teaching for preceptorship nurses and healthcare professionals.
- We spoke with medical staff who confirmed that palliative and end of life care training had been provided in medical school, in hospice placement and on the ward. The SPCT provided training to the junior doctor education programme and junior doctors took part in ward rounds and feedback sessions. The healthcare of the elderly registrar had attachment to the SPCT every six months to ensure coordinated working between services.
- Clinical supervision was provided for ward staff every four to six weeks to enable them to review their practice and identify any support or training needs. The SPCT used the local hospice professional development review for annual appraisals and six monthly reviews. Ongoing supervision took the form of daily meetings and was an opportunity to discuss any issues. Clinical nurse specialists attended six weekly individual supervision sessions.
- The bereavement staff had been identified at the previous inspection as not having any emotional supervision or support for their role. This continued to be the case with staff working at lower levels of staffing and at full capacity.
- Since the last inspection a non-executive role to challenge end of life care at board level had been filled by the hospital Chairman. Minutes evidenced that this role had been undertaken.

Multidisciplinary working

- The SPCT worked closely with the Acute Oncology Service to identify patients who needed SPCT support.

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The Acute Oncology service attended the medical assessment unit at 11am each day to review any admissions or readmission patients and would alert the SPCT to any patients who needed their combined support. This multi-disciplinary working meant that some inappropriate admissions to Brent ward could be avoided. At 4pm each day all admissions through this route were reviewed to ensure that the right environment had been identified for each of those patients.

- The patients at end of life may be under the care of numerous consultants. This is managed through multi-disciplinary meetings and the decisions made there as to who would lead the care being provided.
- The emergency department would also contact the SPCT should their input be required. The SPCT also worked in collaboration with all wards and departments in the hospital. Ward staff told us that they could contact the SPCT at any time and that they were prompt in their response. Out of SPCT hours, ward staff were aware they could contact the local hospice for specialist advice.
- Multi-disciplinary (MDT) meetings for all cancer specialities were held each week with up to 30 meetings being held. The capacity of the SPCT would not enable attendance for each meeting. The MDT for upper gastrointestinal and lung cancer was attended by a SPCT nurse. Other MDT meetings which identified the need for palliative consultant input were prioritised and attended as needed. The SPCT confirmed their involvement at these meetings when a need was identified.
- We attended a specialist palliative care team MDT morning meeting, 19 patients were discussed and decisions made about who would visit and the priority of patients. We saw full and comprehensive discussion of each patient which included their physical, psychological, spiritual and social needs. Any needs to refer to the community team were discussed and the IT system which linked to community services was used. We saw good communication and good cross team working. Although each patients care was medically led we saw that the SPCT played a vital role in the planning and management of care.
- Weekly community MDT meetings took place and were attended by the consultant working at both the local hospice and at Derriford hospital. This provided opportunity for follow up and continuity of care.
- The specialist palliative care team worked closely with the community hospice service and in collaboration with the Hospice at Home team and the Crisis Care team. This integrated working meant that there was an ongoing communication between these services during hospital admission, discharge and any readmissions. The IT systems in place were linked between the SPCT, community team and hospice to ensure a smooth transfer of information and ongoing review for any readmissions. The integrated working had identified a reduction in avoidable admissions during 2015 with an identified bed days saving each month. For example, in December 2015, 85 bed days had been saved by an admission prevention action by the crisis community team working with the other integrated services including the hospital teams.
- Two outpatient's clinics took place for patients receiving palliative care. There were also pain clinics at the hospital and at the local hospice. This enabled the SPCT to refer patients to these clinics to prevent admissions and enable cross team working and support. Patients could also be referred to The Mustard Tree, a day care facility at the hospital available for patients receiving oncology or palliative treatment. The Mustard Tree staff could also refer to the SPCT to enable patients to be seen there.
- The hospital had an adequately staffed and accessible pastoral care team to ensure the spiritual needs of the dying patients and those close to them were met. Chaplaincy staff told us that prompts in the last days of life care plan were there to remind staff to discuss and refer to the chaplaincy for support if needed. The chaplaincy staff were aware that there was a place for them to record their visits in the care plan but said they often didn't. This meant that any audit would not reflect the chaplaincy input.
- Following the last inspection a post for a full time palliative care/end of life chaplain had been funded and was being recruited to. Interviews were underway during our inspection. The role would be to work with the ward staff and specialist palliative care team to provide pastoral, spiritual and religious support for patients and staff involved in palliative and end of life care. The chaplaincy staff told us that they also worked in the community to provide a continuity of service to patients who were discharged and did not have pastoral or spiritual support at home.

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- Ward staff told us about the support they received from the hospital chaplaincy and its positive impact on end of life care. Recently staff had raised the request to support a patient at the end of their life with a wish to marry. This had not been possible but a ceremony tailored to the patient and their partner had been undertaken to recognise the blessing of lifelong love and commitment. Staff told us about how they appreciated the support provided by the chaplaincy.
- End of life meetings enabled all areas, with an input in end of life care, to meet and discuss risks and reflect on current practice. Ward link nurse champions reported to this meeting and this meeting fed information to the end of life committee.

Seven-day services

- The Specialist Palliative Care Team were available seven days a week from 08:30 to 4:30pm. Consultant presence out of hours was an on call arrangement in the hospital and contact with the local hospice by telephone.
- Availability of out of hours imaging, physiotherapy and occupational therapy was provided by the hospital team and was available as needed.

Access to information

- Staff had access to the information they needed to deliver effective care for patients at the end of life. Two IT systems were in place for end of life, the internal hospital system (EPACS) and the system which linked with the community services (Crosscare).The SPCT had access to both systems. The EPACS system was used by the hospital and the out of hour's doctors service to access information about the patient. The end of life link nurses on the wards could access and upload information on the EPACS for patients receiving care on the ward. This enabled a continuity of records for each patient.
- Patients had access to their records, should they want to. Patients were well informed and a written record was provided of conversations. We observed a discussion with a patient, at that time the nurse noted down the salient points and the written record of verbal discussion and decisions was given to the patient for their information and to take home with them. This enabled patients to have a record of conversations and a reference for later.
- When patients were discharged, a letter was sent to the patients GP, either by email or by letter. This was done within 24 hours of discharge. The electronic recording system (EPACS) used by the hospital and was also available to out of hours GP's services to enable information to be available to the doctor.
- Bereavement cards were now being sent to families who had been involved in the care of their relatives. This card included an invitation to return to the ward and discuss any areas of concern which on reflection, they may have. Time was allocated by the ward matron to answer their questions. This practice had been running for the last two months with 20 cards being sent out in May 2016 and so far six relatives had taken up this offer.
- We saw that some wards had an electronic board at the ward entrance which had patient's names and coded indicators to inform staff of patient's needs. We discussed with staff how access to information was limited to support patient confidentiality. On one ward, where the board access had created issues of confidentiality the board was switched off when staff were busy and a smaller screen used at the nurses station.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had replaced Do Not Attempt Resuscitation (DNAR) with the Treatment Escalation Plan (TEP) documentation, which had been in place since 2012. The TEP form was a Devon wide document and recorded important clinical decisions regarding resuscitation and other ceilings of care.
- The end of life Standard Operating Procedure (2016) stated that, a treatment escalation plan should be in place for all patients identified as being in the last year of life. The TEP identified appropriate treatment options for the patient, and those which may be inappropriate. When this was not possible, the priority of TEP completion was for patients who were receiving end of life care and palliative treatment. The TEP forms were completed by medical staff and training and guidance was provided to medical staff for the correct completion of these forms. TEP education remains an integral part of all resuscitation training programmes**.** The TEP form stated clearly that the form was for clinical guidance and did not replace clinical judgment. Medical and nursing staff told us that should the patient not have capacity in an urgent situation then clinical judgment would be considered to be in the patient's best interest.

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- The end of life risk register noted the variance in completion of the treatment escalation plan depending on the individual doctor completing the form. The level of doctor signing the forms varied. The head of nursing for cancer services confirmed that if the patient was for resuscitation a junior doctor could complete the form without consultant review. However, any decisions for a patient to not be for resuscitation were reviewed by the patient's consultant. We observed that at the midday patient review any patient without a TEP was followed up with the ward doctor and a TEP completed.
- A monthly audit of treatment escalation plans completion by service lines was being piloted and was undertaken by ward doctors and uploaded to service line dashboards. As a result the audit tool had been amended once and was in the final stages of revision. Whilst the finalised audit tool was being agreed, paper audits were being maintained. It was planned to upload the final results to service line dash boards from August 2016 to enable ownership and governance within service lines and care groups.
- We saw the end of life TEP audit (June 2016) included review of 33 records over nine wards. The results showed that 23 of TEPs showed completion above 80%. Of those, 17 scored 100% of completion. The main reason for non-compliance was the mental capacity question not being completed (33%) others included wrong version of TEP (1), discussion with family or patient not evident(1), no rationale(1).
- The TEP Emergency Calls Retrospective Audit (May 2016) undertaken by the resuscitation team showed the Treatment Escalation Plan (TEP) and Resuscitation Decision Form was present and completed in the medical notes of 70% of those patients who had had a call for the emergency team to attend. The team attended not only resuscitation calls but included slips, trips and falls. There were 67 notes reviewed. 93% of patients had the rationale documented for the decision 'not to resuscitate' and had ceilings of care determined for their future management. 87% of patients/relatives had been involved in the resuscitation decision process. We spoke with the resuscitation lead who had noted some improvements in the way the TEP's were being completed.
- In the same audit for April 2016, 77 notes were reviewed. Patients who were not for resuscitation but had rationale and discussion documented on their TEP were reviewed, 100% had a rationale recorded and 85% had a discussion recorded.
- The head of nursing for cancer services told us that as well as end of life TEP audits and audits by the resuscitation team, impromptu reviews took place on wards to check in the interim that TEP forms were being completed. They had found a general improvement but further work was needed.
- We observed two occasions when the TEP form was discussed between the consultant and the patient. On each occasion this was done with sensitivity and ensured the patient understood what they were agreeing to.
- We looked at 25 TEP forms and saw a general improvement in their completion. Some forms were incomplete with some wards better than others at completing them with some lacking confirmation of the patient's capacity and a further record of decision making made by the doctor in the patient's records. The narrative used as a rationale for decision making had improved across the six wards we visited.
- We saw that consent for procedures were recorded in the patient's notes. Verbal consent to procedures and nursing care was heard to be requested and seen documented in patient's notes.
- For those patients who lacked mental capacity to give an informed consent, policies were in place to follow the Mental Capacity Act (2005). The legal framework for this policy requires organisations to work towards the best interest of adults at risk and vulnerable individuals who lack mental capacity.
- Medical and nursing staff confirmed that should a patient not have sufficient capacity to make decisions, a best interest process was followed. We saw information for staff on the wards to inform them about the Mental Capacity Act (MCA) and best interest process.
- For patients who lacked mental capacity and were facing serious medical decisions, and who had no-one to support/advise them, referral to the Independent Mental Capacity Advocate service (IMCA) was arranged by staff. An IMCA would be involved to support a patient who lacked mental capacity and would work to support the patient's best interest.
- We spoke with medical and nursing staff that had a clear understanding of the Mental Capacity Act and the use of

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best interests meetings and IMCAs to ensure the patients best interests were acted upon. Training for this process had been provided as part of the nurse mandatory training and the junior doctor training programme.

- Patients who lacked Mental Capacity to consent to treatment and needed longer term restraint or restriction of behaviours, as part of their clinical care, were referred for Deprivation of Liberty Safeguard (DoLS).
- Authorisation for the clinical team to deprive a patient of their liberty, for their own safety, were applied via the DoLS office within the hospital safeguarding adult's team and Plymouth City Council. Where such patients do not have a relative or representitive an IMCA should be involved.
- The trust Deprivation of Liberty guidance had been revised and updated this year (2016). To ensure compliance with DoLS processes, staff confirmed further training and revised local processes had been delivered. Medical staff confirmed they had DoLS training as part of a rolling programme.
- From April 2014 to March 2015 23, DoLS applications were made. From April 2015 to March 2016 148 DOLS applications had been made. The increase was due in part to the changes made to the criteria for referral.
- We spoke with medical and nursing staff who explained the referral process in detail. The decision to refer to DoLS was a joint decision at multi-disciplinary level. The criteria for referral was considered and agreed between nursing and medical staff. The medical staff completed the referral and submitted to the local council.
- An email receipt was stored to enable an audit trail of actions taken. Staff then assumed a seven day timescale for holding the person on the ward. Prior to the end of those seven days, staff considered submitting for a further seven day extension. A 28 days request (standard application) was submitted at the same time as the urgent application. Records were maintained by nursing and medical staff of any DoLS undertaken. An incident report was completed, a safeguarding alert recorded with the hospitals safeguarding team and a note put on the wards patient record board to ensure staff were aware of when the seven days were completed. All decisions about DoLS were risk assessed to ensure they maintained patient safety.

Are end of life care services caring?

Outstanding ☆

Are end of life care services responsive?

Good

Are end of life care services well-led?

Good

Outpatients and diagnostic imaging

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

Information about the service

Plymouth Hospitals NHS Trust outpatient services were provided at Derriford hospital with a small amount delivered 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).

Plymouth Hospitals NHS Trust provides a full range of diagnostic imaging, including general radiography, computed tomography (CT), ultrasound, magnetic resonance imaging (MRI), nuclear medicine, cardiac imaging and interventional radiology at Derriford hospital. They also provide radiotherapy services. Plymouth Hospitals NHS Trust also provides general radiology services at six satellite sites.

The outpatients service saw 512,613 patients at Derriford Hospital between January 2015 and December 2015 split between many specialities. Of these specialities 62% were follow up appointments and 32% of these were new appointments. The remaining 6% were appointments which people did not attend. The largest percentage of patients attended the specialities of ophthalmology, trauma and orthopaedics, dermatology and cardiology.

A small proportion of outpatient and diagnostic imaging appointments were conducted at Mount Gould Hospital which has a separate report. Other locations included Liskeard Community Hospital, The Child Development Centre, and The Plymouth Dialysis Unit which were not inspected during this focused inspection.

Radiology services are managed within the Clinical Support Services Care Group and perform approximately 24,000 examinations each month. Inspectors visited the East and West radiology departments, MRI department, breast imaging, ultrasound, Healthy Bones service, nuclear medicine and radiotherapy. We spoke to a wide range of people, including radiologists, radiographers and patients.

The purpose of this follow-up inspection was to look at how the outpatient and diagnostic imaging teams had addressed our previous concerns in relation to safety, effectiveness, responsiveness, and well-led domains. During our last inspection we rated safety, responsiveness and well led to be inadequate. Effective was not rated due to insufficient data being available to rate this domain nationally. Caring was rated good. As a result we did not inspect this domain during this inspection.

During our inspection (between Wednesday 20 and Thursday 21 July 2016) we visited: the main outpatients department; the ear, nose and throat clinic, trauma and orthopaedics, rheumatology, ophthalmology, urology, audiology, radiotherapy and oncology outpatients departments. We also visited the therapies department (including physiotherapy, speech and language therapy (SALT), dietetics and occupational therapy). We also visited East and West radiology departments, MRI department, breast imaging, ultrasound, Healthy Bones service, nuclear medicine and radiotherapy.

We spoke with five patients, 69 members of staff including managers, administration staff, matrons, nurses, health

care assistants, radiographers, assistant practitioners and doctors. We spoke with one therapies student and looked at 10 sets of medical records some of which were computer based.

Summary of findings

We rated the outpatients and diagnostic imaging service as good because:

- We found that although there were still people waiting too long for their follow up appointment the numbers of patients waiting had significantly reduced with work ongoing to reduce this further. Innovative approaches to care, such as overbooking and patient initiated contact had reduced waiting lists by thousands of patients making the demand more manageable. We also saw that clinics were being well utilised with minimum clinic spaces not being used.
- There were innovative approaches to managing the capacity and demand of outpatient's clinics which was under constant review and scrutiny from senior managers. We were told by senior managers that the Director of Transformation was having a hugely positive impact on facilitating changes within the outpatients service.
- There was an open and honest safety reporting culture which all staff were engaged with. All staff we spoke with were able to describe their responsibilities to report incidents, could give examples when they last reported an incident and could describe learning from incidents which were shared in several forums.
- Although some service lines had minimal vacancies most were fully staffed and staff were able to utilise their time well to manage the needs of patients. Staff records showed that mandatory training rates were the highest in the trust (although slightly below the trusts target of 100%). Access to additional training and competencies was good and appraisal rates were high.
- There was a positive patient centred culture within the outpatient and diagnostic imaging services with many areas being designed to support people living with dementia or learning difficulties. Some areas such as MRI and the physiotherapy department had made changes to support bariatric patients. All staff were trained in dementia (as part of their mandatory

Outpatients and diagnostic imaging

training) and staff in outpatients used prompt cards to access support services such as the learning disability team, dementia team and safeguarding teams.
- The trust had good oversight of compliance with the health and social care act 2010 regulations through the use of 'fundamentals of care' and the 'Departmental Nursing Assessment and Assurance Framework' to gain assurance of individual clinics.

However:

- We found that some medical records were not being stored securely overnight in the oncology outpatients department.
- With limited capacity within the outpatients unit, people were still waiting too long for a follow up appointment in outpatients increasing the risk of harm being caused as a result of waiting.
- The strategy for outpatient services was not well represented in service line strategies meaning that there were limited well defined objectives based on the trusts vision and values.

Are outpatient and diagnostic imaging services safe?

Good

We rated safe to be good in outpatient and diagnostic imaging services because:

- There was a good incident reporting culture and openness and transparency was encouraged. All staff we spoke with understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and staff were fully supported when they do so. We saw evidence of action being taken when trends in incidents occurred to prevent them from happening again.
- We found that when something went wrong, people received a sincere and timely apology and were told about any action to improve processes and to prevent the same thing happening again. We were given multiple examples of apologies to patients through conversations with staff and looking at investigation records.
- There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse. All staff we spoke with had a good awareness of safeguarding legislation and many had been given prompt cards to assist them in the identification of abuse. Staff knew what to do when they suspected abuse.
- Staffing levels and skill mix were, planned and implemented to keep people safe at all times and staff shortages were kept to a minimum. We also found that all staff in the outpatients and diagnostic imaging services had received all their mandatory training in line with trust policy.
- Risks to people who used the services were assess, monitored and managed in line with national legislation and guidance, particularly around the use of radiation and non-ionising radiation. We also found that environments and equipment in outpatient and diagnostic imaging kept people safe from harm and were clean. Techniques used to ensure cleanliness were in line with NICE quality standards.

However:

- We found that records were not always stored securely. In oncology outpatients we found that records were kept in unlocked trolleys in unlocked rooms overnight.
- Not all diagnostic images that required documented evaluations had them recorded. This is a safety concern as conditions requiring treatment may be missed if the images are not reviewed.

Incidents

- Between May 2015 and April 2016 there were a total of 345 incidents attributable to outpatients with 252 of these resulting in no harm. Of the remaining incidents 14 were classed as moderate and three as severe. The large quantity of no harm incidents indicated a good incident reporting culture. One of the severe incidents was reported when a patient lost vision in an eye due to follow up appointments for laser eye surgery not being received. Of the moderate incidents there were multiple occasions where delays in follow up resulted in harm to the patient such as worsening diabetes or side effects due to over use of steroids. All of these incidents had appropriate investigation, root cause analysis, learning identified, and an apology made to the patients.
- During the last inspection we found that staff were confident to report incidents using the computer system and could give examples of when they had used it. We saw evidence of senior staff conducting risk assessments and root cause analysis through the same computer system. During this inspection all staff we spoke with in both outpatient and diagnostic imaging areas understood their responsibilities to raise concerns, record safety incidents and near misses and could give recent examples of when they had reported an incident. Staff in diagnostic imaging told us that they felt confident to raise concerns because they felt that management would listen to them.
- Staff understood their responsibilities to report externally. Between June 2015 and May 2016. no Never Events and one Serious Incident Requiring Investigation (SIRI) reported externally The serious incident involved the misidentification of a patient in ophthalmology. The importance of a three point identification check (name, date of birth and address) was shared with all staff in the ophthalmology department and was regularly audited showing near 100% compliance.
- NHS trusts are required to report any unnecessary exposure of radiation to patients under the Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R. Diagnostic imaging services had procedures to report incidents to the correct organisation, ensuring that all radiation incidents were fed into risk management. There was a specific policy for extravasation incidents which was available on an electronic document management system available in diagnostic imaging. The radiographers in computed tomography (CT) told us that they reported all extravasation incidents via the electronic reporting system.
- Lessons were being shared well in both outpatients and diagnostic imaging to make sure action was taken to improve safety beyond the affected service, but could be improved in main outpatients. Staff told us feedback and learning from incident investigations was shared during regular staff meetings. They also told us any changes to practice implemented following an incident were communicated to staff by email in addition to being discussed at staff meetings. Several radiographers also told us they had received an email with feedback following an incident investigation. In oncology following any incident being reported the reporting staff member received a personal email from their manager with feedback. Any action plans created as a result of an incident were shared through email to all staff. If an incident occurred in an outpatient area learning would be shared in a morning safety huddle to ensure it was widely distributed. If staff were not at the huddle the relevant information was circulated via email and on newsletters. Safety huddles occurred every morning in all outpatient and diagnostic imaging areas and discussed the safety challenges of the day. During the last inspection we were told the main outpatients department received little feedback from incidents which occurred in speciality service lines, which limited learning. Although this had improved staff said it could be better. Managers in the main outpatients now felt they could follow up service lines more for feedback when an incident occurred.

Duty of Candour

- People who used services were told when they were affected when something went wrong. The duty of Candour states that as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, a health service body must notify the relevant person that the incident has occurred and provide reasonable support to the relevant person in relation to the incident and offer an apology. Staff we

spoke with, from all levels in the organisation, had a good understanding of duty of candour and could describe when it would be used. They went on to describe the open and honest culture towards patients regardless of meeting the threshold for duty of candour and could give example of lessons learnt from The Francis Report and within their own hospital. Staff could give examples where they had been open and honest when things went wrong and how that was documented. We looked through a selection of incident reports and found that they adhered to the duty of candour regulation, including processes and evidenced written apologies. Every radiographer we spoke to knew what 'duty of candour' was and all said they would be open and honest with a patient if something had gone wrong. We also saw screen-savers displayed on computer screens that reminded staff about duty of candour.

Mandatory training

- Almost all staff received effective mandatory training in the systems, processes and practices which helped keep people safe. Data provided by the trust showed that in July 2016; 91% of outpatient and diagnostic imaging staff had received resuscitation training, 93% had received manual handling training and 96% had received medicine management training. All staff were required to attend a 'trust update' on a yearly basis which included key skills and knowledge training (such as fire policy, manual handling and information governance) which 96% of staff had attended. The trust had a 100% target for all areas in mandatory training. Although the outpatients and diagnostic imaging departments performed below this target for some of the mandatory training requirements they were performing better than the rest of the trust.
- Managers and individuals were informed through email when mandatory training was due to expire and staff described being supported to book and attend planned sessions. Oversight of mandatory training was gained through an outpatients and diagnostic imaging audit tool called the Departmental Nursing Assessment and Assurance Framework. Although this has only been in use for a short amount of time improvement over time had been seen in the audit results.
- It had been identified in the immunology/ allergy and chemotherapy services that there was a greater risk of a patient collapsing during treatment. As a result, all registered nurses were trained in either intermediate life support or advanced life support.

Safeguarding

- There were systems, processes and practices in place to keep both adults and children safe from abuse which was reflective of relevant legislation. The trusts safeguarding policies described the definition of abuse and who might be at risk, the rationale of assumed capacity, and the responsibilities of individuals. 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. These policies were easily accessible on the trusts intranet pages along with information provided by the trusts safeguarding team (including contact details and phone numbers).
- Staff in many outpatient areas were given prompt cards in order to give them easy access to phone numbers and processes involving safeguarding of both adults and children. Staff we spoke with found these to be a good source of information and allowed quick action to any concerns. When inspectors asked staff questions about safeguarding of adults and children, staff were able to demonstrate a good understanding by explaining their responsibilities and the process involved both with and without the use of the prompt cards.
- Safeguarding has three levels of training; level one for non-clinical staff, level two for all clinical staff and level three for staff working directly with children and young people. Plymouth Hospitals NHS Trust supplied all three levels of safeguarding training to its staff which was delivered depending on the individual's roles and responsibilities. Training records provided by the trust showed that as of July 2016 all staff in outpatients and diagnostic imaging had received safeguarding level one and two training. However, only 74% of staff in outpatient and diagnostic imaging requiring level three training had received it which was below the trusts target of 100%.
- There was a safeguarding lead both in outpatients and within diagnostic imaging. There were posters about safeguarding issues displayed in most outpatient and diagnostic imaging staff areas. We also saw in diagnostic imaging a "Quick reference guide for children who are

not brought in for a hospital appointment" ,which described the process for informing referrers of children who do not attend for an appointment on two occasions and also how to escalate any concerns to the safeguarding team.

Cleanliness, infection control and hygiene

- In all outpatient and diagnostic imaging areas high standards of cleanliness were maintained. Areas were visibly clean and equipment was cleaned on a daily basis. Staff knew this through the use of dated 'I Am Clean' stickers. These showed equipment was cleaned on a daily basis. Equipment used in ultrasound and the Healthy Bones service had separate cleaning records which were complete and up to date.
- In all outpatient and diagnostic imaging areas we saw staff bare below the elbow. Staffused aprons and gloves correctly to prevent the spread of infections. We saw that all staff were washing their hands or using sanitiser gel immediately before and after patient contact which was in line with the National Institute of Clinical Excellence (NICE) Quality Statement 61 (Statement 3).
- In all outpatient and diagnostic imaging areas disposable curtains were in use to prevent the spread of infections. These were dated and changed regularly according to the trusts policy. All curtains we checked were within the policy's time frame of being changed every three months. In the therapies department traditional curtains were used as disposable ones were noisy. These were changed on a monthly basis to ensure hygiene standards were maintained.
- We saw cleaning schedules for computed tomography (CT), magnetic resonance imaging (MRI) and ultrasound which showed that areas were cleaned on a daily basis.
- NICE quality statement 61 (Statement 4) states that people who need urinary catheters have to have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the catheter. Catheter insertion audits were completed monthly in the Chestnut Unit (Urology outpatients) to assess if aseptic technique was used correctly. The audits showed that 100% of the audited patients had the correct aseptic technique used.
- NICE quality statement 61 (Statement 5) states that people who need a vascular access device have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the device. Peripheral vascular catheters (PVC) and central venous catheters (CVC) were audited for the correct techniques used to gain access to Veins or vessels. If the correct techniques were used this reduced the likelihood of the patient acquiring an infection. All outpatient areas were compliant with CVC audits. Areas such as the pain clinic performed well on a 95% compliance target with an average score of 98% in PVC audits. The hospital set a target for 95% staff inserting PVCs to have done so correctly. In pain clinic 98% of staff were seen to be doing this, however in CT 73% of staff were inserting PVCs were using the correct technique.
- All but a few outpatient and diagnostic imaging areas had link nurses for cleanliness, infection control and hygiene who were responsible for the implementation of safety systems, processes and monitored compliance.
- Cleanliness audits were conducted on a monthly basis to ensure there was continual monitoring of compliance above a 95% trust target. Most outpatient areas were 100% compliant; however some areas such as dermatology and the Royal Eye Infirmary had their overall compliance reduced due to non-submissions of the data. In diagnostic imaging we saw evidence of a cleanliness inspection taking place in April 2016 showing an overall compliance rate just below the trusts target which was displayed in the waiting area. The actions from this audit had been completed and were to include cleanliness audit results as a standing item for senior staff meetings and to increase the frequency of audits in the poorer performing areas.
- In main outpatients when asked what precautions were taken when seeing people with suspected communicable diseases we were told it was easy to contact cleaners to come and deep clean all areas affected. We were told that X-ray East was used by the emergency department at night for patients who had a suspected communicable disease to control the risk of spread and minimise disruption in the emergency department.

Environment and equipment

- The design, maintenance and use of facilities and premises generally kept people safe. Staff in the chemotherapy outpatients commented that there was limited seating in chemotherapy outpatients. However, funding had been agreed to increase the number of chairs from 17 to 22 in a different area. This was

identified on their risk register. When there were not enough chairs patients had to have their chemotherapy as an inpatient which disrupted wards and staff. This was well managed and the nurses worked well with ward staff. During the last inspection it was noted that self-check-in counters had screens which were visible to other people waiting in line. Although this was still the case they had been moved further apart and business plans had been submitted to add screen dividers in main outpatients.

- The maintenance and use of equipment kept people safe. Imaging equipment in diagnostic imaging had regular services carried out by manufacturer engineers as well as routine servicing. Alongside this, robust quality assurance processes for imaging equipment were regularly conducted through the use of daily, weekly and monthly checks. There were clear processes in place for retesting or taking equipment out of use when a problem was identified. All other equipment used in both outpatients and diagnostic imaging which we checked was appropriately serviced apart from an echocardiograph machine and blood pressure monitoring equipment found in MRI. This was raised at the time of the inspection and addressed immediately.
- In diagnostic imaging we saw evidence of a rolling programme of dose audits performed over a three-year period. Medical physics staff showed us data from the last quarter that demonstrated some minor differences between some examinations performed on the CT scanners that resulted in some scanners using a slightly higher dose for the same examination. However, medical physics staff told us that they were in the process of addressing these minor variations through action plans and risk assessment. The radiographer responsible for CT dose audits had protected time to collect data.
- A capital replacement programme within radiology was in place. The radiology risk register had several entries relating to equipment considered to be beyond 'end of life' however; radiology management told us that they did not feel that the aging equipment experienced greater downtime and had not impacted on the service to patients. The only exception to this was an X-ray machine at the South Hams satellite centre where the equipment had to be taken out of use because replacement parts no longer being available. Radiology management had located a mobile X-ray machine at South Hams to ensure that a service could continue to be provided. However, this service was reduced by approximately 20%, as the mobile equipment was not appropriate for all examinations. This decision had been risk assessed with involvement of the medical physics department to ensure the service was safe. Radiology management told us they were investigating a number of financial options for replacing the X-ray equipment at South Hams.
- Management within radiology have worked to ensure that all imaging equipment was listed on the trust inventory. This inventory had allowed them to prioritise the replacement of equipment and input into the trust 5-year business plan. Medical physics staff told us that equipment issues are also raised with the radiation protection committee.
- In diagnostic imaging there were appropriate arrangements in place to restrict access to both ionising and non-ionising radiation premises in compliance with the ionising radiation (medical exposure) regulations (IR(ME)R) 2000 and the ionising radiation regulations (IRR) 99.In addition, we saw a sign displayed in one of the CT control rooms in CT East reminding visitors not to distract the radiographers. This sign had been put up following incidents where a noisy and distracting control room had been shown to be a contributory factor to minor and no harm incidents. However, we saw that the control room was still very busy at the time of our visit.
- The facilities for the administration of high radiation dose therapies such as Iodine 131 (used to treat cancer of the thyroid), were sufficient to protect staff and members of the public, as well as the patient undergoing therapy. For example, the room used to isolate patients during their therapy had lead lined doors and thick concrete walls, which meant any radiation was contained inside the room. Staff also used dedicated handwashing and radiation monitoring facilities to make sure no radiation was on their hands after administering the Iodine therapy.
- In the dermatology outpatient unit staff worked well with the Sterile Services Department to ensure that re-usable equipment with outpatient procedures was removed and replaced with new minor operation packs where required. The majority of equipment was single

use only so was disposed of after use. All equipment in dermatology was managed by a link nurse in the surgery care group who had oversight of service history, electrical safety testing and the central register.

Medicines

- We found that in both outpatients and diagnostic imaging arrangements for managing medicines and contrast media kept people safe. It was identified in the last CQC report that in main outpatients staff who shouldn't have access to medicines cupboards were holding the keys. This was raised at the time and rectified. During this inspection we found that all prescription forms (known as FP10's) were locked away securely and in most outpatient areas only the nurse in charge had access to the keys. After clinics were finished in main outpatients the keys were securely locked away in a keypad cupboard.
- We checked the contrast warmers throughout the department and all bottles of contrast were found to be in date. We were told that Patient Group Directions (PGDs) were in place for all appropriate radiographers. These documents allow radiographers to give patients contrast agents and a very limited number of medicines without an individual prescription from a doctor. We also saw some examples of these PGDs in CT, MRI and radiotherapy.
- We checked the controlled drugs cupboard in CT and MRI. We found that records were accurate and up to date with one exception where we found some out of date medicines in a cupboard in MRI. This was raised with staff who addressed the problem at the time of the visit. We also saw the use of stickers to highlight any short-dated drugs.
- In outpatients safety systems to ensure the safe management of medicines was regularly audited. The ownership of the medicines keys was regularly audited and evidenced in the trusts quarterly report. As part of the 'Departmental Nursing Assessment and Assurance Framework' (known as the DAAF) there were eight questions relating to medicines management. The audit showed that all but the chest clinic were managing medicines appropriately and an action plan was created to raise compliance.
- There were appropriate arrangements to ensure the safety of controlled drugs and chemotherapy.

Additionally to this, in order to ensure that the correct person was in the clinic room in oncology outpatients two nurses checked wristbands to prevent miss-identification of a patient.

Records

- Peoples individual care records were written and managed in a way that kept people safe. In outpatients we looked in five sets of notes and in diagnostic imaging we looked at five sets of electronic notes and found that records were accurate, complete, legible and up to date. We also saw that additional checks had been completed in diagnostic imaging such as the checking and documentation of patient pregnancy status in line with departmental protocol.
- We saw that a majority of notes in the outpatients and diagnostic imaging areas were locked away securely. However we found the Audiology/ Ear Nose and Throat outpatients area that there were 13 boxes of patient notes being stored in a corridor. These were not secure meaning that patients and unauthorised staff had access to them. This was raised with senior staff and although they were not removed immediately, they were moved prior to the end of the inspection. We also found in oncology outpatients that there was no appropriate storage to keep records secure. The trolleys in use were not lockable so had to be stored during the day in line of sight of the receptionist. This did not entirely prevent unauthorised access to patient records. Overnight records stayed in the unlocked trolleys and were moved into a clinic room. Although the clinic room itself could not be locked the unit was locked at 7pm. Between the clinic ending and the building being locked the unit was cleaned and there was no one monitoring the notes to ensure that security was maintained.
- There were a variety of records available on computers in both outpatient and diagnostic imaging areas, for example the use of radiology information system (RIS) and picture archiving and communication system (PACS). A trust wide action plan showed that the trust had completed a project to increase awareness of the importance of locking computers.
- Computers were appropriately locked when not in use and access to specific information was password protected, in line with trust policy.
- Records were regularly monitored through regular audits (as part of the environment audit) for the safe storage of notes. This was reported to the trust board.

Results showed that between June 2015 and May 2016; 95% of notes were locked away in trolleys or attended by an identifiable member of staff. Similarly the audit showed that between June 2015 and May 2016; 89% of notes were stored securely.

Assessing and responding to patient risk

- Comprehensive risk assessments were carried out for people who used both outpatient and diagnostic imaging services in line with national guidance. We found that in dermatology an adapted version of the world health organisation (WHO) safer surgery checklist was in use to ensure that surgical procedures were conducted safely. We were also told that the unit was about to move towards the main surgical unit's WHO checklist for continuity between services.
- The therapies unit had access to a hydrotherapy pool. There were always three members of staff on duty when the pool was in use to allow for safe evacuation. There was always a member of administration staff in the pool office who was trained in basic life support.
- In oncology outpatients all patients were telephoned a day before their appointment to check how they were feeling which was captured in the patient notes and compared to a pre-chemotherapy symptom scale. Bloods were checked by a healthcare assistant prior to commencing treatment.
- Patient safety checklists were used in CT and MRI, and MRI also had a paediatric safety checklist. We looked at approximately 10 patient safety checklists, all of which had been accurately completed. MRI staff told us that patients were risk assessed as part of the safety checklist. Any patients with mobility issues were allocated to one of the static scanners, as the mobile MRI scanner was not suitable for those patients.
- Staff we spoke with were able to describe the processes involved when managing a deteriorating patient and some could give inspectors examples of when they had to quickly call for other members of staff or the crash team. We checked four resuscitation trolleys in both outpatients and diagnostic imaging and found that they were all appropriately located and checked daily. All of the trolleys had tamper-evident sealing mechanisms to identify if they had been opened. Staff in main outpatients described processes that took place for the re-checking, stocking and sealing the trolley after use. The trusts resuscitation officer had organised some training sessions for all MRI staff to ensure that staff knew how to manage a cardiac arrest situation in the scan room.
- In diagnostic imaging there were suitable arrangement in place to meet national legislation around the risk of the use of radiation to staff, patients and visitors. Local rules were seen as required under Ionising Radiations Regulations 1999 (IRR99) and were within review dates with the exception of those displayed in CT East which should have been reviewed in November 2015. IRR99 are a statutory instrument, which form the main legal requirements for the use and control of ionising radiation in the United Kingdom. The Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) procedures were in place and all documentation was available on a shared drive. This ensured only the most recent versions were available for staff to reference.
- There was easy access to the radiation protection advisor (RPA) for providing radiation advice to staff. There were radiation protection supervisors (RPS) for each controlled radiation area. Plymouth Hospitals NHS Trust was supported by an 'in-house' radiation protection service. They provided the RPA, radiation waste advisor (RWA), medical physics expert (MPE), for diagnostic imaging, nuclear medicine, and provided support for lasers and magnet use within diagnostics throughout the trust. There was also a radiotherapy physics department which supported radiotherapy.
- Within radiology there was a duty radiologist room. A radiologist who was a point of contact for any staff wanting to discuss a patient was based in this room. Staff told us that this had decreased the amount of time spent looking for someone to speak to and had decreased the number of interruptions for other radiologists allowing them to concentrate on the work they were doing.
- Under IR(ME)R 2000, all medical images must have a documented evaluation recorded. This means that a doctor has to look at the image (not necessarily a radiologist) but this must be written or recorded somewhere, such as in the patients notes. The trust had recently audited if this was being done in different specialties, and had found this was not the case. This information had been passed on to the patient safety team, who had requested evidence from the specialty teams that evaluations of images were being consistently recorded. We were told that of those that

did respond, compliance was shown to be mixed. We saw one of the audits, which showed that only 36% of cardiothoracic images had a documented evaluation. This is a breach of IR(ME)R and is a potential safety concern as conditions requiring treatment may be missed if images are not reviewed. Medical physics staff expressed concerns about a lack of engagement from service lines who are responsible for providing evidence of compliance to radiology staff. They told us that they felt that data return and the provision of follow-up information was very slow and that this had an impact on action being taken to address audit outcomes.

- This issue was picked up in a CQC report completed in 2010 and again in the fully comprehensive report from 2015 with no tangible improvements being made.

Nursing and allied health professional staffing

- Staffing levels compared well with the planned staffing levels which helped keep people safe at all times. Discussions with the matron of main outpatients said they were fully staffed apart from an 8 hours a week post which they were holding back to make a full time post.
- Managers said that they tried not to use bank or agency staff as the skills required of an outpatient nurse were very specialist and it wouldn't be appropriate or safe to use agency staff. Where there was sickness staff covered each other's shifts through goodwill.
- Therapies (speech and language therapists, dietetics, physiotherapists and occupational therapists) had various vacancies at different bandings which had increased between January 2016 and April 2016. The vacancy rate between all four of these specialities in April 2016 was 13%. The lowest was occupational therapy with only 3.5% vacancies and the highest was speech and language therapists with 19.7% vacancies in April 2016. Staff felt that staffing levels were good compared to similar services they had worked in and said that where cover was necessary goodwill was used. These vacancies made the teams busier and managing their time more difficult.
- Diagnostic imaging was almost fully staffed to its establishment which meant people were kept safe at all times. At the time of the inspection there was only one agency radiographer employed by the trust who was providing cover for a permanent member of staff working on a project. The breast imaging department were staffed slightly below their establishment. They told us that they had tried to recruit additional radiographers but that it was difficult to get mammography-trained staff so had trained up existing staff instead. They told us this had taken some time as they could only train one radiographer at a time. An assistant practitioner position was vacant but due to difficulty in identifying training courses meant management were able to change it to a band 5 radiographer post. In radiotherapy there were 1.5 whole time equivalent posts vacant. However, this had been recently appointed to an agency radiographer until full time cover could be achieved.
- We were told of one vacancy within medical physics however, there was difficulty in finding a suitable candidate to fill the post. This had resulted in the department looking for candidates from the nuclear industry who would then be trained 'in-house' to ensure they had the suitable skills required for the healthcare sector. Medical physics staff told us that the trust had used this approach in the past which had proved successful.
- Radiology management described their staff as hard working and flexible and were proud of the quality of the service they provided and the level of expertise. They also told us they were proud of the way staff in MRI had improved flow and access to MRI services seven days a week. We were told the staff in medical physics were very flexible and provided support at weekends to reduce equipment downtime during the week and a potential reduction in the service provided to patients.

Medical staffing

- The individual specialities arranged medical cover for their clinics, and were manged within each service line, which oversaw the structure of the clinics and the patient numbers. We were told in ophthalmology that the use of locum staff was unpredictable. We were given an example where a locum doctor left the trust only a few weeks into their contract commencing due to the high pressure of working in The Royal Eye Infirmary. However, since the last inspection vacant posts had been reduced in this service line.
- Staffing levels and skill mix were planned so that people received safe care and treatment at all times. In Radiology there were consultants and registrars who provided on-call medical cover. The registrars were based on site at Derriford with the Consultants working from home with an on-call laptop to provide assistance to the registrar. Radiology management told us that at

the time of the inspection there were five radiologist posts vacant, although the trust had appointed two radiologists who will be in post by the end of the year and another post was being advertised for a second time as no suitable candidate was found previously.

Major incident awareness and training

- We saw a major incident folder in the viewing area in X-ray West, ED X-ray and in CT. All staff we spoke to in these areas were aware of this policy. In outpatients it was their responsibility to support wards and other areas during a major incident when required.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Although we inspected the effective domain in outpatient and diagnostic imaging service we did not rate them due to the lack of national data available to the CQC. We found that:

- Peoples care and treatment in both outpatients and diagnostic imaging was planned and delivered in line with current evidence based guidance, standards, best practice and legislation. We saw evidence of audit to ensure that practice was monitored ensuring consistency.
- Staff were suitably qualified and had the skills to carry out their roles effectively and in line with best practice. The learning needs of staff were identified through appraisal and generally training was put in place to meet these learning needs.
- When people received care from a range of different staff, teams or services, this was coordinated well ensuring that all relevant teams were involved in the planning and delivery of peoples care and treatment. Staff discussed with inspectors how important it was to work collaboratively to meet the needs of the patient and could give us multiple examples where this was taking place.

However:

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

Evidence-based care and treatment

- Relevant and current evidence based guidance, standards, best practice and legislation were identified and used to develop service and were generally disseminated well through outpatients and diagnostic imaging. When safety alerts were released they were circulated to all staff by email. It was an expectation that all staff read the alert and signed a signatory sheet when a safety alert was released. The outpatient matron followed up anyone who had not signed the sheet to ensure completion. In oncology National Institute of Clinical Excellence (NICE) guidelines were disseminated through the chemotherapy operations group which met monthly. Examples of these guidelines included changes to drug lists to be in line with best evidence based practice. In diagnostic imaging we saw that policies and guidelines were available through the trust's digital document management system and staff told us they had opportunities to access computers to view these. However, on a couple of occasions when staff tried to show us documents on this system they could not locate them. Several radiographers told us they did not feel confident using the system as it had been adopted only recently by radiology and they had not all received training on how to use it. Diagnostic imaging management told us that the clinical care groups shared any new information relating to changes in national guidance; however, there was no specific radiologist responsible for each specialty to discuss the recommendations and raise any concerns relating to potential increased demands for radiology services.
- The diagnostic imaging service used diagnostic reference levels (DRLs) as way to check the correct amount of radiation was being used to image a particular part of the body. Staff were able to locate and explain how they used these as a tool. We saw DRLs on display and staff could demonstrate how they referred

to them in their daily work. The trust had established a combination of local and national DRL levels within diagnostic imaging and we saw that they were displayed in all areas visited.

- We saw 'Pause and Check' posters displayed in all imaging areas visited (The Society and College of Radiographers produced 'Pause and Check' resources to reduce the number of radiation incidents through mis-identification occurring within radiology departments).For all examinations we observed, staff identified patients in line with the pause and check process.
- Both the outpatient and the diagnostic imaging services audited locally against national guidelines. In outpatients we saw various audits which demonstrated this. We saw evidence of a monthly audits performed within the Healthy Bones service. These audits had included a review of patient dose, whether pregnancy status had been checked, evidence of a clinical evaluation and whether that evaluation was correct. The audits seen showed no areas of concern. We saw an audit of the justification of CT examinations which showed that the radiologists were not checking whether the patient had had previous imaging. This meant staff may not detect duplicate referrals and patients may receive an unnecessary radiation dose due to having another examination. Radiographers in MRI told us that they had performed an audit of prostate MRI procedures. This audit had shown that there was variation with how the scans were performed. Staff took action to standardise practice and provided additional training for staff. A follow up audit showed an improvement in standardisation and a more consistent service for patients.

Pain relief, nutrition and hydration

- Audits showed that staff knew how to access clinical guidelines for pain management and knew how to escalate concerns and according to records, pain was managed in a timely way. The audit did identify however, that not all clinic areas had sufficient training to manage pain relief. The audit also found that where applicable in oncology outpatients, fluid charts were completed appropriately. In other clinics patient weights were recorded appropriately.

Patient outcomes

- Patient outcomes were monitored in the therapies unit and recorded on computer systems. They were then benchmarked against other services in terms of DNA rates, patient progress (in terms of cost after treatment) and number of treatments available to patients. The unit performed well on these benchmarks compared to the national picture and work was being done to bring better services to the unit. Many staff members were involved in research and clinical audit to improve the service.

Competent staff

- Staff had the right qualifications, skills, knowledge and experience to do their jobs. As a way of better managing the consultant demand in ophthalmology, nurses had been upskilled to manage fast track cataract clinics and high volume clinics. This required the nurses to complete a competency assessment with 'sign off' conducted by a consultant. All nurses in ophthalmology were trained to lead injection clinics and macular clinics. They gained competency through an ophthalmology nursing course and in-house consultant led training and assessment. There was a clear written competency tool based on best practice. Staff said they wished to be upskilled further to manage the consent of patients which was being considered by the ophthalmology consultant team.
- In chemotherapy there were dedicated training DVD's for nurses as part of their competencies. All staff working in this area had either in-house specialist training or attended an external course provided by a nearby acute trust. Staff we spoke with in main outpatients, audiology, and urology had received specialist training to gain the skills needed in their roles. This included, specialist training in stoma care, tissue viability, and continence. Radiotherapy staff told us that there was a radiographer-led skin review clinic, in line with Society and College of Radiographers guidelines.
- We saw evidence of role development in diagnostic imaging. Staff told us that assistant practitioners operated the limb MRI scanner once they had completed training on the equipment. This provided more flexibility for radiographer staffing in other areas. They also told us that there were a number of reporting radiographers undertaking musculoskeletal work as

well as CT head reporting. We were told that there were plans to train radiographers to report chest X-rays. We saw evidence of non-medical reporting for some nuclear medicine scans of the lungs, bones and kidneys.

- The nurses who worked in the early pregnancy unit all had post-graduate qualifications (this included one nurse with a master's degree) in ultrasound. There was training programme support for staff who were studying for a master's degree and a succession plan was in place.
- We saw the radiology and radiotherapy staff induction packs. These were comprehensive and included training on all equipment at the Derriford and satellite sites where appropriate. Radiology management told us that agency staff had the same induction process as permanent staff.
- Staff had their learning needs identified through an appraisal. Most outpatient, diagnostic imaging and therapies staff (a combination of physiotherapy, occupational therapy, speech and language therapy, and dietetics) staff had an in date appraisal and the managers had oversight of when they were due. Staff said they found that their appraisals had changed since the last inspection from a 'tick box exercise' to being more constructive and useful and more staff focused. One member of staff said they felt more like a conversation.
- Staff told us radiology management had introduced Continuing Medical Education (CME) days on a monthly basis. Staff told us they valued being able to attend these days and had noticed an improvement in the quality of the service they provided through the additional training received. Staff allocation on CME days ensured all staff could attend for at least part of the day whilst also providing cover for urgent or emergency examinations, although a few staff members told us they had found it difficult to attend on some occasions due to staff shortages. Radiographers told us everyone actively participated in CME days. Radiographers told us they often complete continuing professional development (CPD) activities on days when they were rostered at the satellite radiology departments. This was due to the satellite sites being less busy compared to the Derriford site.
- Diagnostic imaging management told us that they check the qualifications and expertise of the staff employed by the external reporting providers to report radiology examinations performed at Plymouth Hospitals NHS Trust. These external providers were contracted by the trust to address the backlog of unreported images.

Multidisciplinary working

- We found that all necessary staff, including those in different teams and services were involved in the assessment, planning and delivery of treatment. The immunology and allergy service was heavily involved in research and worked closely with both the pharmacy and dietetic departments. We were told relationships with these units were good and provided a quick service for patients. In radiotherapy we were told of specialist head and neck treatment clinics which involved a head and neck nurse specialist, a dietician and a speech and language therapist. This meant the patient only had to attend one meeting after their main treatment to discuss side effects and medications. The therapies team worked closely with the palliative care team and clinical psychologists, particularly in the rapid eye movement clinic to ensure a quick recovery after trauma. Radiographers told us, and we observed that there was always at least one radiologist based in both the CT and MRI. This ensured that radiographers could discuss queries relating to patient scans and seek advice from a radiologist. Staff in the breast-imaging department told us they held monthly 'rota meetings'. These meetings were multi-disciplinary and ensured that staff were aware of developments in service. Staff in the nuclear medicine department told us they sometimes had difficulty accessing nursing support from the radiology department. This had a knock-on effect for the scheduling of patients who required drug-based procedures and had caused some delays to appointments.
- The outpatient's service made good use of clinical nurse specialists. Many clinics around the hospital, such as main outpatients and ophthalmology, were nurse led with support given from consultants. Where there were issues there were clear and quick escalation processes. The early pregnancy unit, located in the Lancaster Suite, was a nurse-led service. The nurses examined, scanned, diagnosed and treated the patients but could also arrange consultant-level investigations where appropriate.
- Diagnostic imaging staff were involved in the assessment and planning of ongoing care. Radiologists

supported all multi-disciplinary team meetings (MDTs) that required their input. We were told that radiologists were given dedicated time to prepare for all MDTs. We were also told that the number of cases that can be discussed at each MDT had been capped to ensure that the quality of these meetings was maintained and to avoid large numbers of cases being discussed where a previous MDT has needed to be rescheduled, such as after a bank holiday. It was trust policy to never cancel an MDT, so cases had previously been cascaded over to the next meeting.

Seven-day services

- Although many services were still traditionally five day services, some service lines had set up weekend clinics on an ad-hoc basis. An operational delivery group had been set up to improve the use of weekend clinic times in the outpatients unit.
- The radiology service provided emergency cover 24 hours a day, seven days a week across CT, ultrasound, interventional radiology and cardiology as well as plain film imaging. CT ran extended days for booked appointments 8am – 8pm Monday to Friday. MRI provided appointments from 8am – 8pm seven days a week. Radiology management told us that additional weekend lists were offered for CT and ultrasound appointments; however, these lists were staffed on a voluntary basis and were arranged on an ad hoc basis when waiting times for these scans start to increase. A patient told us that they were happy that they could have their MRI scan at the weekend.

Access to information

- The information required to deliver effective care and treatment was predominately in patient case notes and the availability of these in outpatient clinics had improved since the last inspection. This was a requirement of NICE quality statement 15 (statement 12) which states that patient should experience coordinated care with clear and accurate information exchange between relevant health and social care professionals. Case note audits were carried out on a monthly basis around the hospital. This included checking the volume size, safeguarding cards, and tracing (to name three examples on a 25 point check). Compliance in the hospital was good, in particular The Royal Eye Infirmary scored 97.6% compliance in February 2016 and the fracture clinic scored 99% in March 2016. We found that since the last inspection the number of temporary notes in circulation had reduced from 6000 to 2000. This was a result of regular audits, improved note tracking and regular reports from service lines. Although the numbers of temporary notes had significantly reduced there were still incidents where large numbers of temporary notes were in use. We were given examples where an additional records trolley was needed for a clinic to hold the additional volumes of temporary notes. We saw multiple patients had temporary notes in the audiology clinic and we were given one example in main outpatients where there were 18 separate sets of temporary notes for one patient which was reported on the incident reporting system. This meant that clinicians were making decisions on treatment without all of the patients information available to them.
- When people moved between teams the case notes required for ongoing care were generally transferred in a timely way. A case note support officer had been appointed to manage the return of notes and notes management was part of the e-learning package all staff completed on a yearly basis. This improved staff awareness of proper tracking and note management systems. However, in main outpatients we were shown a cupboard where there were multiple case notes stored for collection by the secretaries. We were told that if these are there for longer than seven days they were returned to Bush Park (the main case note warehouse). We also found in dermatology there were lots of notes stored in offices which were kept there for 12 weeks with no reason as to why.
- Training for the management of e-notes was due to be rolled out in November 2016 with the first service going live being paediatrics. A clinical lead for e-notes was continuing their work to ensure that this project ran on time. A scanning bureaux was planned to be set up within the trust to ensure that all paper information was transferred effectively.
- The service provided electronic access to diagnostic results and that access to images and reports were generally timely. The Trust used a radiology information system (RIS) and picture archiving and communication system (PACS). This meant patient's radiological images and records were stored and reported on securely. We were told all examinations performed within radiology received a report by a radiologist, with the exception of images taken in theatre, images for patients from the

fracture clinic and post-operative cardiothoracic patients which had been agreed by the trust to be reported by the clinicians in those specialties. We saw data from July 2016 that showed that 72.5% of examinations requiring a radiology report were reported with two weeks.

- The previous inspection had found a backlog of over 7,000 unreported examinations within radiology that had led to patients experiencing delays in receiving diagnosis and treatment. We saw evidence that this backlog has reduced to approximately 2,000 examinations and that systems were now in place to monitor on a weekly basis the time taken to report each examination and ensure that urgent and high-risk examinations were reported as a priority. The trust had contracted two external reporting companies to assist with addressing the reporting backlog. The amount of out-sourcing had gradually reduced in response to the reduced backlog and changes to the way that work was allocated to the trust radiologists, which also contributed to the backlog reduction.
- Radiologists told us that they had daily reporting sessions on the intensive care unit (ITU). These sessions provided instant information to the clinicians on ITU, ensured all images were reviewed and provided teaching opportunities for the clinicians.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with understood the relevant consent and decision making requirements of the legislation and guidance including that of the Mental Capacity Act 2005. Staff we spoke with could describe the process of gaining informed consent in all outpatient and diagnostic areas we visited. In oncology outpatients and radiotherapy all consent forms were checked prior to and treatment was delivered in accordance with legislation and following national guidance.
- All staff we spoke with in all areas had a good understanding of the mental capacity act and deprivation of liberty safeguards. Staff were able to describe the processes involved and who to contact for more information. One healthcare assistant in the main outpatients unit had done a piece of work on their diploma level three training in deprivation of liberty safeguards. In immunology and allergy service the mental capacity act was regularly discussed to ensure continual awareness and learning. As a result of this staff had a strong understanding of the mental capacity act.
- Where capacity was not an issue patients relatives and carers were invited to clinic appointments to help support people make decisions. Also, information leaflets were available prior to any treatment in a variety of languages or formats. Understanding about best interest decisions was good in ophthalmology with all staff after a patient living with dementia left the unit without treatment due to questions about capacity. Staff we spoke with had a good understanding of best interests decisions and the processes required to make them.

Are outpatient and diagnostic imaging services caring?

Good

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated outpatients and diagnostics responsiveness to be requires improvement because:

- There were long waiting times and delays for an outpatient appointment. Although significant improvement had been made some people were not able to access the services for assessment, diagnosis or treatment when they needed to due to the management of the backlog in appointments required and high levels of over referral to services. There were a total of 30,862 patients in breach of their see by date at the time of the inspection.

However:

- Services were planned and delivered in a way that met the needs of the local population and took into account the need of flexibility, choice, and continuity of care. We

also found that there was a proactive and innovative approach to how clinic utilisation and capacity was managed. Particularly in rheumatology, psychology and breast imaging.

- The needs of different people were taken into account when planning and delivering service. This was particularly evident with the reasonable adjustments made for patients living with dementia and learning disabilities. We found that environments were equipped to manage the specific needs of these patients and that training had been rolled out to all staff.
- Complaints were managed well within the outpatients and diagnostic imaging services and people we spoke with knew how to make a complaint. Lessons were learnt from complaints and were disseminated well to different teams. We saw that outcomes to complaints were explained to the complainant and always offered an apology.

Service planning and delivery to meet the needs of local people

- Since the last inspection service lines had been working to better understand and manage the needs of the local population to inform how services were planned and delivered particularly around capacity, demand, and clinic utilisation management. The trusts clinic admin dashboard showed that 90% of clinic slots were booked into which showed that the trust was utilising the available clinic space and staffing availability well.
- Specialities such as rheumatology had introduced patient initiated contact for certain groups of patients. This meant that when the patients felt they needed to contact a consultant they could but were not on a rolling check-up programme. Of the 5000 patients on the rheumatology waiting list this applied to 1000 patients, reducing the waiting list by a fifth and reducing demand on the outpatient service. This system was due to be rolled out to irritable bowel syndrome, and the Parkinson's and headache patients shortly after the inspection. In the psychology service a mobile phone application had been developed for patient initiated contact clinics to reduce the demand on the outpatient service and assisted patients in managing their own care. This application was due to be rolled out to the chronic pain service. In the immunology and allergy service staff were providing training to patients to allow them to manage their own care at home rather than attend a hospital appointment. The breast imaging service had a bespoke booking system which allowed deliberate overbooking of screening mammography appointments to manage high DNA rates meaning that when a patient did not attend their appointment they had someone else who could be seen improving the utilisation of the clinic. This system worked to ensure that there was still capacity should high volumes of patients attend at once.
- Telemedicine was being used for some specialities as an alternative to reduce attendance to clinics as well as virtual clinics (discussions between certain specialties based on the most up to date knowledge of the patient without the use of a clinic space) as an alternative to face to face appointments. This had had a positive impact on the demand of outpatient clinic appointments meaning that there were more appointments available for those who needed it in hospital.
- Some outpatient services were extending their service hours to allow patients to attend before and after work, this was shown to decreased DNA rates and improved utilisation of the clinics. In diagnostic imaging there were extended working hours for CT (running 8am to 8pm) five days a week and MRI (running 8am to 8pm) seven days a week. A patient told us that they were happy that they could have their MRI scan at the weekend. In diagnostic imaging, service users were not offered a choice of appointments. We were told however, that patients could phone to change their appointment times where possible.
- The trust was working where it could with external providers and commissioners in the planning of services. They had been working with GP's in the local area to allow them to 'pull' patients from consultant led follow up in the acute hospital to the GP setting reducing the demand on the outpatient service with particular effectiveness in ophthalmology and audiology. The matron of ophthalmology said that they were looking at "different ways of supporting patients". The service was in the process of moving its macular clinics to a different hospital to reduce demand on the outpatients unit at Derriford hospital. The trust was also looking at spreading referrals out to other acute hospitals in the South West of England with less of a workload.

Outpatients and diagnostic imaging

- In diagnostic imaging an external MRI service had been contracted to provide additional capacity for patients where demand was too great. This was working well and there were clear policies in place to manage this contract.
- A pilot in the neuro-surgery outpatients unit where patients were asked if they would prefer to have their appointment elsewhere to reduce demand on the outpatient service. Of the 370 patients phoned only 60 opted to go elsewhere meaning it was less successful than the trust anticipated.
- Despite making significant improvements since the last inspection it had been identified by senior trust management that there was a clear disparity between the clinics capacity and the demand put on the service. Although conversations with the Clinical Commissioning Group (CCG) were ongoing about relocation of these patients to other hospitals, specialities were still struggling to meet demand. As of March 2016 services which had a significantly higher demand were neurosurgery (2350 additional referrals), plastics (950 additional referrals), colorectal surgery (2061 additional referrals) and Ophthalmology (2000 additional referrals). Expected referrals was consistently over 50%and in one week 72% over. A trust wide action plan identified that as a result of referral to treatment targets and the urgency of two week cancer referrals competing for prioritisation maintaining capacity and demand was an ongoing challenge.
- We found that environments were generally appropriate and patient centred with sufficient and comfortable seating, toilets and drinks machines. The waiting area for oncology outpatients and the breast imaging unit were light and airy with sufficient seating. Tea, coffee, water and vending machines were available for patients and visitors in outpatient and diagnostic imaging areas. In oncology outpatients, bags were available to put wet umbrellas in to prevent the floor from getting wet and slippery when it was raining. This area also had a café for patients and visitors. The waiting area in ophthalmology also had a café and had a waiting area co-ordinator to look after patients, ensuring they stayed refreshed and gave updates about clinic times while they waited. We saw a separate waiting area for in-patients in beds in X-ray East. The area was divided into male and female bays. However, in ultrasound although there were separate inpatient and outpatient waiting areas, patients that had changed into gowns had to sit in the waiting room compromising privacy and dignity. We also found in ophthalmology that although there was a separate seating area for children, there was no direct observation from staff or a barrier between the adult and children's areas. This meant that an adult could be unchallenged when entering the children's waiting area.
- Some areas had environments which were not entirely appropriate or patient centred. we were told in ophthalmology that over-crowding was still an issue when clinics were busy. Business plans were ongoing with the trust to obtain more clinic space outside of The Royal Eye Infirmary which would have an impact on this. Staff in the chemotherapy outpatients commented that there was limited seating. However, funding had been agreed to increase the number of chairs from 17 to 22 in a different area. This was identified on their risk register.
- MRI had a separate area where staff could cannulate patients to avoid delays in the scan room and improve patient throughput. However, this area was also used for reporting scans. This increased the risk of radiologists being interrupted while reporting which could potentially result in errors. A business case had been submitted for the redevelopment of the MRI waiting area.
- Radiology had a dedicated team of porters. The porters told us that turnaround times for collecting patients could be slowed when the lifts were out of action.
- Patients referred for a duel energy X-ray absorptiometry DEXA scan (a type of X-ray that measures bone density) were asked to contact the department to arrange an appointment. They were offered a choice of times and dates as well as the option of attending a mobile scanner if one was going to be near where they lived. This department also offered 'stand-by' appointments for patients who were able to attend at short notice. Information was provided to patients in accessible formats before appointments. All outpatient services had access to a telephone translation service which was always readily available when required. In oncology outpatients were offered a patient information DVD which provided information about the processes involved with chemotherapy. This was a good alternative to written information. Prior to any chemotherapy a nurse would have a conversation with the patient to discuss side effects. This was aided with a computer tablet to display more information.

Outpatients and diagnostic imaging

- Staff in radiotherapy told us they had a patient liaison. The patient liaison radiographer facilitated 'first-day chats' for patients who attended for their first radiotherapy appointment, which allowed the patient to have more time with a radiographer, and allowed the treatment radiographers to see other patients and avoided delays to treatment lists. They also provided both written and verbal information to patients. All patients were given a card with contact details for the patient liaison service. Radiotherapy staff told us that the Mustard Tree unit provided support groups, finance advice, counselling services, complementary and alternative therapies, and 'living beyond cancer' care and support.
- Patients and staff raised concerns about traveling to and from the hospital. Patients said that although there was usually a parking spot available there were limited spots near specific clinics. For example some patients said they had to get up a steep hill to get to the main outpatients department which could be difficult if they had limited mobility. Patients in oncology outpatients and radiotherapy were given tokens to reduce the parking to a set low rate regardless of how long they were attending. This reduced patient anxiety about parking costs.
- Generally the outpatient and diagnostic imaging departments were well signposted both at the entrance to the buildings and at lifts and stairwells with volunteers at the hospitals main entrance and to the entrance of outpatients.

Meeting people's individual needs

- Services were mostly planned to take into account the needs of different people. Several outpatient areas such as main outpatients and the Chestnut unit (urology outpatients) had received dementia friendly status. This was obtained by all staff attending training, and making reasonable adjustments such as appropriate décor and signage.. As part of the Fundamentals of Care audit, gaining dementia friendly status was a condition for compliance. In oncology adjustments had been made to ensure that the toilets were dementia friendly. Training in dementia had become part of the trusts mandatory training. There was a separate area in ophthalmology for paediatric patients as well as in X-Ray West. Also in X-Ray west there was a dedicated paediatric X-ray room with suitable décor to meet the needs of this patient group.
- However, there were some areas where the service was not planned appropriately to take into account the needs of different people. The waiting area for nuclear medicine was highlighted as an area of concern in the last inspection. However, we found during this inspection that this had not improved. The waiting area was a corridor and there was no separation between radioactive and non-radioactive patients. There was no separate waiting area for inpatients although part of the waiting area had a curtain that could be drawn around ward patients. This would not have been appropriate for any patient who was very ill or upset or those living with dementia. We also found that in the early pregnancy unit staff had access to counselling rooms where they could give bad news (for example the loss of a child). These patients would then have to walk out of this area through the day assessment unit where pregnant women would wait. Due to limited space in oncology outpatients patients were only able to bring one visitor with them which had to be allocated. This meant that patients who had a visitor had to go in a side room.
- There was disabled access to all outpatient and diagnostic imaging areas and there were drop off points outside of The Royal Eye Infirmary and main outpatients. Hallways were uncluttered allowing easy access. Areas such as the physiotherapy department had made adjustments to allow access for bariatric wheelchairs and had a dedicated bariatric treatment bed available. Also in chemotherapy outpatients all of the chairs had weight limits which supported bariatric patients. In diagnostic imaging the unit had acquired an MRI compatible wheelchair to allow patients with less mobility easy access to the suite.
- Transport was available for service users with mobility issues and was sub-contracted by the trust. Staff said it was sometimes difficult for patients to get home if they travelled by ambulance. The ambulances often gave more time than was necessary for the patient between being dropped off and picked up. This meant that sometimes patients could be waiting a long time to be picked up. In main outpatients a late shift nurse was allocated to stay until all patients had been collected.
- In main outpatients, patients with known diagnosis of dementia or learning difficulties were collected at reception by a nurse and were allowed to bypass queues. This occurred when clinics were both on time or running late.

Outpatients and diagnostic imaging

- Outpatient and diagnostic services took into account the individual needs of patients with complex needs, learning disabilities, and dementia. Staff we spoke with said that patient's with learning difficulties were usually flagged by the computer system before they attended the clinic. The learning difficulties team were able to attend an appointment in either outpatients or diagnostic imaging when required. Staff said there was easy access to the learning difficulties team and they would either give advice or attend an appointment if requested. Staff in diagnostic imaging also told us the learning disabilities team were very good at ensuring that patients were prepared for their diagnostic examinations. The telephone numbers for the learning difficulties team were on the prompt cards given to all staff in outpatients. The main outpatient department and the Chestnut unit were active participants of the memory café for patients and carers and Memory box's were available in the department. These boxes contained items which allowed patients living with dementia to reminisce. Twiddle muffs (knitted gloves to be worn which are designed to provide stimulation activity for restless hands for patients living with dementia)were also available to ease the anxiety of patients living with dementia. In the main outpatients department there was a notice board specifically for dementia with multiple leaflets for the management of the disease. We saw signage for reminisce sessions for people living with dementia which discussed topics such as 'memories of work', 'memories of childhood' and 'memories of school days'.

Access and flow

- We saw a significant improvement on the numbers of patients awaiting an outpatient follow up appointment. Although there were still large numbers of patients waiting beyond their see by date. During the last inspection in April 2015 we found that there were a total of 110,657 patients on a follow up waiting list with 36,724 of these patients in breach of their see-by date, and 1961 additional patients did not have any see-by date. Of these patients 26,000 did not have appointments. A trust wide action plan showed that progress had been made and that in May 2016 this number had reduced to a total of 30,862 patients in breach of their see-by dates (a reduction in 5862 patients) with 9667 patients (31%) of these having an appointment.
- During the last inspection there were 3000 patients waiting over one year for a follow up appointment. During this inspection this had been reduced to 560 patients with half of them having a follow up appointment.
- The service prioritised care and treatment for people with the most urgent needs. During the last inspection in April 2015 there were a total of 5408 patients who had been identified at risk of harm as a result of the delays through the use of a flagging system to identify patients at 'time critical'. We found that 3077 (56%) 'time critical' patients had received an appointment date. Not all service lines had gone through the verifying processes to identify time critical patients. During this inspection we found that all service lines had identified which patients were time critical and oversight of this was being managed through a trust wide action plan. There were a total of 5408 patients identified as time critical with the most being on ophthalmology (a total of 2462 patients which was higher than a year ago), neurology (with a total of 510 patients) and gastroenterology (with a total of 381 patients). Colorectal surgery had reduced their time critical patients to 115.
- The radiology department were meeting the 2-week cancer target for just over 90% of patients. The service line manager attended weekly meetings with the performance team to review patient waiting times. Staff in nuclear medicine told us that all 2-week cancer target patients were scanned within one week and all other patients were scanned within 6 weeks.
- In diagnostic imaging a pilot of an e-vetting system was underway. It was hoped that this system would improve flow through the department, as it would simplify the way imaging requests were reviewed and how appointments were sent to patients. Radiographers electronically vetted all GP referrals so that they were available for clerical staff to book appointments quickly.
- In outpatients referral to treatment targets (within 18 weeks) on average were slightly better than the national average between May 2015 and February 2016. However some specialities performed worse than the England average. These included Gastroenterology (62.2% of patients seen within 18 weeks), thoracic medicine (66.2% of patients seen within 18 weeks), and neurosurgery (73.5% of patients seen within 18 weeks). Referral to treatment targets in therapies was well within the 18 week target averaging 6.8 weeks for treatment.

Outpatients and diagnostic imaging

- Urgent GP cancer referrals needed to be seen within 2 weeks to ensure timely diagnosis and treatment. The trust performed worse than the England average of 95% by only seeing 93% of patients within 2 weeks.
- National targets state that diagnostic scans should be done within 6 weeks of referral. The trust was performing slightly worse than the England average of 98% by seeing 96% of patients within 6 weeks.
- Between January 2016 and April 2016 on average 22.3% of clinics were cancelled with 7.6% of clinics being cancelled within 6 weeks. The most common causes were study leave, ward commitments, and clinical profile change.
- The most recent 'Do Not Attend' (DNA) data provided by Health Episode Statistics showed that between January 2015 and December 2015 rates were comparable with the England average of 6%. DNA rates in therapies were low compared to the rest of the trust with an average of 2.5% between new and follow up appointments. Outpatient managers discussed the use of automatic texting system which alerted patients of an upcoming appointment in order to reduce DNA rates. Alongside overbooking of clinics with a high DNA rate, automatic rebooking systems were being looked into as a method of decreasing empty clinic slots due to late cancellations.
- There was a breast-imaging department within the Primrose breast care unit. This unit provided breast screening, one-stop clinics and accepted referrals from GPs. Staff told us that waiting lists were well managed and reviewed at monthly 'rota meetings'. They told us of an example where the number of patients requiring a stereotactic procedure had increased so additional clinics were organised to respond to this need.
- We found that generally clinics ran on time and when there was disruption people were informed both when they arrived for their appointment and at regular intervals whilst waiting. As part of the nursing and diagnostic imaging forum there was a topic about what happens when there are delays in a clinic. Individuals had been made accountable to produce a best practice document around this topic. Staff we spoke with in outpatients said they would greet patients as they entered the clinic area if they were running late and ensured that someone would go and give an update on timeliness every 20 minutes. We saw in an audiology clinic that television screens were used to display waiting times. In diagnostic imaging we saw an audit of patient waiting times once they had arrived in the radiology department. This showed that from April – June 2016 43.3% of patients were seen before their appointment time and 36.8% were seen on time. Only 2.3% of patients had waited 30 minutes or more after their appointment time

Learning from complaints and concerns

- Patients and visitors we spoke with knew how to make a complaint or raise a concern. There were leaflets available in the outpatient area to direct people to the patient advice and liaison service (PALS). Concerns (comments made short of complaints) were encouraged through feedback forms and friends and family questionnaires. Staff were audited through the 'Departmental Nursing Assessment and Assurance Framework' on their ability to direct patients and visitors to the PALS department. This audit showed that all staff asked in outpatient areas were aware of the complaints process and could direct people to the PALS office
- The NHS constitution gives people the right to have complaints dealt with efficiently, investigated thoroughly, and know the outcome of the investigation. Complaints were investigated by service lines who reported through care group managers . We looked at four complaints and found that the complainants received a response in a timely way with an outcome of the investigation, lessons learnt and actions taken as a result of the complaint to improve quality of care.
- The outcome letters from these four complaints were explained appropriately to the complainant. They were empathetic, apologetic, open and transparent and were all signed by the director of nursing. They set out clearly what happened and identified any learning from the trust. One of these complaints had an action plan which resulted in admin staff having access to appropriate phone numbers for the patients advice and liaison team.
- Where lessons had been learnt from concerns and complaints this was shared with the complainant. Learning from complaints was regularly shared at governance meetings, team meetings and through the morning safety huddles to ensure that this information was disseminated appropriately to all staff. Radiation incidents were discussed at radiology clinical

governance meetings. In therapies staff said they would like to see the response sent from PALS to the complainant so they could personally learn from the issues raised.

- Between April 2014 and April 2015 the outpatients department received a total of 306 complaints with 193 of these being upheld. Of these complaints a total of 76 were concerning delays in appointments. However, since the last inspection the number of complaints in ophthalmology about waiting times had significantly reduced due to improved access and flow.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well-led in outpatient and diagnostic imaging services to be good because:

- There were good governance structures, processes and systems in place throughout outpatients and diagnostic imaging to ensure accountability, the management of risk, the management of performance, and regular review to gain oversight of how the services were performing. This was particularly highlighted through the oversight and challenge of the management of the outpatients follow up backlog.
- The leadership in outpatients and diagnostic imaging were supportive of their staff and had the knowledge, skills, experience, and time to manage the outpatients and diagnostic imaging services. Service line managers were particularly positive about the Director of Transformation and the impact their skills and experience has had on services.
- Leadership had good oversight of the quality of care though the 'fundamentals of care' and the 'Departmental Nursing Assessment and Assurance Framework' measuring against the requirements of the health and social care act. This had a positive impact on individual clinic and diagnostic imaging areas and action plans had been created and were actioned to improve the quality of care patients receive.
- Staff and patients were engaged in how care was delivered. Staff felt as if they were active contributors to how the service was developed and were often given the opportunity to raise concerns or ideas to senior staff members. Patients had various forums in which they could raise concerns and ideas including 'tea with matron' sessions.

However:

- Although there was a clear trust wide statement of vision and values, driven by quality and safety. It was not translated into a credible strategy for outpatients with limited defined objectives that were regularly reviewed and relevant. In the service line strategies we looked at, outpatients was rarely mentioned and some strategies had not been updated since 2012.

Vision and strategy for this service

- There was a clear vision and set of values which set out to put patients first, take ownership, respect others, be positive, and to listen learn and improve. Staff we spoke with were clear about what the values of the organisation were and could give examples of how they had demonstrated them. There were posters around all outpatient and diagnostic imaging areas with information about the vision and values of the hospital.
- We saw a detailed strategy for the diagnostic imaging service which was aligned with the trusts strategy. Radiology management told us that they had agreed a new strategy for the radiology department and that this would be published in the autumn and shared with the radiology team. They also told that previously the departmental strategy had been reactive whereas now it was more proactive.
- However, there was no overarching strategy for the outpatients department but was part of strategies for service lines. Within these strategies there was no discussion of objectives in outpatients or how they were going to be achieved to deliver good quality care. Of the six strategies we were presented with; oncology had not been updated since 2012 (which was before the most recent trust wide strategy was published), immunology/ allergy and haematology had not been updated since 2014.

Governance, risk management and quality measurement

- There was an effective governance framework to support the delivery of good quality care. Structures were clear and showed lines of accountability from service lines to trust wide level. Information was

disseminated down to staff through team meetings, information delivered through email, and most effectively through the use of morning 'safety huddles'. These were used to discuss the running of the day and staffing issues but were also used as a forum to discuss risks, learning from incidents, and learning from complaints.

- There was an outpatient and diagnostic imaging nurses forum where good practice could be shared and concerns discussed. Prior to the last inspection, senior managers felt the outpatient service was fragmented. However, now they feel that service leads and the executive team were working much closer together. Actions from this forum included updating certain leaflets in some clinic areas, ensuring full circulation of audits and discussions about prompt cards and fundamental standards.
- There were effective arrangements in place to monitor and mitigate risks in a timely way. Risk registers were used by service line to manage risks to their services and were discussed at trust wide governance meetings. These were updates in a timely manner and documents showed that progress had been made to mitigate risks. Each risk had an accountable individual assigned to it and a deadline date for completion. The trust wide CQC action plan showed good oversight at a trust wide level of issues in outpatients and showed ongoing improvements to the service. In therapies there was a clear governance structure with various meetings including board meetings, therapies governance meetings, and team meetings. This ensured that issues were escalated appropriately and information was disseminated down from the executive team. These meetings were held on a monthly basis.
- In diagnostic imaging the service line manager and clinical director meet on a weekly basis to discuss any issues that might affect the service. The service line manager also met with the leads in each area within radiology each month. Radiology management told us that they had identified the need for a governance manager within radiology however; the exact responsibilities for this role seemed unclear. We saw evidence that this post was out to advert at the time of the inspection. Regular radiology clinical governance meetings included discussions on complaints, incidents and any learning from incident investigations. Actions from these meetings fed into the radiation protection committee, which met four times a year. The committee had recently increased the frequency of meetings because the number of areas for discussion was too great for an annual meeting. The radiation protection committee provided an annual report to the Quality Assurance Committee. Medical Physics staff told us they felt that governance within the trust was the most robust it had ever been, although they did say that this was generating additional work for their department.
- The trust had good oversight of quality and safety in the outpatient and diagnostic imaging services through the use of both the 'Fundamentals of Care' audit and the 'Departmental Nursing Assessment and Assurance Framework' (known as the DAAF). The 'Fundamentals of Care' audit assessed on the quality of interactions between staff and patients (five to ten patients a month), and environmental checks (on a weekly basis). The DAAF asked 85 questions about safety and quality based on the needed compliance to meet the regulations set out in the Health and Social Care Act 2012. Individual clinics were responsible for completing these assessments and were held to account by the Heads of Nursing for medicine and surgery who reported to the director of nursing. Where 'green' status had been achieved a certificate was signed by the director of nursing and delivered to the clinic to highlight good practice. Through the use of the fundamental standards assessment in ophthalmology staff were putting particular emphasis on gaining dementia friendly status as this was an area that needed improvement. The dementia lead for the unit was working with the trusts estates team to gain the dementia friendly certificate. In interventional radiology it had been identified that there was not appropriate seating so the decision was made to hold the unit accountable to the same environmental standards as general theatre.
- There were clear systems in place for the management of external companies used in diagnostic imaging and we found that they were still held to account for incidents and issues. Systems had been put in place to ensure that any discrepancies in the reports produced by the external companies could be highlighted.

Leadership of service

- Leaders had the skills, knowledge, experience and integrity to manage the outpatients and diagnostic imaging services. During April 2015 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 line. During this inspection we found that there was good oversight through the trust wide action plan with monthly data available to show improvement. Where significant improvements had been made, such as in diagnostic imaging, the service lines were given management responsibility to maintain compliance.

- A follow up manager had been appointed to hold the service lines to account when booking and managing their backlog of patients. Daily reports were produced and was presented at monthly governance and service line meetings. This individual worked well with the director for transformation to ensure that continual progress was being made. The senior team worked closely with the service lines working to "unlock the potential capacity".
- Trust leaders understood the challenges to good quality care in the outpatients unit and helped service line managers identify the actions needed to address them. Managers told inspectors that before the last CQC inspection it felt like they were told to make actions and improvement without being appropriately supported to do so. Since the last CQC inspection managers said they now have a greater visibility in the trust wide team and support from directors. Service line managers across the hospital commented how approachable the Director of Transformation was and how crucial they were in the turnaround of backlogs and waiting times. One manager said that he was "fantastic" and he "understands what is important and reflects our views higher up in the hospital". Another service manager said "he wants to help you solve problems and that he "listens, understands and represents us at a higher level". Radiology management told us that the relationship with senior management was good and that the service line managers were more visible since the last inspection. Radiology management told us the relationship with senior management had improved, and the service line was more visible than it had been previously. One result of this was a much improved recruitment process and we were told of one example where a business case for a new radiologist post had been approved and the post advertised within two weeks. A common theme from our discussions with radiographers was that "people listen to you now".
- Staff told us that leaders were visible and approachable. The senior management team held regular structured safety walk around's as well as unstructured adhoc walk arounds. Structured safety walk around's included the completion of safety audits. All staff were welcome to attend a monthly forum called 'Your Voice' where staff had the opportunity to raise issues with the Chief Executive and other members of the senior team. The chief executive also had an open email address where any member of staff could contact them to raise concerns. In individual outpatient areas staff told us how well they were supported by their managers and that they were always visible and approachable. In therapies staff said they were respected and valued by their managers and they were always approachable although sometimes busy. Staff within radiotherapy told us the management team were very approachable and encouraged staff to develop ideas. They also told us the consultants were very supportive although occasionally took a while to respond when asked to input on policy decisions. Radiographers in CT told us previously they had felt very stressed and 'bombarded' with information via email. They told us the CT superintendent had changed the processes within CT and the radiographers were now only informed about relevant information. The radiographers told us "the difference was amazing".

Culture within the service

- The culture was centred on the needs and experiences of the people who use services and this was recognised and rewarded to individuals and teams by the trust. Many staff in outpatients areas had received 'Wow' awards. These were awarded by the trust based on nominations from patients and visitors to the hospital for going above and beyond what was expected of them. Staff we spoke with said that receiving one of these awards was rewarding to a whole unit and built staff morale. One staff member said that these awards "demonstrated the excellent caring patient centred culture". We saw 'Wow' awards in chemotherapy outpatients and therapies. Staff in the early pregnancy unit told us that morale was very high and that they had a very good team working culture.

- Staff we spoke with felt respected and valued by their peers and managers. Staff commented how lucky they were to work there and that staff had worked for the trust for many years because of the patient centred culture. One member of staff we spoke with had worked for the trust for over 20 years. Staff we spoke with in main outpatients and ophthalmology said they felt confident to raise issues with managers and to challenge peers when necessary (including consultants) which encouraged a culture of candour, openness and honesty.

Public and staff engagement

- Peoples views and experiences were gathered to shape and improve the services and culture. 'Tea with matron' was a service which offered patients and carers the chance to share their experiences with a hospital matron offering free tea and cake. We were told that these were very effective in main outpatients and in ophthalmology. Patients came into the hospital just to attend this session and to share their experiences.
- There were friends and family questionnaires and feedback forms on the exit to every clinic we looked in and we were given examples from staff when things had changed as a result of patient feedback. Staff we spoke with shared with inspectors learning from the friends and family test scores and in the Chestnut Unit (urology) told us about the positive feedback and the impact it had on the team.
- Staff we spoke with felt actively engaged and that their views were reflected in the planning of the service. Staff said they regularly received positive feedback from their managing staff. Some staff commented about patient feedback received from senior staff in the trust and discussed how appreciative they were of the recognition of good work. In the immunology service there was a white board which staff could use to suggest improvements to the service. All managers we spoke with told inspectors that they felt more valued as an outpatient department than they did before the last inspection and felt they were on 'equal footing with the wards at a trust level'. Key information for staff was shared through a variety of emails, newsletters and computer screensavers. Staff we spoke with said they found the screensaver information particularly useful as it was always prompting them or reminding them of changes. Radiology management told us of a monthly radiology newsletter that they send to staff via email. This newsletter included information relating to recent incidents and any learning from investigations.

Innovation, improvement and sustainability

- Staff in both the outpatients and diagnostic imaging services were able to give multiple examples of where developments had an impact on the quality of the service. In neurology there was a change to the urgent referral pathway to enable patients to go straight for a scan without a clinic attendance reducing the time spent waiting for treatment. In renal we were told about clinics run off the main site which received very positive feedback from patients and increased clinic capacity in Derriford hospital In ophthalmology a new scanner had been purchased which was the first of its kind in the United Kingdom for the scanning of retinas. We also saw the use of flash cards in outpatients to improve the availability of information for staff with regards to safeguarding and mental capacity act. Staff in the nuclear medicine department told us that the radiopharmacy had a new hydrogen peroxide gas cleansing system for their class A isolators. We were told that this was the only one of its kind in the country.
- The trust had developed a number of alternative delivery options for planned care services in response to prolonged and predictable disruption to the Planned Investigation Unit. Examples we were told about included a mobile infusion service (to provide infusions onsite in a custom built infusion wagon); an MDT approach to developing and expanding capacity within the Birch Day Case unit; and an off sight infusion space at Mount Gould in corroboration with a community provider making good use of collective resources Feedback from these projects has been very positive."
- The nuclear medicine department had introduced a new programme for patients involved in live-donor kidney transplantation. This programme ensured that these patients have every test required as part of a pre-operative check performed on a single day. These tests included a nuclear medicine scan, chest X-ray, ultrasound scan and blood tests. A transplant specialist nurse and a nephrologist also saw these patients. The aim of this programme was to improve public engagement and to make the pre-operative checks easier for patients.

Outpatients and diagnostic imaging

- Plymouth Hospitals NHS Trust had since the last inspection achieved Imaging Services Accreditation Scheme (ISAS) accreditation. Radiology management told us that named staff members were responsible for each area of ISAS accreditation and that these individuals continually reviewed standards. The radiotherapy services at Plymouth Hospitals NHS Trust had ISO accreditation and had been recertified just prior to the inspection.
- Staff in rheumatology won General Medicine Category HSJ award in May 2016 for their patient led appointment system.

Outstanding practice and areas for improvement

Outstanding practice

We saw several areas of outstanding practice including:

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

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

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

Action the hospital SHOULD take to improve

- The provider should translate the vision and values of the organisation and service lines into clear, credible, and well defined objectives for outpatients which are regularly reviewed and remain relevant and achievable.
- Review governance processes within the emergency department to ensure full integration between the medical and nursing teams.
- Strengthen the nursing oversight of the whole emergency department, including majors, minors, resuscitation and the clinical decisions unit for each shift.
- Ensure incidents reported in the emergency department are correctly graded in the severity field.
- Encourage staff to report mixed-sex breaches.
- Use clearer processes in order to be able to identify and evidence, at all times, the percentage of staff across the trust who were compliant with mandatory and role specific training. This would also provide greater safety assurance at service line, care group and trust levels that governance information was reliable and valid.
- Review why surgery has received the most complaints and look at ways of reducing them.
- The provider should ensure that all wards and departments are adequately staffed.
- Consider staffing allocation to allow for management and supervision from senior staff in all paediatric areas.
- The provider should review the arrangements for speech and language accessibility over the weekend to ensure that patients do not remain nil by mouth as a result of waiting for a swallowing assessment.
- The provider should plan to risk assess the impact of the location of the proposed cardiac catheter laboratory, reflecting on the patient journey and pathway.

Outstanding practice and areas for improvement

- The provider should review the environment regarding the safety of patients admitted to wards and departments living with mental illness and especially with the risk of self-harming.
- Continue with the action plan to reduce their referral to treatment times in all surgical specialities.
- Continue to look at ways of reducing the number of cancelled operations and the numbers not re-booked within the 28-day time scale.
- Continue to look at ways of reducing the number of patients who have been waiting for operations longer than 52 weeks.
- Ensure that theatre lists are finalised at 3pm the day before the operations are due to take place.
- The provider should continue to make improvements on the follow up backlog waiting list to meet people's needs and minimise risk and harm caused to patients through excessive waits on follow up of outpatient appointments and excessive waits on the reporting of images.
- The provider should put process in place that ensure all diagnostic imagines that required documented evaluations have one.
- Review the paediatric unit in the emergency department to ensure it is adequately secure to keep children safe.
- Ensure patients in the minors' waiting area in the emergency department are observed so any deterioration can be quickly responded to.
- Ensure all patients awaiting X-ray in the emergency department who are not escorted have access to the portable call bell in accordance with the department's standard operating procedure.
- Ensure patients arriving at the emergency department by ambulance are protected from the elements as best as possible.
- Review the transfer team in the emergency department to ensure that when patients are transferred to a ward a clinically safe handover is completed in all cases.
- Review the hospital's procedure for crowding in the emergency department to include the actions required by the wider hospital in order to support safe patient care.
- Review plans to increase the space in the emergency department to consider how crowding can be reduced and patient flow improved within current financial constraints.
- Progress the work to install an adequate area for the preparation of medicines in the resuscitation area of the emergency department.
- Ensure wasted controlled drugs in the emergency department are disposed of in accordance with trust policy.
- The provider should ensure that medicine trolleys are not left unattended when unlocked and that medicines are secured at all times.
- Ensure height and weight measurements of children are readily available for staff prescribing medications.
- Ensure only current medicine guidance is available in all paediatric areas.
- Review and upgrade computer systems in the emergency department to allow integration with wider hospital systems.
- Ensure computer records are adequately secured when computers are left unattended to prevent unauthorised access.
- The provider should ensure that patient records are consistently completed and are kept up to date.
- Ensure patient details in children's and young people's services are kept confidential and that only authorised personnel are able to access details of care.
- The provider should ensure that where registered nurses were required to countersign the work of health care assistants this was consistently carried out.

Outstanding practice and areas for improvement

- The provider should ensure that all chemicals are secured and not accessible to patients and visitors to wards and departments. Clinical waste including sharps bins should be sealed and dated correctly and removed from the wards promptly.
- The provider should review the layout of wards which had six beds to a bay as in some areas this impeded access to hand washing facilities and clinical waste bins thus potentially compromising the control and prevention of infection.
- The maternity services should ensure the birth pool cleaning policy demonstrates compliance with any manufactures guidelines and recommendations and incorporates any further recommendations from the trusts infection control lead.
- The provider should review the signage for the ambulatory care unit as it was not clear from the main hospital corridors.
- Ensure staff in the emergency department all have name badges which include the role they are in. Consideration should also be given to providing patients with a leaflet that details the different types of uniforms and what they designate.
- Make sure chemicals and substances that are hazardous to health are secured and not accessible to patients and visitors in the Fal unit sluice area.
- Make sure the resuscitation trolley and equipment identified in theatres as needing service in April 2016 is now serviced.
- Make sure the equipment log is up to date with all servicing of equipment.
- The oxygen cylinder for use in emergencies, kept at the Child Development Centre, should be portable and safe for staff to move.
- Make sure that all staff ideas are listened to and reasons given if they cannot be actioned.
- Continue to pursue (with clinical commissioning groups) the development of a dedicated service in line with NICE guidance CG83 to support patients and those close to them in both general/ neurosurgical and cardiac critical care with their psychological and psychosocial needs.
- Complete progress to allow the cardiac critical care service to contribute to the Intensive Care National Audit and Research Centre in order to obtain and learn from valuable benchmarking against other similar units.
- Ensure all patients in the cardiac critical care unit are able to see a clock from their bed.
- Improve the trust website so it has helpful and important information about the critical care services at the hospital.
- Should complete all outstanding refurbishments required on the delivery suite. This includes the remaining nine birth rooms, and the bathrooms and toilets which were shared between patients.
- Should clean the windows on the delivery suite.
- Should provide more equipment to promote normalising birth and movement during labour and to aid pain relief.
- Consider how to raise an alert to potential safeguarding issues if parents or their children do not book appointments that have been professionally advised.
- The trust should consider how they manage and mitigate the risk to lone workers.
- The trust should consider in-house provision of physical intervention trainers to ensure appropriate staff in the children and young people's service are fully trained.
- Ensure that local audits for the 'Last days of Life Care Plan' are put in place to provide evidence or any changes needed in practice.
- Ensure the ongoing completion of plans in place to develop rooms for privacy for patients at the end of life and suitable environments for private discussion and the delivery of bad news.
- Continue to explore options to increase space for multi-faith prayer and facilities for ablutions prior to prayer.

Outstanding practice and areas for improvement

- Where the end of life quality improvement in the environment project has identified improvements ensure these have shorter timescales for completion to improve the experience of patients and their families

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

Requirement notices

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

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

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

This section is primarily information for the provider

Requirement notices

Equipment stored on wards and in corridors could obstruct or impede the access to and through fire exits.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements of this part. 17(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; (d) maintain securely such other records as are necessary to be kept in relation to the management of the regulated activity. (f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e) Governance meetings in the emergency department were not recorded accurately in minutes to provide assurance that learning points were identified and actioned, and that progress was monitored. Data relating to the performance of the emergency department was not recorded consistently and did not provide adequate assurances.

This section is primarily information for the provider

Requirement notices

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

Data provided by the trust showed the initial assessment time from ambulance arrival was consistently within one minute. However, the manner in which the data was entered into the system failed to consider the time the patient was waiting before the nurse in charge took the handover.

The processes and systems to monitor the number of clinics cancelled was not effective, and the reasons for last minute cancellations were not recorded consistently or reviewed by senior staff.

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 was continuing to increase. This placed patients at risk of harm due to delays in treatment and assessment.

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

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

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