Care Quality Commission

Royal Devon and Exeter NHS Foundation Trust

Royal Devon & Exeter Hospital (Wonford)

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	**Good**
Urgent and emergency services	Outstanding
Medical care (including older people's care)	Good
Surgery	Good
Critical care	Outstanding
Maternity and gynaecology	Good
Services for children and young people	Good
End of life care	Good
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected Royal Devon and Exeter NHS Foundation Trust as part of our programme of comprehensive inspections of all NHS acute trusts. The trust was identified as a low risk trust according to our Intelligent Monitoring model. This model looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Level 6 is the lowest level of risk which the trust had been rated since march 2014.

The inspection took place on 3 – 6 and 10 and 16 November 2015 and included Wonford Hospital and Mardon Neuro-Rehabilitation Centre

We did not inspect the following locations:

Royal Devon & Exeter Hospital (Heavitree)

Honiton Hospital

Okehampton Community Hospital

Tiverton District Hospital

East Devon Satellite Kidney Unit

Exmouth Hospital

Axminster Hospital

South Devon Satellite Kidney Unit

Victoria Hospital Sidmouth

North Devon Satellite Kidney Unit

We rated the Royal Devon and Exeter NHS Foundation Trust as good overall. Wonford Hospital was rated as good overall with two services, urgent and emergency care being rated as outstanding overall. The teams in these areas demonstrated they were very well led clinically and went the extra mile in caring for their patients. The Mardon Neuro –rehabilitation Centre was rated as requires improvement overall. At trust level safety was rated as requires improvement and we rated it as good for effective, responsive and the well-led key questions. As well as the two services – A&E, and critical care, where caring was judged to be outstanding, all other services were rated as good for caring with an overall trust rating of outstanding for this domain..

Our key findings were as follows:

- The chief executive had been in post for 18 years at the time of the inspection. It appeared that the Chair and Chief Executive had a supportive relationship and worked well together. The board overall had the experience, capacity and capability to lead effectively.
- The trust culture is strongly focused on quality and safety with patients being the absolute priority. There was tangible evidence of the culture in trust policies and procedures. This was also a consistent theme in the feedback from staff at all levels in the focus groups and drop in sessions held during the inspection.
- There was an incident review group which reports to the Clinical Governance Committee reviews all incidents that are categorised as amber or red. The culture of reporting incidents was seen to be good with all staff being aware of their responsibilities.
- Staffing in wards was reviewed on a regular basis with evidence of skill mix changes and additional posts being created in some areas. Other areas were finding it hard to recruit with some reliance on bank or agency staff.

Summary of findings

- There had been no grade 3 or 4 hospital acquired pressure sores for 10 months prior to the inspection. Where increases in pressure ulcers and falls had occurred staff worked together to review practice and implement new ways of working to reduce risk and maintain patient safety. Of note was the emergency department, where staff worked closely with the ambulance service to identify patients at risk of pressure damage prior to arrival. This meant measures to further reduce risk were put in place in a timely way.
  - Survival rates for patients who suffered a cardiac arrest were double the national average. An area in which the trust had worked hard to improve outcomes for patients.
  - Medical records were not always kept secure to prevent unauthorised access. We have raised this in the areas of concern for the trust to take action.
- The trust had not met the cancer referral to treatment targets for some months but had worked to put in place additional urology and endoscopy lists and was anticipating being back on target by December 2015.
- The overall trust target for mandatory training was 75% which had been achieved for topics such as safeguarding. There were some topics which were above the target and some slightly under the target.
- Staff reported communication was good in their local teams through use of 'Comm cells'. These took place regularly with discussions including training, complaints incidents and well as feedback of results of audits.
- We observed good interactions between staff, children, young people and their families. We saw that these interactions were very caring, respectful and compassionate. Parents were encouraged to provide as much care for their children as they felt able to, whilst young people were encouraged to be as independent as possible.
- Meeting the needs of people living with dementia was being developed on Kenn and Bovey wards with activities such as knitting, reading and discussion. The staff had recognised the need to relieve patient boredom which may have resulted in patients challenging behaviour.
- The trust had no never events since 2013. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. NHS trusts are required to monitor the occurrence of Never Events within the services they commission and publicly report them on an annual basis.
- The trust performed well on infection rates having had no incidents of MRSA blood stream infection since 2011.
- Outcomes for patients were good in all services and outstanding in emergency care. All participated in programmes of audit in line with national guidelines and evidence based practice. The trust performed well in a number of these including patient reported outcomes of hip and knee surgery and audits for lung and bowel cancer.
- In line with national changes to guidelines, the trust and specialist palliative care team had responded to the 2013 review of the Liverpool Care Pathway by putting temporary guidelines in place to ensure appropriate care was maintained. The hospital was one of only three acute hospitals in the UK to have wards recognised to meet the standard of the Gold Standards Framework for the care they provide to patients who are nearing the end of their lives. This was awarded to Yeo and Yarty wards.
- Leadership in the majority of services was seen to be good and at times outstanding, with governance systems and culture driving improvements in treatment and person centred care.
- Access and flow was managed and overseen by the bed management team who met three times a day to assess the flow and bed status of the hospital. These daily meetings included a range of senior staff attending. We saw that a cohesive approach to the anticipated number of admissions, discharges and any other operational issues were discussed and plans to maintain flow reviewed at each meeting.

We saw several areas of outstanding practice including:

- The emergency department had agreed with the ambulance service that crews would radio ahead to tell staff that that they were bringing a patient with a suspected broken hip. This gave nurses time to inflate a pressure relieving mattress for the trolley on which the patient would be treated. In this way, pressure ulcers would be prevented but X-rays could still be carried out without moving the patient.

Summary of findings

- The computer system would alert staff when a child with a long-term illness arrived in the emergency department. Care plans for each child were immediately available so that they received treatment and care that was specific to their condition.
- The care being provided by staff in the critical care unit went above and beyond the day-to-day expectations. We saw patients' beds being turned to face windows so they could see outside, staff positively interacting with all patients and visitors and evidence of staff going out of their way to help patients. Patients and visitors gave overwhelmingly positive feedback.
- A member of staff was on duty at the reception area of the maternity wards to ensure the security and safety of the wards, women and babies. One member of staff employed through an agency to provide security was spoken of highly by patients and staff alike. They commented on their unfailing cheerfulness, politeness and support to them during visiting times and when staying in the hospital.
- Royal Devon and Exeter NHS FoundationTrust is one of only two trusts in the country with recognition in achieving the Gold Standards Framework for end of life care, with three wards accredited and one deferred. Plans to extend the gold standard to further wards demonstrated an outstanding commitment by ward staff and the specialist palliative care team to end of life care.
- A significant training programme 'opening the spiritual gate' had been invested in and had been rolled out to medical, nursing and allied health professional staff to offer spiritual care, especially around the end of life.
- The cancer service was leading a project centred on the 'Living with and beyond cancer' programme. This programme was a two year partnership between NHS England and Macmillan Cancer Support aimed at embedding findings and recommendations from the National Cancer Survivorship Initiative into mainstream NHS commissioning and service provision. Patients in the cancer service who were deemed to be at low risk, were discharged and given open access to advice. In the gynaecology clinic, clinicians contacted patients by telephone to follow up treatment and in haematology; this process was done by letter. Results showed that 94% of patients who were participating in the programme rated it as good or excellent.

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

Importantly, the trust must:

- The trust must take action to ensure that facilities for children in the emergency department comply with the national Standards for Children and Young People in Emergency Care Settings 2012.
- Ensure patient information remains confidential through appropriate storage of records to prevent unauthorised people from having access to them in medical, surgical and maternity wards and outpatients departments.
- Ensure staff have access to current trust approved copies of the Patient Group Directions (PGDs) and that only permitted professional groups of staff, as required under the relevant legislation, work under these documents.
- The critical care unit must ensure adequate medical staff are deployed at all times. Current overnight levels did not meet the ratio of one doctor to eight patients, as recommended by the Core Standards for Intensive Care Units (2013).
- Chemicals and substances used for cleaning purposes that are hazardous to health (COSHH) were observed in areas that were not locked and therefore accessible to patients and visitors to the wards. The trust must ensure that cleaning materials including chlorine tablets are stored safely.
- Ensure that adequate medical physics expert cover is available in the nuclear medicine service.
- Ensure there are sufficient staff deployed to meet demand in ophthalmology and gastroenterology outpatient clinics
- Ensure patient privacy in outpatient clinics is maintained.
- Ensure the steps put in place to reduce the length of time that patients living with cancer must wait for treatment are sustained to deliver services in accordance with the 'cancer wait' targets set by NHS England.

In addition the trust should:

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- Ensure that there is sufficient space to treat patients requiring resuscitation and major treatment in the emergency department.
- Ensure that all patients in the emergency department waiting room can be observed by staff at all times.
- Ensure that there is band 7 nurse in charge of the emergency department on each shift in line with NICE recommendations.
- Ensure that accurate, complete and detailed patient records are maintained.
- Medicines must be stored securely and safely at all times. Intravenous fluids should be stored securely so as not accessible to the public and patients.
- Ensure that appropriate measures are put in place on admission to the AMU for patients who are at risk from attempting suicide. This should include the appropriate assessments of risk for staff to follow and a suitable and safe environment for patients.
- Ensure where patients between the ages of 16 and 18 are admitted to the AMU that this is agreed to be the most appropriate environment for them.
- The maternity service should review and record the staffing levels to ensure all maternity wards are safely staffed at all times including theatre and recovery
- Ensure that all areas used by children are child friendly and should particularly consider improving the environment for children in the outpatients department and theatre recovery rooms.
- Ensure staff on the critical care unit are fully aware of their duty to report incidents, including near misses and no-harm incidents.
- The critical care unit should review compliance against the Department of Health's building note HBN 04-02
- Resuscitation trolleys in the critical care unit should be tamper-evident.
- Staff in the critical care unit should have a thorough understanding of the Deprivation of Liberty Safeguards.
- Mandatory training updates and annual appraisals for critical care staff should meet trust targets.
- There should be access to a follow-up clinic for patients discharged from the critical care unit.
- The hospital should improve the access and flow of patients in order to reduce delays from critical care for patients being discharged to wards and reduce occupancy to recommended levels.
- Screening of patients who were admitted as an emergency to hospital for gynaecology care and treatment should consistently be screened for MRSA.
- Action should be taken to address the shortfalls identified in staff hand hygiene audits in the maternity services.
- The labour ward should ensure that emergency resuscitation equipment was checked regularly and a record maintained to show it was ready to use.
- Care plans should be consistently completed to provide staff with full detail regarding the patients' assessed care needs. End of life documentation in patient records is completed consistently.
- The trust should take action to ensure compliance with national guidelines regarding baby identification labels.
- The maternity service should provide evidence to demonstrate women received pain relief in labour within appropriate timeframes. Sufficient equipment should be available, for example pumps to self-administer analgesia, for women during labour.
- Ensure all decisions around 'do not attempt resuscitation' status and treatment escalation plans are communicated at nurse-doctor handover
- Review the leadership and accountability structure of the medical outpatient service
- The hospital should review the facilities available for children in the outpatient service.
- Ensure staff in the orthopaedic outpatients department are able to access equipment to take patients height and weight.
- Ensure that all clinical staff receive adequate clinical supervision to support them in their role

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	Outstanding ☆	Overall, we rated the emergency department as outstanding. There was a committed team of staff who demonstrated a cohesive, multidisciplinary approach to the care and treatment of their patients. They respected each other's skills, experience and competencies in a seamless and professional manner that benefitted the people who used the service. Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. They were fully supported when they did so. When something went wrong, there was an appropriate and thorough investigation that involved all relevant staff. Lessons were learned and communicated widely to support improvement. Facilities for children did not fully comply with national standards. Children's treatment rooms were not separated from adult areas and the equipment was not always suitable for a children's environment. Staffing levels and skill mix were planned, implemented and reviewed. Staff had received up-to-date and relevant training and were encouraged to develop their skills. Risks to people who used the department were assessed, reduced, monitored and managed on a day-to-day basis. All staff were actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking, peer review, accreditation and research were proactively pursued. High performance was recognised by credible external bodies such as the National Patient Safety Agency. Feedback from people who used the service and those close to them was continually positive about the way staff treated them. They thought that staff went the extra mile and the care they received exceeded their expectations. There was a strong, visible person-centred culture. Staff were highly

Summary of findings

motivated to offer care that was kind and promoted people's dignity. Interaction between patients, those close to them and staff was strong, caring and supportive.
Changes had been made to working practices in order to reduce delays. Waiting times and avoidable delays were minimal and managed appropriately. The department had been meeting the four hour target to admit or discharge patients since June 2015. Performance throughout the year had varied from 93% to 96% which was better than most other hospitals in England. There were very few delays for ambulance patients and people were kept informed of any disruption to their care or treatment. The needs of people with complex needs were well understood and addressed appropriately. People with dementia received care and treatment that was sympathetic and knowledgeable.
It was easy for people to complain or raise a concern and they were treated compassionately when they did so. There was openness and transparency in how complaints were dealt with. Governance and performance were proactively reviewed and reflected best practice. Lessons learned and changes in practice were communicated to staff via monthly governance meetings and newsletters. More immediate feedback was given to staff via thrice weekly "Communication Cells". Leaders displayed a strong sense of shared purpose, strived to deliver excellent patient care and motivated staff to succeed.
There was strong collaboration and support between all groups of staff and a common focus on improving quality of care and people's experiences. This led to high levels of staff satisfaction across all groups. Staff were proud to work in the department and spoke highly of the culture.

Medical care (including older people's care) — **Good**

Safety in the medical directorate was rated as requires improvement.
People were not always protected from the risks relating to the control substances hazardous to health (COSHH) such as cleaning materials stored in unsecured areas that patients and the public could access. Patients with mental illness in the acute

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medical unit (AMU) were not always well managed. The environment and management of risks was not always possible to keep those vulnerable patients safe.

Management of medicines was not consistently safe and did not meet pharmaceutical guidelines. Cupboards for intravenous fluids were not all lockable with some doors missing. This meant those fluids were not secured.

The management of patient records did not ensure patient's details were safe and that confidentiality was assured.

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

Patients received their care and treatment from competent staff who were provided with appraisals and training. But staff training to support patients with learning disabilities was limited. Dementia training varied from ward to ward so staff skills varied.

Caring for patients in the medical areas was assessed as good. Patients and their relatives spoke positively about the care they received at the Royal Devon and Exeter Hospital. Patients were treated with respect and dignity and their choices and preferences were taken into account when planning care and treatment. Patients felt included in decisions about them and were clear about their plan of care and what was happening next for them. However, we saw two occasions when care was not always good and staff did not ensure patient dignity was maintained.

Services were mostly responsive to patient's needs. The bed management team ensured flow through the hospital. There were some delays in discharge but wards and departments were working to ensure areas of delay were identified and plans put in place to improve discharge.

The medical services were well led. At ward level junior medical and nursing staff were clear about how to ask for help and how to escalate concerns; they had confidence in senior ward staff. Staff were aware of leadership at a divisional level. Some disconnect was noted at this level with staff not

sure how information they had provided was used once escalated. Staff were aware of the hospital board staff and felt they were accessible in the hospital.
Staff were aware of the hospitals vision and values and staff spoke of the family atmosphere of working in the hospital.

Surgery

Good

We have judged surgery overall as good.
Staff were open and honest about incidents and knew how to report them using the trust system. We saw evidence of learning from incidents and staff were able to tell us about the changes to their practice that had taken place as a result.The trust encouraged an open culture. Staff were aware of the principles of duty of candour and always apologised to patients when things went wrong.
We observed good use of five steps to safer surgery that included the surgical safety checklist and briefing sessions, which all staff were aware of their roles and responsibilities.All the wards and units we visited were clean and staff followed infection prevention and control protocols. We heard high praise from patients for the domestic staff.The trust had no reported cases of hospital associated methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia since September 2011.
The hospital performed well in a number of national audits, including the Patient Reported Outcome Measures (PROMs) for April 2014 to March 2015 which is based on patients reporting to the hospital on their outcome following surgery for groin hernias, hip replacements, knee replacements, and varicose veins. The trust also performed well in national cancer audits, including those for lung and bowel cancer. A number of the surgical specialties were involved in national audits and were introducing new initiatives including a remotely led clinic for monitoring patients with prostate cancer.
There was a varied result in the standardised risk of readmissions to elective and non-elective patients (readmission rates after surgery for corrective measures or infections). There was a slightly higher risk of readmission for elective patients compared

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with the England average, and a slightly lower risk for non-elective patients. The average length of stay (LOS) for surgical patients within the hospital was the same as the England average.

All the feedback we received from patients and their relatives about their treatment by staff was positive. Patients gave us individual examples of where they felt staff 'went the extra mile' and exceeded expectations with the care they gave. Patients felt staff maintained their privacy and dignity at all times and provided them with compassionate care.

Between April 2013 and February 2015, the trust performed better than the England average for the percentage of admitted patients seen within the 18-week target time following referral. The number of operations cancelled at the hospital was below (better than) the England average until the months of October to December 2014. The percentage of patients not treated within 28 days of a cancelled operation was above (worse than) the England average for January to June 2015. This improved and, at the time of our inspection, the number of patients not rebooked in the 28-day time scale was below the England average.

Staff supported people with a learning disability and those living with dementia to improve their experience of hospital. Staff were kind and patient with people living with dementia and we observed one-to-one care taking place. A specialist team of nurses in the hospital provided support to patients living with a learning disability and staff caring for them.

The service leadership was good, and a cohesive clinical governance structure showed learning, change and improvement took place. Managers regularly reviewed the approach to risk management in the departments. A number of specialty meetings fed into the overall clinical governance and provided board assurance.

The trust used patient feedback to make changes to its services.

We found patient records were not being stored securely on the wards so that unauthorised people had access to them.

We found Patient Group Directions (PGDs), (written directions that allow the supply and / or

administration of a specific medicine by a named authorised health professional to a well-defined group of patients for a specific condition) were being used without the correct trust authorisation and this potentially breaches the Human Medicines Regulations and this potentially placed both patients and staff in the West of England Eye Unit at risk.

Critical care

Outstanding ☆

We have judged the overall critical care service as outstanding. Caring and leadership was outstanding. The safety, effectiveness and responsiveness of the service were good, with some elements of outstanding.

Treatment by all staff was delivered in accordance with best practice and recognised national guidelines. There was a holistic and multidisciplinary approach to assessing and planning care and treatment for patients. Patients were at the centre of the service and the overarching priority for staff. Innovation, high performance and the highest quality care were encouraged and acknowledged. All staff were engaged in monitoring and improving outcomes for patients. They achieved consistently good results with patients who were critically ill and with complex problems and multiple needs. The whole service had a collaborative approach with a multidisciplinary attitude to patient care.

Patients were truly respected and valued as individuals. Feedback from people who had used the service had been overwhelmingly positive. Staff went above and beyond their usual duties to ensure patients experienced compassionate care and that care promoted dignity. People's cultural and religious, social and personal needs were respected. Innovative support for patients, such as the development of patient diaries, was encouraged and valued. Staff took the time to ensure patients and their families understood and were involved with care plans.

The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. All the senior staff were committed to their patients, their staff and their unit with an inspiring shared purpose. There was strong evidence and data to base decisions upon

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and drive the service forwards from a clear programme of audits and national evaluative studies. Staff, patients and their families were actively engaged with to identify areas of good practice, as well as areas that could be improved. There was a high level of staff satisfaction, with staff saying they were proud of the unit as a place in which to work. They spoke highly of the culture and consistently high levels of constructive engagement. The leadership drove continuous improvement and staff were accountable for delivering change. Innovation and improvement were celebrated and encouraged, with a proactive approach to achieving best practice and sustainable models of care.

There was a good track record on safety, and lessons were learned and improvements made when things went wrong. This was supported by staff working in an open and honest culture and by a desire to get things right. There were reliable systems and staff received training to keep people safe from abuse. The environment did not meet all the requirements for modern critical care units, being an older unit, and this was recognised by the trust. The unit was generally clean and well organised. Staff adhered to infection prevention and control policies and protocols. There were good levels of nursing staff meeting the Core Standards for Intensive Care Units (2013) to keep patients safe. However, overnight medical cover did not meet the core standards and there were times when a doctor was not available on the unit because they were attending a medical emergency call elsewhere in the hospital.

The critical care service responded well to patients' needs. Communication aids, including translation services, were available for patients who could not otherwise communicate easily or effectively. There were bed pressures in the rest of the hospital that meant about 50% of patients were delayed in their discharge from the unit, but the numbers of these incidences were below the NHS national average. Very few patients were discharged onto wards at night and there was a very low rate of elective surgical operations being cancelled because a critical care bed was not available. The facilities for patients, visitors and staff in critical care were good.

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There was quick input from consultants and nurses when new patients were admitted. Patients were treated as individuals, and link nurse roles were used to support specific aspects of patient need.

Maternity and gynaecology

Good

We judged the maternity and gynaecology services were effective, responsive and well led. We rated the maternity and gynaecology services as outstanding for caring.

We have judged safety in the maternity and gynaecology services as requiring improvement. Medicines was not secured at all times which meant it could have been used or abused by visitors or patients on the ward. Cleaning chemicals were not stored securely on the wards and units which meant they were accessible to patients and visitors who may have been at risk from these.

Patient's confidential and personal information was not stored securely at all times on the wards and in the clinics. This meant it was accessible to others.

The staffing levels on the maternity unit were affected when cover was required in the labour ward to ensure women received 1:1 care. At times this meant other areas were left staffed below the planned establishment level. The midwife to patient ratio was below the recommended levels set by the Royal College of Obstetricians and Gynaecologists (RCOG 2007) Safer Childbirth Minimum Standards for the Organisation and Delivery of Care in Labour. The RCOG states there should be an average midwife to birth ration of 1:28 but at this trust in September 2015 the ratio was 1:34.

Nursing and midwifery staff were encouraged to report incidents and robust systems were in place to ensure lessons information and learning.

The maternity and gynaecology service were responsive to the needs of women living locally and those further away from the hospital. Services were provided in the areas where women lived for example, ante and postnatal clinics. Women had access to maternity and gynaecology emergency clinics seven days a week.

All wards and departments we visited were visibly very clean and hygienic in appearance. We saw staff

adhered to the trust policies and procedures regarding infection control. However, audits conducted by the trust showed inconsistencies amongst staff regarding hand hygiene.
Care was delivered in line with the Royal College of Gynaecologists and Obstetricians standards and the National Institute for Health and Care Excellence (NICE) guidelines
It was clear that staff worked well as a cohesive and effective team across the maternity services and gynaecology speciality as well as with other departments of the hospital. The culture of the hospital was inclusive, supportive and staff spoke often as being part of a large family when at work. This cascaded to the patients who spoke of a warm and caring environment.
Women received their care and treatment from trained and competent staff who were supported by their line managers to provide an effective service. Consultant, nursing and midwifery leadership was described as good, with practical examples given by staff to support their experience.
These were overwhelmingly positive and complimentary about the care and service provided with the exception of one comment where the patient felt they had received conflicting information. Patients all said they were treated with respect, their dignity promoted and that staff were kind and helpful.
We observed patients were treated with respect, their dignity promoted and they were involved in discussions about their care and treatment. Patients felt they were listened to and their choices and preferences respected.
The organisation welcomed feedback from staff and there was a culture of listening to staff and learning from incidents. Clear evidence was available to support that the services were well led at a local level. Staff were able to meet with their managers regularly and approach them for support and guidance. Staff all commented they felt proud to work in the trust and felt they were a cohesive dedicated team who were well supported in their roles.

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There were comprehensive risk, quality and governance structures and systems in place though some risks had been on the risk register for a considerable length of time.

Services for children and young people

Good

Services for children and young people were judged to be good. We found that services were safe, effective, caring, responsive and well-led.
Risk was managed and incidents were reported and acted upon with feedback and learning provided to most staff. Staff adhered to infection prevention and control policies and protocols. The units were clean and well organised and suitable for children and young people.
Treatment and care were effective and delivered in accordance with best practice and recognised national guidelines. There was excellent multidisciplinary team working within the service and with other agencies.
Children and young people were at the centre of the service and the priority for staff. Innovation, high performance and the highest quality of care were encouraged and acknowledged.
Care and treatment of children and support for their families was delivered in a compassionate, responsive and caring manner. Parents spoke highly of the approach and commitment of the staff who provided a service to their families. Children, young people and their families were respected and valued as individuals. Feedback from those who used the service was consistently positive. Children received excellent care from dedicated, caring and well trained staff who were skilled in working and communicating with children, young people and their families.
Staff understood the individual needs of children, young people and their families and designed and delivered services to meet them.
There were clear lines of local management in place and structures for managing governance and measuring quality. The leadership and culture of the service drove improvement and the delivery of high-quality individual care.
All staff were committed to children, young people and their families and to their colleagues. There

were high levels of staff satisfaction with staff saying they were proud of the units as a place to work. They spoke highly of the culture and levels of engagement.
There was a good track record of lessons learnt and improvements when things went wrong. This was supported by staff working in an open and honest culture with a desire to get things right.

End of life care

Good

End of life care was judged to be good overall. The service had enough staff with the appropriate skills to provide care. Although the trust had identified vacancies across nursing and medical staff posts this had not affected end of life care. Trust staff and the end of life team followed systems, processes and practices to keep patients safe. Staff kept adequate patient records, which were audited, and we found evidence of continuous improvement in record-keeping.
The service learned lessons from incidents and complaints, and made improvements when things went wrong and had followed duty of candour process.
Patients' care, treatment and support achieved good outcomes, promoted a good quality of end of life and was based on the best available evidence. Staff assessed patients' needs and provided care and treatment in line with legislation, standards and evidence-based guidance including well managed pain and nutrition and hydration. The service monitored patients' care and treatment outcomes through audit, which compared well with other similar services. Specialist staff had the skills, knowledge and experience to provide effective end of life care. Training rates in relation to end of life could be improved across the trust. End of life care documentation (for instance, treatment escalation plans) and recording in patients' notes had improved but use of some forms and sharing of information needed improvement which had been noted in audit outcomes.
Staff treated patients and those close to them with kindness, dignity, respect and compassion. Hospital staff demonstrated an understanding of patients personal, cultural, social and religious and spiritual needs. Patients and bereaved relatives were involved as partners in their care contributing to

patient records and engaging in bereavement groups set up by the trust. Support was available to enable patients and those close to them to have the support they needed to cope emotionally with their care, treatment or condition with the provision of support from volunteers and chaplaincy services. Services were planned and provided to meet the needs of patients and those close to them, taking account of the needs of patients including those with learning disabilities and those with dementia,. Patients could access care and treatment in a timely way with a few exceptions such as occasional delays in discharge. There were excellent communication links between specialist palliative care team members, palliative discharge team and community nursing staff and others. Patients and those close to them who raised concerns and complaints were listened and responded to, and staff used the experience and information shared to improve the quality of care.

The leadership of end of life care was evident from all staff. The service had a clear vision and strategy to provide good quality end of life care, and leaders recognised that progress was still needed. The governance framework ensured that responsibilities were clear and lead roles within the trust and specialist palliative care team had a detailed service level agreement.

The trust encouraged openness and transparency and promoted good quality care. Patients and others who used the service, the public and staff were engaged and involved in the delivery and development of it.

Outpatients and diagnostic imaging

Requires improvement

We judged the outpatients and diagnostic imaging services as requiring improvement overall. Safety was rated as requires improvement. In some clinics, patient records were not always stored securely and this meant that the confidentiality of patient information could not be guaranteed. We saw that staffing was a challenge for some teams. In particular, there was insufficient medical physics cover to provide consultation on patient dosimetry, quality assurance, and advice regarding radiation

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protection concerning medical exposures. Staff were aware of their responsibility to raise safeguarding concerns and they understood their responsibility to report incidents.

We saw that some aspects of care in the outpatients service were not effective. Clinical supervision was not offered to nursing staff. This impacted upon patient care because it meant that staff were not regularly reflecting on their performance in terms of the quality of care given to patients. However, outpatient teams were utilising a quality assessment tool to peer review the quality of care received by patients in the clinics. There was some evidence of best practice within radiology. Referrers to the radiology department were encouraged to use an evidence based referral system and the radiology service held accreditation with the Imaging Services Accreditation Scheme. However local diagnostic reference levels had not been adopted in radiology.

We rated caring as good Staff in all departments including those in managerial and clerical roles demonstrated a compassionate understanding of the needs of patients. Patients told us they were able to understand their condition because the nurses had taken time to explain it to them

We rated responsiveness as requires improvement. There were long waits for people who needed treatment for cancer. During 2014/2015, 115 patients had waited more than 62 days for their cancer treatment. There were also delays for treatment in ophthalmology, orthopaedics, and cardiology. Rapid access clinics had been introduced where needed and the teams had used creative ways to reduce the requirement for face to face consultations In some clinics, the privacy and the safety of patients was not well accommodated by the environment, for example there was insufficient room in the ophthalmology department to fit adequately curtained vision aisles.

We rated well led as good. There was a vision for the remodelling of the outpatients service as a whole, and the challenges regarding lack of capacity within the ophthalmology service were being addressed by the planned relocation of the service in January 2016. There was clear governance process around the risks associated with delays to treatment for

Summary of findings

patients living with cancer. The trust had a clear and focussed plan to reduce the time that patients had to wait for treatment for cancer and for other conditions. Key aspects of the plan were already in place with additional capacity fully commencing in December 2015. Leaders in the trust were well respected and staff told us they felt proud to work for the trust

Royal Devon & Exeter Hospital (Wonford)

Detailed findings

Services we looked at

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

Detailed findings

Contents

Background to Royal Devon & Exeter Hospital (Wonford)

Royal Devon and Exeter NHS Foundation Trust (RD&E) operates two principal hospital sites of which Wonford Hospital is the largest.

The Trust is a teaching trust and the lead centre for the University of Exeter Medical School.

The Trust reports working in partnership with other NHS providers at other locations in Exeter, Mid Devon, East Devon and North Devon and Torridge and reports delivering some specialist services are delivered more widely across Devon, Cornwall and parts of Somerset.

The RD&E provides specialist and acute hospital services to approximately 460,000 people in Exeter, and East and Mid Devon.

Exeter, ranked 139/326* in 2010 Indices of Deprivation. Six Health Profile indicators are significantly worse than England including Alcohol-specific hospital stays (under 18), Incidence of malignant melanoma, Hospitals stays for self-harm, and Hospital stays for alcohol-related harm.

Mid Devon, ranked 155/326*, has two indicators significantly worse than England, but has very high life-expectancy.

East Devon, ranked 209/326* has high life-expectancy and three indicators significantly worse than England.

The inspection team inspected the following eight core services at Wonford Hospital

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children's and young people
- End of life care
- Outpatients and diagnostic imaging

Our inspection team

Our inspection team was led by:

Chair: Ted Baker, Deputy Chief Inspector of Hospitals, Care Quality Commission

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

The team of 47 included CQC inspectors and a variety of specialists: a retired divisional director of medicine, a paediatric consultant and consultant obstetrician, a consultant vascular surgeon, a consultant in palliative medicine, a speciality registrar doctor, consultant in anaesthesia, orthopaedic services matron, childrens

nurse, accident and emergency nurse, consultant midwife, a head of clinincal governacne and a student nurse. The team were supported by an Expert by Experience.

How we carried out this inspection

We carried out the announced part of our inspection between 3 – 5 November 2015 and returned to visit some wards and departments unannounced on 10 & 16 November. During the inspection we visited a range of wards and departments within the hospital and spoke with over 300 clinical and non clinical staff, patients, and relatives. We held focus groups to meet with groups of staff and managers.

Prior to the inspection we obtained feedback and overviews of the trust performance from the New Devon Clinical Commissioning Group and Monitor (the Foundation trust regulator).

We spoke with HealthWatch Devon who shared with us views they had gathered from the public in the year prior to the inspection. In order to gain feedback from people and patients we held some listening events. One of these events was held at a venue in Exeter city centre and two others were held at Honiton and Tiverton Libraries. A total of 50 people came to share their experience with us and we used what they told us to help inform the inspections. We also received feedback people provided via the CQC website.

Facts and data about Royal Devon & Exeter Hospital (Wonford)

The Royal Devon and Exeter NHS Foundation Trust employs 5,826 Staff (Whole Time Equivalent): 5,826 of which 664 are medical staff, 1,570 nursing staff and 3,592 other staff groups.

Wonford Hospital is the largest of the 10 sites where treatment and care is provided with the overall trust inpatient beds being 838. Of these 131 are day beds, 759 acute, 57 maternity, 13 critical care and 4 paediatric high dependency.

During 20145/15 the trust had 125,000 inpatient admissions, 350,000 Outpatient (total attendances) and 100,000 Accident & Emergency (attendances). Bed occupancy quite high over previous eight quarters, but comparable to England rate. The two winter periods have seen the highest bed occupancy (89 and 91%)

The Trust revenue for 2014/15 was £399,129,000 with full cost £410,347,000. The years surplus (deficit) for 2014/15 was (£11,218,000)

The trust had good performance for infections with 0 MRSA blood stream infections since June 14. The levels of Clostridium difficile were low and within the target set for the trust by the department of health.

There was also a low prevalence of incidents with harm and pressure ulcers and falls with harm were below average.

Inspection history

- Wonford Hospital:
  - March 2014 and found to be compliant with the 16 standards inspected
  - August 2013 and found to be compliant with the 3 standards inspected
  - November 2012 and found to be compliant with the 7 standards inspected

Feedback from patients using services demonstrated good results in the Cancer patient experience survey 2013/14 where the trust scored in the top 20% of trusts for 19/34 questions.

In the friends and family test scores these were usually better than the England average for the period July 14 – June 15. For example in the emergency department results from the Friends and Family test showed that, on average, 89% of people would recommend the

Detailed findings

department. This is slightly better than other hospitals in England. The department performed better than many others in the national CQC A&E survey. Answers were particularly positive for the following questions.

- If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?
- Did a member of staff tell you about medication side effects to watch for?
- Did hospital staff take your family or home situation into account when you were leaving the A&E Department?
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the A&E Department?

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Good	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Good	☆ Outstanding	Good	☆ Outstanding	Good

Notes

Urgent and emergency services

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

Information about the service

The emergency department (ED) at the Royal Devon and Exeter hospital is open twenty-four hours a day, seven days a week. It treats people with serious and life threatening emergencies and those with minor injuries which need prompt treatment such as lacerations and suspected broken bones. Major trauma cases usually go to the major trauma centre at Derriford Hospital in Plymouth.

The department has a three-bay resuscitation room. One bay contains equipment for children. There is a major treatment area with five curtained cubicles and four rooms with doors. Less seriously ill or injured patients are seen in the minor treatment area which has seven cubicles. There are two rooms equipped to treat children who also have their own waiting room. Outside is a helipad in order for an air ambulance to land. The emergency department last year (ending June 2015) saw approximately 103,000 patients. Approximately 19,000 of these were children. There was an adjacent NHS walk-in centre which was run by another organisation.

We visited between 3 and 6 November 2015. We observed care and treatment of patients and looked at 22 treatment records.

During our inspection we spoke with approximately 30 members of staff including nurses, consultants, doctors, receptionists, managers, support staff and ambulance crews. We talked with 21 patients and five relatives. We received comments from patients and the public at our listening events, and we reviewed performance information about the department.

Summary of findings

Overall, we rated the emergency department as outstanding. There was a committed team of staff who demonstrated a cohesive, multidisciplinary approach to the care and treatment of their patients. They respected each other's skills, experience and competencies in a seamless and professional manner that benefitted the people who used the service.

Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. They were fully supported when they did so. When something went wrong, there was an appropriate and thorough investigation that involved all relevant staff. Lessons were learned and communicated widely to support improvement. Facilities for children did not fully comply with national standards. Children's treatment rooms were not separated from adult areas and the equipment was not always suitable for a children's environment.

Staffing levels and skill mix were planned, implemented and reviewed. Staff had received up-to-date and relevant training and were encouraged to develop their skills. Risks to people who used the department were assessed, reduced, monitored and managed on a day-to-day basis. All staff were actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking, peer

Urgent and emergency services

review, accreditation and research were proactively pursued. High performance was recognised by credible external bodies such as the National Patient Safety Awards.

Feedback from people who used the service and those close to them was continually positive about the way staff treated them. They thought that staff went the extra mile and the care they received exceeded their expectations. There was a strong, visible person-centred culture. Staff were highly motivated to offer care that was kind and promoted people's dignity. Interaction between patients, those close to them and staff was strong, caring and supportive.

Changes had been made to working practices in order to reduce delays. Waiting times and avoidable delays were minimal and managed appropriately. The department had been meeting the four hour target to admit or discharge patients since June 2015. Performance throughout the year had varied from 93% to 96% which was better than most other hospitals in England. There were very few delays for ambulance patients and people were kept informed of any disruption to their care or treatment. The needs of people with complex needs were well understood and addressed appropriately. People with dementia received care and treatment that was sympathetic and knowledgeable.

It was easy for people to complain or raise a concern and they were treated compassionately when they did so. There was openness and transparency in how complaints were dealt with. Governance and performance were proactively reviewed and reflected best practice. Lessons learned and changes in practice were communicated to staff via monthly governance meetings and newsletters. More immediate feedback was given to staff via thrice weekly "Communication Cells". Leaders displayed a strong sense of shared purpose, strived to deliver excellent patient care and motivated staff to succeed.

There was strong collaboration and support between all groups of staff and a common focus on improving quality of care and people's experiences. This led to high levels of staff satisfaction across all groups. Staff were proud to work in the department and spoke highly of the culture.

Are urgent and emergency services safe?

Good

We rated the emergency and urgent care services as good for safety. By safe, we mean that people are protected from abuse and avoidable harm.

Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. They were fully supported when they did so. Monitoring and reviewing activity enabled staff to understand risks and gives a clear, accurate and current picture of safety. When something went wrong, there was an appropriate and thorough investigation that involved all relevant staff. Lessons were learned and communicated widely to support improvement.

Staffing levels and skill mix were planned, implemented and reviewed. A recent review showed that there were not sufficient band 7 nurses to take charge of the department on every shift. There were no plans to change this. However any staff shortages were responded to quickly and adequately and there were effective handovers at each shift change. Staff had received up-to-date training.

Risks to people who used the department were assessed, monitored and managed on a day-to-day basis. These include signs of deteriorating health, medical emergencies or behaviour that challenged. Facilities for children did not fully comply with national standards. Children's treatment rooms were not separated from adult areas and the equipment was not always suitable for a children's environment. Plans were in place to respond to emergencies and major situations. All relevant parties understood their role and the plans were tested and reviewed.

Incidents

- All staff that we spoke with were aware of their responsibilities in reporting incidents and we saw examples which had been submitted. Staff understood the value of reporting "near misses" and described examples of these.
- Incidents and accidents were reported using a trust wide electronic system. All staff had access to this and knew which incidents required reporting. Senior staff

were aware that incidents often happened when the department was at its busiest and had devised a quick paper-based system of recording the key elements of an incident. Staff could later refer to this when the incident was logged on the system.

- We looked at the ED incident reports from April to July 2015. They had been logged appropriately, were clearly described and appropriate remedial action had been taken when necessary.
- There were two serious incidents in the emergency department in the year ending July 2015. These had been investigated in an open, honest and thorough way. All contributing factors were taken into account and measures were identified to help prevent a repeat of similar incidents. Learning points from these incidents were clearly described in governance meeting minutes.
- There were a number of systems to ensure that learning from incidents was shared throughout the department. Minutes of governance and staff meetings demonstrated learning from incidents. There was a monthly newsletter produced by the leadership team which was shared across the departments. Staff said that this was useful. Immediate issues were also discussed at multidisciplinary "Comm. Cell" meetings held three times a week.
- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have, occurred.
- All staff that we spoke with understood the principles of openness and transparency that are encompassed by the duty of candour. We were told that incident reporting system automatically alerts staff when an incident is subject to the duty of candour. Senior staff demonstrated detailed knowledge of the practical application of this new responsibility. They described discussions that had taken place with the patients concerned and their families and it was clear that they had fulfilled the requirements of the legislation.
- The ED holds mortality and morbidity meetings monthly. Some cases were also discussed at the monthly governance meetings (for example if linked to a complaint, investigation or for shared learning).

Cleanliness, infection control and hygiene

- We observed support staff cleaning the department throughout the day and walls, floors and surfaces were visibly clean. We observed nurses and support workers cleaning the mattresses on trolleys between patients but noticed dust and some staining on the base of three trollies. We brought this to the attention of the nurse-in-charge who took immediate action to remedy the situation. We later saw an updated checklist that helped to ensure that all trollies were numbered and cleaned regularly.
- Hand washing facilities and hand cleaning gels were available throughout the department and we saw good examples of hand hygiene by all staff. This helped to prevent the spread of infection.
- Hand hygiene audits took place monthly and consistently showed compliance of between 90% and 100%.
- We observed staff treating a patient who was suspected of having a contagious infection. Isolation techniques were used in accordance with trust policies and procedures. This included the appropriate use of gloves and disposable aprons.
- Staff were aware of the actions necessary to look after someone with, or who may have been involved in, the recent Ebola outbreak. There were notices in the entrance asking people to inform the receptionists if they had recently travelled to the affected countries.

Environment and equipment

- We were told that the department was designed for 70,000 patients per year but that over 100,000 were currently attending. This meant that some treatment areas did not have sufficient capacity for the patients using them. Temporary improvements had been made to ensure that the risk to patients was minimised. For example, two cubicles in the major treatment area had been equipped with resuscitation equipment and cubicles in the minor treatment area had been adapted for major treatment patients. There were plans to build a larger resuscitation room.
- Patients in the waiting room could not be observed by receptionists and only intermittent observation was possible by clinical staff. This meant that patients' condition could deteriorate without staff being aware, particularly at night when less staff were on duty.

- There was a quiet room for the assessment of patients with acute mental health problems. This was comfortable and safe with an alarm system if help was needed urgently. The room had two doors to allow rapid entry and exit should a violent incident occur.
- There was a good range of resuscitation and monitoring equipment. This was clean and ready for use. Equipment in the resuscitation room was checked daily.
- Facilities for children only partially met the national "Standards for children and young people in emergency care settings". There were only two children's rooms and these were within the an adult treatment area, This meant that there was no audio-visual separation from the adult environment and that children could sometimes hear and see activity that they might find distressing. The national standard states that there should be a dedicated child-friendly treatment space for every 5,000 children seen per year. This department sees 19,000 children a year and so should have a minimum of three children's treatment rooms.
- The standards also state that children's area should be monitored securely and zoned off, to protect children from harm. Access should be controlled. This was not possible within the layout the current department.
- Although the children's rooms were well equipped the arrangement of the equipment did not enhance safety. For example, examination equipment was fixed to the wall at a height where unsupervised children could play with the cables. Clinical waste bins had been placed in such a way that small children could open them. We were told that children were never left unsupervised in these rooms.
- We were shown documents that recorded the maintenance and servicing requirements of all equipment. All were up-to-date. The hospital had an online and telephone reporting system in place for anyone to report damage to essential equipment. We observed maintenance staff repairing equipment during the evening and were told that they were also present in the hospital at week-ends.
- The estates department carried out an annual visual inspection of all electrical installations and undertook a five yearly full inspection and testing programme.
- We found an unlocked cleaning cupboard containing hazardous cleaning chemicals. Although this was not in a patient area there was a risk that the chemicals could have been used inappropriately.
- The ED was immediately adjacent to the imaging department. Two x-ray rooms were set aside for ED patients and there was easy access to CT scanners.
- The helipad was immediately outside the department and easily accessible.

Medicines

- Medicines were stored correctly in locked cupboards or refrigerators. Controlled drugs and refrigerator temperatures were regularly checked by staff working in the department and seen to be within required parameters.
- The key code locks on the medicine cupboards in the resuscitation room were old and stiff which made locking the cupboards difficult.
- Unused medicines were disposed of in accordance with hospital policy.
- We observed staff administer intravenous fluids safely and correctly. They accurately completed details on the medicine chart.
- Allergies were clearly documented on medicine charts and antibiotics were prescribed according to local protocols.
- Emergency nurse practitioners used patient group directives (PGD) in order to administer a number of different medicines such as painkillers and some antibiotics. Whilst the trust had a system for approving PGD's which included senior clinicians and lead pharmacist sign off, we found an unsigned copy of one in the department for an antibiotic.

Records

- The departmental computer system produced a patient record in paper format and all healthcare professionals documented care and treatment using the same document. Additional documents were added to patients file as and when needed. They were kept securely in ring files which were then stored in discrete storage trolleys.
- We looked at eighteen patient records and found them to be clear, complete and easy to follow. They had all been signed and dated by staff and were accurate. There was space to record appropriate assessment, including assessment of risks, investigations, observations, advice and treatment and a discharge plan. These were all complete where appropriate for the records reviewed. Previous medical records were routinely requested for all patients in the resuscitation

room, children's areas and the major treatment area. Response from the medical records department was good. Previous records arrived in 15 minutes for resuscitation patients and 30 minutes for all other patients.

Safeguarding

- Staff that we spoke with were aware of their responsibilities to protect vulnerable adults and children. They understood the safeguarding procedures that were in place and how to report concerns. There were clearly documented procedures for responding to patients who had suffered from domestic violence and female genital mutilation (FGM). The "At risk" register was checked for all children up to and including the age of seventeen if there was a safeguarding concern.
- All clinical records for children contained a risk assessment tool aimed at quickly identifying any concerns regarding child welfare. These were completed correctly in the records that we reviewed.
- At the time of our inspection 95% of staff had completed annual training in adult safeguarding and 91% had completed children's safeguarding training. This was better than the hospital target of 75%.
- .All consultants and children's nurses had undertaken recent training in children's safeguarding at level three (advanced).
- All staff (including administrative staff) were expected to do level 2 child protection training and senior clinical staff were expected to undertake the more advanced level 3 training. Records showed that 90% of consultants and 100% of children's nurses had completed this training.

Mandatory training

- There were a wide range of topics included in mandatory training. For example, conflict resolution, domestic violence, dementia, falls prevention and information governance. This was in addition to fire training, waste management and infection control.
- Some of the topics were covered by e-learning and others took place during mandatory training sessions which were tailored to the specific needs of the staff attending.
- Each month the hospital's essential learning co-ordinator would send a training report to the department so that senior staff were aware of the training that had been undertaken. At the time of our inspection 91% of staff had completed training in the last year.

Assessing and responding to patient risk

- Patients arriving by ambulance as a priority (blue light) call were taken immediately to the resuscitation area. Such calls were phoned through in advance so that an appropriate team could be alerted and prepared for the arrival of the patient. We observed staff responding calmly and effectively when this occurred.
- Other patients arriving by ambulance were taken to the rapid assessment and treatment (R.A.T.) room where they were assessed by senior nursing and medical staff. Investigations were arranged, treatment prioritised and an appropriate treatment area agreed. The assessment was clearly recorded. Hospital figures showed that the average (median) waiting time for initial assessment of ambulance patients was three minutes and during our inspection we saw no delays at all.
- Patients who walked into the department, or who were brought by families or friends, reported to the reception desk. This was shared with the adjacent walk-in centre. Once initial details had been recorded patients were asked to sit in the waiting room while they waited to be assessed by a nurse. This assessment was required in order to determine the seriousness of the patient's condition and to make plans for their on-going care. This is often known as triage. All new patients were assessed by the triage nurse, even if they intended to be seen in the walk-in centre, with the exception of patients whose presenting complaint meets set criteria which mean that they can go straight to the walk -in-centre.
- Guidance from the Royal College of Nursing (RCN) and Royal College of Emergency Medicine (RCEM) states that "Triage is a face to face encounter which should occur within 15 minutes of arrival." We observed that, on the whole, this standard was being met. Although some patients were not triaged for 18 minutes, they were attending the walk-in centre which was run by another organisation. We were told that a longer triage time was in line with their clinical guidelines.
- A triage nurse told us that, if people were waiting more than 10 minutes, she would look at the reason they were attending, their age, and when the injury or illness had first happened. She would then prioritise the people who were most likely to need emergency treatment.

- Patients in the waiting room could not be observed by reception staff. Triage nurses told us that they observed activity in the waiting room whenever they called their next patient. However, some of the chairs had been placed behind vending machines and could not be observed. This meant that someone's condition could deteriorate without staff being aware.
- Patient early warning scores (EWS) were used throughout the department. This was a quick and systematic way of identifying patients who were at risk of deteriorating. Once a certain score was reached a clear escalation of treatment was commenced. We observed the EWS being used to prioritise patient care during handovers.

Nursing staffing

- The ED senior nurse told us that a review of staffing levels had taken place in March 2015 following the publication of new guidance from the National Institute for health and Clinical Excellence (NICE). The review found that there were sufficient nurses to comply with the guidance although sometimes there was a lack of more experienced nurses.
- We looked at nurse staffing for the month prior to our inspection and compared it to the NICE guidance. All treatment areas complied with the recommendations and there was a second triage nurse on duty on a late shift.
- There were not enough band 7 nurses to take charge of the department on every shift as recommended by NICE. During the night the nurse in charge was always a band 6. We could only see two nights when there was a second band 6 on duty. We were told that the lack of band 7 nurses at night was normal practice throughout the hospital.
- There was at least one registered sick children's nurse on duty at all times although they did not always looks after children.
- On most shifts one or two nurses were from an agency. However, permanent nursing staff told us that the majority worked in the department on a regular basis and were aware of local working practices. We were shown an informative orientation pack and letter of welcome that was given to nurses when they came to work in the department for the first time.
- We observed a handover between nurses on the day and night shifts. This was well-structured, comprehensive and used as an opportunity for teaching.

Medical staffing

- The department employed ten consultant doctors. Their rota ensured a consultant presence from 8am until 10pm. This was less than the 16 hour consultant presence recommended by the Royal College of Emergency Medicine (RCEM). One of the consultants had completed further training in the treatment of children in emergency settings.
- There was a consultant on-call from home at night. Staff told us that they appreciated the rapid, expert advice that this provided. The on-call consultant rarely had to attend the department during the night.
- There were few locum doctors working in the department. Those that were had worked there for several months and were familiar with local working practices. They had received appropriate induction when they started.
- Junior doctors spoke positively about working in the ED. They told us that the consultants were supportive and always accessible. In-house teaching was well-organised and comprehensive.
- The least experienced doctors (F1s) only worked during the day so that there was always a consultant present to advise them when necessary. Other doctors in the department told us that their rota was well-organised and provided them with valuable experience balanced with sufficient rest days.
- We saw consultants working clinically in the department. They led the treatment of the sickest patients, advised more junior doctors and ensured a structured clinical handover of patient's treatment when shifts changed.
- Handovers between different teams of doctors was well-structured and detailed.

Major incident awareness and training

- The hospital had a major incident plan (MIP), which was up-to-date and detailed. The MIP provided clinical guidance and support to staff on treating patients of all age groups and included information on the triaging and management of patients suffering a range of injuries. These included injuries caused by burns, blasts or chemical contamination.

Urgent and emergency services

- Staff in the department were well-briefed and prepared for a major incident and could describe the processes and triggers for escalation. Similarly they described the arrangements to deal with casualties contaminated with chemical, biological or radiological material (HAZMAT).Decontamination facilities following a HAZMAT incident were spacious and effective. Major incident training had taken place in the last year.
- Equipment and documentation was kept in a locked room. The key was kept in a locked cupboard in the resuscitation room but was accessible within one minute.
- We observed security staff supporting nursing staff in the department. They were calm and polite and reassuring. They told us that they had been trained in conflict resolution and the safe restraint of violent people and spoke knowledgably about the techniques to use. Staff told us that they responded quickly when called.

Are urgent and emergency services effective?

(for example, treatment is effective)

Outstanding ☆

We rated emergency and urgent services as outstanding for effective. By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Outcomes for people who used the emergency department were consistently better than expected when compared with other similar services. National audits showed that performance in the treatment of sepsis (a life threatening infection of the blood), paracetamol overdose and fitting children was particularly good. If any weakness were identified, immediate action was taken and a re-audit took place to ensure that the action had been effective. There was an holistic approach to assessing, planning and delivering care and treatment to people who used the department. The safe use of innovative approaches to care (such as the treatment of certain fractures and dislocations) and how they were delivered was actively encouraged. New evidence-based techniques such as rapid assessment and treatment were used to support the delivery of high quality care.

There was multi-disciplinary engagement in the monitoring and improvement of quality and outcomes. Opportunities to participate in benchmarking, peer review, accreditation and research were proactively pursued. If benchmarking with other hospitals showed any weaknesses, practice was changed. For example, new proformas had been developed to guide staff in the treatment of asthma attacks in children, cognitive assessment for elderly people and support for people with mental health problems. High performance was recognised by credible external bodies such as the National Patient Safety Awards. The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care. Continuous learning was a feature of clinical practice and we observed teaching taking place whenever the opportunity arose. Staff were proactively supported to acquire new skills and share best practice.

Evidence-based care and treatment

- The emergency department used a combination of National Institute for Health and care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines to determine the treatment that was provided. Guidance was regularly discussed at governance meetings, disseminated and acted upon as appropriate. For example, the response to early warning scores had recently been changed.
- A range of clinical care pathways and proformas had been developed in accordance with national guidelines. These included treatment of strokes, sepsis, asthma and fractured neck of femur (broken hips) and also assessment of older people and people with mental health problems. At monthly governance meetings any changes to guidance and the impact that it would have on practice was discussed. Recently there had been changes in the way medicines were prescribed for patients who were able to go home after treatment.
- There was a multidisciplinary approach to audits used to monitor the compliance with these guidelines. Audits currently in progress included blood tests used to diagnose heart attacks, using appropriate painkillers and monitoring vital signs in children.

- There were sufficient staff with specialist qualifications and experience to comply with the national "Standards for children and young people in emergency care settings". However we noted that there was not a play specialist available to provide distraction therapy.
- Research into the best treatment for an irregular heartbeat had been carried out in the department. One of the consultants had helped to write a research paper which had been published in an internationally renowned professional journal (The Lancet). This meant that patients attending with this condition received the most up-to-date treatment.

Pain relief

- Patient records showed that a pain score was always calculated and recorded.
- We observed that nurses administered rapid pain relief when they assessed patients who had walked into the department and those who had arrived by ambulance.
- During our inspection we observed timely pain relief administered to children. The results of the pain relief were monitored and additional treatment given if necessary.

Nutrition and hydration

- Following the assessment of a patient, intravenous fluids were prescribed and administered and recorded when clinically indicated.
- We observed nurses and healthcare assistants making hot drinks and snacks for patients and those close to them. This was recorded in the care record.
- Patients that we spoke with told us that they had been offered drinks and snacks where appropriate.

Patient outcomes

- The department had taken part in seven Royal College of Emergency Medicine (RCEM) national audits in the last two years. Performance in the treatment of sepsis (a life threatening infection of the blood), paracetamol overdose and fitting children was better than many other emergency departments in England.
- The results of the consultant sign-off audit were also good. This measured a number of outcomes, including: whether a patient has been seen by an ED consultant (or senior doctor in emergency medicine) prior to being discharged from the ED when they have presented with non-traumatic chest pain (17 years of age or older), children under one year of age presenting with a high temperature and patients who present back to the ED within 72 hours of previously being discharged by an ED.
- Results for treating children with asthma, adults with acute mental health problems and assessing cognitive impairment in older people were mixed. Although some aspects were better than average there were elements which could have been improved. As a result, changes in practice had been made.
- A new proforma had been developed and implemented for children with asthma. A new audit had taken place and data collection was completed at the end of September 2015. The results were about to be finalised at the time of our inspection.
- Improvements had been made to the response to patients with acute mental health problems. A dedicated assessment room had been developed for mental health patients and more psychiatric liaison nurses had been recruited. 85% of patients with mental health problems were now seen by a specialist within one hour if they were referred before 10pm. Although the response was not yet as fast during the night, recruitment continued in order to provide a continuous and effective service.
- A cognitive impairment assessment now took place for all patients aged 75 years and over and for patients aged 65 years and over if they had a broken hip. This was clearly recorded and a clear pathway of treatment resulted based on the outcome.
- Although the results of the sepsis audit were good, staff in the department thought they could be better still. They developed a "sepsis sticker" which displays a checklist of all tests and treatment that need to happen in the first hour of someone arriving. This is securely attached to the front of the patient record and helps to ensure that nothing is forgotten. In addition, on each shift there is a designated "sepsis nurse" who co-ordinates the care of patients with sepsis and makes sure that no delays occur.
- The average unplanned re-attendance rate within seven days for the year ending May 2015 was 7.4%. This was similar to other hospitals in England. There were a small number of people who re-attended on a frequent basis. If a patient attended more than 15 times in six months a case conference was arranged. It would include specialists with expertise in the specific problems that

the patient was describing. A bespoke treatment plan would be agreed so that the patient received effective and consistent care. This approach was in line with recent guidance from the RCEM.

Competent staff

- Doctors and nurses new to the department took part in a structured orientation programme. Staff that we spoke with told us that they found it informative and effective.
- The orientation programme for nurses lasted four weeks and practice during this time was always supervised. There were specific minor injury and paediatric competency packs that had to be completed as most nurses did not have previous experience in these areas. Each new nurse was allocated two mentors so that there was always an experienced person to work with, irrespective of shift patterns. New nurses did not work in the resuscitation room until specific training had been successfully completed.
- Teaching and staff development was a priority. Each morning one of the emergency nurse practitioners would hold a multi-disciplinary teaching session based on an injury or illness that had occurred in the previous 24 hours. The lunchtime medical handover session always included a two-minute "Learning bite". The session that we observed included teaching about the treatment of arterial bleeding. In addition, we observed that consultants and senior nurses taking the opportunity to teach whenever an opportunity arose. In this way, learning became a continuous process.
- We spoke with junior doctors, who told us that they received regular supervision from the emergency department consultants, as well as twice weekly formal teaching sessions
- Specific learning needs for all staff were identified at the yearly appraisal meeting. We were told by senior staff that all appraisals were up-to-date. However, it was not possible to verify this as the database that recorded the information was not available during the inspection
- Multidisciplinary teaching regarding mental health took place weekly.
- The expertise and previous experience of healthcare assistants (HCAs) was recognised and used to educate all staff. HCAs led teaching sessions on bereavement, compassion and interpretation of ECGs.

Multidisciplinary working

- There was effectivegood multidisciplinary working within the emergency department. This included effective working relations with speciality doctors and nurses, social workers, therapists and GPs.Non-ED staff were made welcome when they visited the department. There was a sense of camaraderie as they worked together to solve problems.
- Medical, nursing staff and support workers worked well together as a team. They knew who had expertise in particular areas and used these to the benefit of patients. We observed that the patient and those close to them were at the forefront of everyone's thinking. If a patient needed something urgently the nearest member of staff would respond, however junior or senior. There would then be immediate communication with other members of the team.
- There was a good working relationship with the child safeguarding team, community paediatric team and the psychiatric liaison team. The service provided by the latter was described as "terrific" by a senior member of staff.
- Access to mental health teams had been improved in the last year. Additional psychiatric liaison nurses had been recruited in order to provide specialist assessment and treatment between the hours of 7am and 10pm. Recruitment was continuing in order to provide a 24 hour a day service.
- Elderly people awere supported to go home if they do not have an acute medical problem. The department has a close working relationship with the acute care of the elderly (ACE) team. A senior doctor from the team spent part of each day in the department in order to assess the medical conditions of elderly people. If they could be treated at homeThey in turn a other members of the team werere able to arrange additional home support within hours so that patients canould safely go home.
- The department had agreed with the ambulance service that crews would radio ahead to tell staff that that they were bringing a patient with a suspected broken hip. This gave nurses the time to prepare a pressure relieving mattress for the trolley on which the patient would be treated. In this way, pressure ulcers would be prevented but X-rays could still be carried out without moving the patient. This approach to the care of people with broken hips had been recognised by the National Patient Safety Awards..

- Opportunities to avoid admitting people to hospital were explored whenever possible. We observed the treatment of a patient with an unusual type of dislocated joint. Usually this would have to be treated under general anaesthetic as an in-patient. However the department is equipped to administer general anaesthetics and so two ED consultants were able to treat the dislocation in the department. The patient went home as soon as he had recovered from the anaesthetic.

Seven-day services

- The department had access to radiology support 24 hours each day, with rapid access to CT scanning when indicated.
- There was an on-call pharmacy service outside of normal working hours.
- ED consultants provided cover 24 hours per day, 7 days per week, either directly within the department or on-call.

Access to information

- Information needed to deliver effective care and treatment was well organised and accessible. Treatment protocols and clinical guidelines were computer based and we observed staff referring to them when necessary.
- There was a departmental computer system that showed how long people had been waiting for and what investigations they had received. Staff that we spoke with said that it was easy to use and reliable.
- The computer system would alert staff when a child with a long-term illness arrived in the department. Care plans for each child were immediately available so that they received treatment and care that was specific to their condition.
- Discharge letters were clear and comprehensive and were sent to GPs on a daily basis.
- Previous medical records were delivered to the department within 30 mins, or within 15 minutes for patients requiring resuscitation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed that consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent.
- Consent forms were available for people with parental responsibility to consent on behalf of children.
- The staff we spoke with had sound knowledge about consent and mental capacity.
- Where patients lacked the capacity to make decisions for themselves, such as those who were unconscious, we observed staff making decisions which were considered to be in the best interest of the patient. We found that any decisions made were appropriately recorded within the medical records.

Are urgent and emergency services caring?

Outstanding ☆

We have rated caring as outstanding. By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Feedback from people who used the service and those close to them was continually positive about the way staff treated people. They consistently reported that staff went the extra mile and the care they received exceeded their expectations. Patients approached us during the inspection to draw our attention to the excellent care they had received.

There was a strong, visible person-centred culture which was owned by the whole of the multidisciplinary team in the ED. One of the consultants had been appointed Care Champion for the department. He undertook regular "care rounds" to check that the care delivered was kind and promoted people's dignity. Interaction between patients, those close to them and staff were strong, caring and supportive even if patients were initially aggressive. These relationships were highly valued by staff and promoted by leaders.

Staff were fully committed to working in partnership with people. They showed determination and creativity in overcoming obstacles to delivering care. One member of staff spent time finding a nearby hotel for a patient who did not live locally. People's individual preferences and needs were always reflected in how care was delivered. People's emotional and social needs were highly valued by staff and are embedded in their care and treatment. An individualised bereavement service was offered.

Compassionate care

- People we spoke with praised the staff for their kindness and compassion and told us the care they had received exceeded their expectations. One patient told us that he had been travelling through Exeter when he experienced sudden and severe pain and had to attend the emergency department. Immediate treatment was given but he had to return the following day to see a specialist and therefore could not continue his journey. One of the receptionists spent time finding him a nearby a hotel to stay in and arranged a taxi to take him there. She also arranged for the taxi to bring him back the following day. He was impressed by the care and helpfulness provided.
- One relative said "We are very lucky to have this hospital. The care and treatment in this department is the best you could possibly get. It is marvellous".
- A third person said "The staff here are so helpful. They are a special sort of people".
- We observed doctors and nurses introducing themselves when they met patients and their families for the first time. All patients were addressed by their preferred name and it was clear that the staff took the time to provide personable care to patients. We saw examples where staff were regularly holding the hand of the patient and maintaining eye contact where possible at all times.
- We saw examples of clear and caring instructions being given to patients during high stress situations. One patient who was having a diagnostic procedure became unwell. The staff calmly talked to him, reassured him and supported him. A second example was with a physically aggressive patient in the resuscitation room. Both the trust staff and the ambulance staff talked to the individual with kindness and compassion, quickly reducing the patient's agitation. Staff were communicating with each other, and other teams, in the same calm and compassionate way to improve the patients' experience.
- Care was delivered with appropriate information and checking of understanding. Staff took time to listen to people's concerns and were observed to act in a respectful, considerate and supportive manner.
- Results from the Friends and Family test showed that, on average, 89% of people would recommend the department. This is slightly better than other hospitals in England. The department performed better than many others in the national CQC A&E survey. Answers were particularly positive for the following questions.
  - If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?
  - Did a member of staff tell you about medication side effects to watch for?
  - Did hospital staff take your family or home situation into account when you were leaving the A&E Department?
  - Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the A&E Department?

Understanding and involvement of patients and those close to them

- The publication of the Francis report in 2013 caused staff in the emergency department to reflect on the meaning of compassion in hospitals. In 2014 senior staff produced a 42 point response to the report with relevance to urgent and emergency care. This was shared and discussed with all staff in the department and has been used to enhance the care provided.
- One of the consultants had been appointed as Care Champion and regularly carried out "Care rounds". After introducing himself to patients he asked "How have we, as a department, cared for you today". The feedback gained from patients and those close to them was fed back to staff in two ways. Immediate feedback is given verbally at the following staff handover session. Any problems were discussed and resolved. Written feedback was contained in the monthly "Care and compassion newsletter". This looked at trends and described new developments aimed at improving care further.
- All new staff, including agency staff, were sent (or given) a letter emphasising the importance of providing "a safe, compassionate and caring service"
- Patients and their families told us they were kept informed of all care and treatment due to be carried out. Medical staff were praised for the quality of the communications to families so that they understood the sequence of events and the likely timings around these.

- Communication with children was well thought out and effective. Staff took time to distract and comfort them during injections and blood tests. Parents were involved in the assessment and treatment of their children and clear explanations were given.
- The department was informed by GPs when one of their patients was nearing the end of their life and did not wish to be resuscitated. A copy of the correctly completed "Do not attempt resuscitation" (DNAR) form was kept in a file in the resuscitation room. This meant that it could be referred to if there was any doubt about whether to resuscitate someone. The patient's wishes would be respected. GPs were contacted on a monthly basis to ensure that that the DNAR form was still current.

Emotional support

- We saw one family being supported whilst their relative was being treated and cared for in the resuscitation room. They were given clear information and their understanding was checked. They were given the opportunity to talk within a private area. One nurse had been given the responsibility of looking after them so they received consistent information and support.
- Special attention was paid to the families of people who had died suddenly in the department. They were told they could spend as long as they like with their deceased relative in a quiet room away from the activity of the main department. There was always a member of staff available to support them. There was a team of multi-faith chaplains constantly on-call should they be needed.
- Staff in the emergency department realised that relatives often had many questions to ask following a sudden death. Therefore, next of kin were sent a letter of condolence and an invitation to return to the department so that their questions could be answered by one of the consultants. We were told that about 20% of families took up the offer. In preparation for the meeting the consultant would gather information from the ambulance service and the post-mortem results. This meant that as much information as possible was available in order to answer the families questions. If a need for bereavement counselling was identified at this meeting a direct referral could be made.
- We observed a nurse putting her arms around a young mother who was upset at the prospect of her toddler being admitted to hospital. The nurse continued comforting the family as they were walking up to the ward. She gave information about the staff on the ward, what to expect next and visiting arrangements. She also checked that the toddler's sibling was safe and comfortable.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Good

We rated the responsiveness of the service to be good. By responsive, we mean that services are organised so that they meet people's needs

Services were planned and delivered in a way that met the needs of the local population. Care and treatment was coordinated with other services and other providers.

Changes had been made to working practices in order to reduce delays. Waiting times and avoidable delays were minimal and managed appropriately. The department had been meeting the target to admit or discharge patients within four hours since June 2015. Performance throughout the year had varied from 93% to 96% which was better than most other hospitals in England. There were very few delays for ambulance patients. People were kept informed of any disruption to their care or treatment.

The needs of people with complex needs were well understood and addressed appropriately. People with dementia received care and treatment that was sympathetic and knowledgeable.

It was easy for people to complain or raise a concern and they were treated compassionately when they did so. There was openness and transparency in how complaints were dealt with. Any concerns were taken seriously, responded to in a timely way and listened to. Improvements were made to the quality of care as a result of complaints and concerns.

Service planning and delivery to meet the needs of local people

- In 2013 the Royal College of Emergency medicine (RCEM) published a report entitled "How to achieve safe, sustainable care in our emergency departments. In response to this the ED instigated closer working

practices with the adjacent NHS walk-in centre and developed their own system of monitoring the quality of the patient experience. This had improved the care of people with non-emergency illnesses.
- Plans were well advanced for expanded resuscitation facilities to meet increased demand.
- The waiting room has recently been modernised. It featured display screens which gave people information about the emergency department and the reasons for their wait.
- There was sufficient seating for the people using the department as well as refreshment facilities and a free-phone service for local taxis.
- The ED hosted a specialist ophthalmology service staffed by doctors and nurses from the eye clinic. This service saw approximately 30 patients a day to manage emergency procedures for eyes. This service had a positive reputation in the local area as opticians directly referred patients, some of which came over 30 miles to be seen there.

Meeting people's individual needs

- The ED team had changed the method of treating some wrist fractures (Colles fractures) in order to meet the needs of people with this type of injury. Previously the ED doctor who manipulated the fracture would also administer the anaesthetic to the lower arm. Following new professional guidance the anaesthetic now needed to be given by an anaesthetic specialist. However, one was not always readily available all the time. In order to prevent patients, who were often elderly, spending hours waiting staff had implemented "Elective Colles reductions". Patients would be given effective painkillers and the arm would be placed in a splint and a sling. They would be asked to return the following day when a specialist team would come to the department to anaesthetise the arm and reduce the fracture.
- Staff that we spoke with demonstrated a good understanding of the requirements of patients with complex needs. There were assessment tools for frailty and confusion that helped to identify immediate treatment needs.
- The majority of staff had undertaken training in the specific needs of people with dementia and learning disabilities and the involvement of families was encouraged. The appointment of a trust-wide learning disabilities team had improved awareness and staff felt able to contact them for advice.
- All patients over 75 years were assessed for the early signs of dementia. Those with known dementia had a blue forget-me-not symbol attached to their records. This prompted all staff to spend extra time explaining what was happening and checking understanding. They tried to treat patients with dementia in a quieter part of the department if possible.
- There was a large noticeboard displaying up-to-date information for staff regarding dementia. It included information about nutrition and hydration, assessing and treating pain and community support.
- Staff showed us some "Twiddlemuffs" that were used to reduce restlessness and agitation in people with dementia. These are knitted woollen muffs with items such as ribbons, large buttons or textured fabrics attached to the inside that patients with dementia can twiddle in their hands whilst waiting in the department. The "Ttwiddlemuffs" provided a source of visual, tactile and sensory stimulation at the same time as keeping hands snug and warm. Staff told us that they had a noticed a marked reduction in the agitation that can often result when people with dementia are in unfamiliar surroundings. The twiddlemuffs stayed with the patient if they were admitted to a ward or went home.
- If a patient was thought to need end-of-life care a butterfly symbol was hung above the curtain of the cubicle. This alerted staff to the need for quiet and calm during this difficult situation.
- Translators could be accessed via the telephone translation system provided by the hospital. However, some translators were not always available at short notice. Therefore, the department kept a record of all the languages spoken by staff. This was updated on a regular basis.

Access and flow

- Emergency departments in England are expected to ensure that 95% of their patients are admitted, transferred or discharged within four hours. During the winter of 2014/15 the department had not quite to achieved this. In the quarter from January to March 2015 93% of patients were admitted or discharged within this time. Since then changes had been made such as the rapid assessment and treatment system, enhancing the

role of patient flow co-ordinators and closer working with on-take medical teams. This has improved patient flow through the department and, since June 2015, the department had been meeting the four hour target.

- On each shift there was a patient flow co-ordinator who managed information about each patient and made sure that the results of tests and investigations were received promptly. If any delays occurred the patient was informed of the reason. In addition, a senior manager acted as "Floor manager" each day. Their role was to solve problems that might lead to delays and to liaise with the rest of the hospital in order to improve patient flow.
- During our inspection there were very few delays for patients waiting for an initial clinical assessment. No more than four minutes for ambulance patients and 12 minutes for walk-in patients. The average wait for initial assessment for the year ending April 2015 was four minutes. This was in line with the RCEM standard that states that initial clinical assessment should take place within 15 minutes.
- The ambulance service records any delays in patient handover of more than one hour (known as black breaches). This had happened five times in the last year but not at all since February 2015. This is better than most other departments in England.
- Ambulance delays between 30 and 60 minutes were minimal. They ranged from 0.004 % per month to 0.01% in the year ending October 2015.
- The average amount of time that patients spend in the department in total is 135 minutes. This is slightly shorter than the national average.
- The department did not record the time when the decision to admit a patient had been made and so it was not possible to know if delays occurred at this stage. We observed no significant delays and clinical staff told us that this was typical. The most common delays followed psychiatric referrals out-of-hours. This has been recognised as risk to patients and has been included in the risk register.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint they were directed to the nurse in charge of the department. If the concern was not able to be resolved locally, patients were referred to the Patient Advice and Liaison Service (PALS), that would formally log their complaint and attempt to resolve their issue within a set period of time. PALS information was displayed on noticeboards throughout the department and was included in patient information leaflets.
- Formal complaints were investigated by senior ED staff. Replies were sent to the complainant in an agreed (PALS) timeframe. The department employed a complaints co-ordinator who ensured that all complaints were investigated quickly and appropriately. Replies that we saw were detailed and considerate.
- We saw that learning from complaints was discussed at ED governance meetings and at nursing staff meetings. For instance, a patient had complained about the questions he had been asked at reception. Following discussion written advice was sent to all receptionists regarding the questions that needed to be asked and how to ask them. The administration manager was monitoring compliance with this advice. There was also a "learning from complaints" folder kept in the staff room. This stored many of the complaints received by the department and explored the learning that could be taken from them. We observed the folder being read by staff when they were on their breaks.

Are urgent and emergency services well-led?

Outstanding ☆

We rated the urgent and emergency care services to be outstanding for well led. By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

The department had a strong leadership team who worked cohesively together and were highly visible in the clinical environment. They demonstrated a patient-centred approach to the management of the department and fostered a strong team spirit amongst staff.

Clear governance structures had been developed and were focussed on improving patient outcomes.

Urgent and emergency services

There was strong collaboration and support between all groups of staff and a common focus on improving quality of care and people's experiences. This led to high levels of staff satisfaction across all groups.

Staff were proud to work in the department and spoke highly of the multi-disciplinary culture. They were actively encouraged to raise concerns where necessary. Staff who had "gone the extra mile" would receive a letter of commendation written by the management team which would be sent to their home address. They were actively encouraged to give feedback to the leadership team by means of monthly feedback surveys.

The leadership team understood the challenges to good quality care and identified the actions needed to address them. Safe innovation such as rapid assessment and treatment techniques and treatment of wrist fractures was encouraged and .celebrated. Senior leaders ensured continuous learning by means of the "learning bite" during handovers and daily ENP teaching sessions.

Vision and strategy for this service

- We were shown the strategic plan for the emergency department (ED), which was aimed at providing a larger modern department with the facilities to meet the needs of the local population. It included working more closely with the providers of the nearby walk-in centre and emergency ambulatory care centre in order to further reduce delays for emergency patients.
- Staff that we spoke with identified with these aims and described some of the changes that were already happening.

Governance, risk management and quality measurement

- There were effective processes in place to identify, understand, monitor and address current and future challenges to high quality care and treatment.
- The department maintained a risk register, which defined the severity and likelihood of risks in the department causing harm to patients or staff. It documented the measures to be taken to reduce the risk. We saw that the risks described accurately reflected the concerns described by staff in the department. The risk register was reviewed at least monthly by the leadership team and severe risks were escalated to the board when necessary.
- A robust governance system was in place with the production of detailed information about the department's performance which was discussed at regular governance meetings and used to demonstrate effectiveness and progress.
- Much of this information was displayed on the "Communication Cell" noticeboard and used to inform thrice weekly multi-disciplinary "Comm. Cell" meetings which are aimed at improving patient care. During the meeting staff review activity, performance, successes and any issues hampering the team from working at their best.
- The senior staff we spoke with were clear about the challenges the department faced and they were all committed to improving the patients' journey and experience.
- Where national audits had demonstrated a weakness in clinical practice the senior clinical team ensured that action plans were developed and re-audit programmes undertaken to ensure improvements to patient outcomes. For example, a new protocol for treating children with asthma attacks and the implementation of a "sepsis nurse" on each shift to co-ordinate the timely treatment of patients with this condition.
- Monthly governance meetings were held and all staff were encouraged to attend, including junior members of staff and students. We saw from minutes that complaints, incidents, audits and quality improvement projects were discussed and acted upon.

Staff told us they were clear about their roles and felt fully supported by their clinical leads and senior managers.

Leadership of service

- The emergency department had an energetic, cohesive and well-motivated leadership team. This consisted of the lead consultant, senior nurse and (non-clinical) cluster manager. They were highly visible in the clinical environment and had established an effective governance framework to support the delivery of high quality care. They demonstrated the skills, knowledge, integrity and experience needed for their roles.
- Staff told us that they trusted the leadership team and expressed admiration for them.. They told us that there was a "no blame" culture that made it easier to admit mistakes and to learn from them and they knew they would be listened to if they raised concerns.

- Debrief sessions were held by senior clinicians after difficult clinical situations.

Culture within the service

- Staff told us that they felt respected and valued by their colleagues and the leadership team within the ED.
- There was a strong sense of teamwork which encouraged candour, openness and honesty. Staff told us that the support that they received from their colleagues in the department helped them cope with the pressures which sometimes arose in an emergency department.
- The culture within the department was centred on the needs and experience of people who used the service. Several staff told us "The patient comes first".

Public engagement

- An information leaflet had been developed which explained the patient journey through the department. It gave information about the different staff who would be involved. The leaflet contained pictures, diagrams and large print so that as wide a range of people could understand it. It was offered to everyone who arrived at reception.
- Contributions are made to some of the regular mental health teaching sessions by people who have suffered from mental health problems in the past. Staff told us that this made the teaching sessions more powerful and improved their understanding of mental illness.

Staff engagement

- The leadership team ask for feedback from all staff on a monthly basis. They hand out feedback cards bearing the questions "How has it been for you? Want went well? Even better if?" A selection of feedback cards was displayed on the staff noticeboard. Themes and information were discussed at staff meetings and used to improve practice.
- The department ran an initiative called "Spotlight". Staff who had "gone the extra mile" would receive a letter written by the management team which would be sent to their home address. Managers said this added a more personal and meaningful touch to commending the good work of staff. Staff that we spoke with said that they appreciated this and that it made them feel special. Up to four of these commendation letters were sent each month and the names of staff and the reasons behind it were shared in the monthly newsletter.
- One nurse told us that she had worked in two other EDs but this one was the best. It had taken some time before a vacancy became available but it had been worth the wait because nursing standards were so high at Exeter.

Innovation, improvement and sustainability

- Following concerns about pressure ulcer prevention senior nurses worked with the hospital's tissue viability nurse to develop a risk assessment specific to ED patients. A wide range of measures had been implemented to prevent pressure ulcers. The range of devices and techniques available was displayed on a large noticeboard in the staff corridor. The information was updated when necessary. This innovation had been shortlisted for a National Patient Safety award. An article about the initiative was accepted for publication in a professional journal (Wounds UK) in July 21015.
- Finding pressure relieving devices for people with suspected broken hips had proved difficult as they can cause difficulties when taking x-rays. Nursing staff had discovered a "trolley topper" that did not interfere with X-rays. The ED matron had gained agreement from the ambulance service that they would contact the department in advance when they were bringing someone with a suspected broken hip,. In this way there was time for the trolley topper to be prepared and for the patient to use it from the moment they arrived in the department. Later patients were transferred to an inflatable pressure relieving mattress.
- Continuous learning was a feature of this department. Apart from the formal training sessions for junior doctors and nurses there was also the daily "learning bite" which took place during the main handover session at lunchtime. In addition, the emergency nurse practitioners (ENPs) undertook daily teaching sessions based on real cases that had presented in the previous 24 hours.
- The hospital holds annual "Extraordinary people" awards. In 2014 the ED was the winner of the Extra Mile team award. In 2015 two consultants won individual awards. One for his work with bereaved relatives and the other for the implementation of care rounds.
- A senior doctor had been seconded from the Acute Care of the Elderly team works for four days a week. This role provide excellent leadership for the care and treatment of the complex needs of elderly people and also ensures constant practical teaching for the whole of the ED team.

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

Royal Devon & Exeter Hospital is a teaching hospital providing medical care and services to a population of about 460,000 in Exeter, and East and Mid Devon. In 2014/2015 there were 58,814 medical admissions.

There are a total of 388 medical beds spread across 15 wards. The trust provides acute and general medicine including the following specialties: care of older people, stroke care, cardiology, respiratory medicine, gastroenterology, endoscopy, neurology, oncology, dermatology, endocrinology and nephrology.

The medical assessment unit has 43 beds in a two ward area and eight side rooms and two PODs. This is a short stay area aiming to ensure that no patient remained on the unit for longer than 48 hours. There is also a medical triage unit attached to the ward with 6 beds, one trolley and one chair facility. This is opened from 10am to 10pm and has 50-65 admissions per day and can stay open later if needed. There is an ambulatory care unit to provide walk in care for up to nine patients and aims to reduce hospital admissions.

During our inspection we visited the following wards and departments and met with patients and staff;

- Avon, Taw and the coronary care unit all of which come under the cardiology services
- Cardiac catheter laboratories, endoscopy services and the high dependency care available on the respiratory Culm East and Culm West.
- Ashburn, Bovey, Bolham and Kenn – care of older people with Bolham also specialising in the care and treatment of Parkinson's disease
- Lowman and Torridge ward – general medical wards with Lowan providing specialist endocrinology care and Torridge specialising in infection control and healthcare for older people.
- Clyst ward which is the dedicated stroke unit
- Yealm ward providing rehabilitation services
- Cherrybrook which provides specialist oncology care and treatment
- Okement which provides gastroenterology care and treatment
- Yarty which provides haematology services.

We spoke with 49 patients and ten relatives and 94 members of staff including doctors, nurses, therapists, administrators and housekeeping staff. We reviewed 17 sets of patient's notes and reviewed information provided to us by the hospital and trust.

Medical care (including older people's care)

Summary of findings

Safety in medical services was rated as requires improvement.

People were not always protected from the risks relating to the control substances hazardous to health (COSHH) as cleaning materials stored in unsecured areas that patients and the public could access. Patients with mental illness in the acute medical unit (AMU) were managed within the resources available. The environment and management of risks was not always possible to keep those vulnerable patients safe.

Management of medicines was not consistently safe and did not meet trust policies. Cupboards for intravenous fluids were not all lockable with some doors missing. This meant those fluids were not secured.

The management of patient records did not ensure patient's details were safe and that confidentiality was assured.

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

Patients received their care and treatment from competent staff who were provided with appraisals and training. But staff training to support patients with learning disabilities was limited. Dementia training varied from ward to ward so staff skills varied.

Caring for patients in the medical areas was assessed as good. Patients and their relatives spoke positively about the care they received at the Royal Devon and Exeter Hospital. Patients were treated with respect and dignity and their choices and preferences were taken into account when planning care and treatment. Patients felt included in decisions about them and were clear about their plan of care and what was happening next for them.

However, we saw two occasions when care was not always good and staff did not ensure patient dignity was maintained.

Services were mostly responsive to patient's needs. The bed management team ensured flow through the hospital. There were some delays in discharge but wards and departments were working to ensure areas of delay were identified and plans put in place to improve discharge.

The medical services were well led. At ward level junior medical and nursing staff were clear about how to ask for help and how to escalate concerns; they had confidence in senior ward staff. Staff were aware of leadership at a divisional level. Some disconnect was noted at this level with staff not sure how information they had provided was used once escalated. Staff were aware of the hospital board staff and felt they were accessible in the hospital.

Staff were aware of the hospitals vision and values and staff spoke of the family atmosphere of working in the hospital.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Safety in medical services was rated as requires improvement.

People were not always protected from the risks of substances hazardous to health. Cleaning materials were stored in unsecured areas that patients and the public could access. These areas included wards where patients were confused, had mental illness or had dementia.

The storage of some medicines was not always secure and did not meet trust policies.

Patients living with a mental illness were not always well managed in the acute medical unit (AMU). The environment and management of risks meant it was not always possible to keep vulnerable patients safe.

The management of patient records did not ensure patient's details were safe, secure and that confidentiality was assured.

The management of Early Warning Scores ensured the safety of patients whose health was deteriorating.

Incidents

- Staff reported incidents, accidents, concerns or identified risks through the trust's electronic reporting system. They received feedback and felt the trust used incidents as a learning opportunity. Staff told us that learning from other areas was also cascaded from senior staff to their area to promote trust wide learning. We saw evidence of this as part of the 'Comms Cell' meetings undertaken daily on wards and departments. Comms cell meetings were an opportunity for staff to discuss risk areas and incidents were discussed to promote good risk management
- The Trust used a two stage grading approach on the electronic reporting system. An incident was graded on the actual consequence from the outcome of the specific incident and a matrix was used to assess the potential of this incident reoccurring.
- There were six serious incidents reported associated with medical wards between August 2014 and July 2015. These included three pressure ulcers, two diagnostic incidents and one slip trip or fall. All incidents were reviewed fortnightly at the Incident Review Group. Any questions raised were discussed, resolved or cascaded to the medical division.
- Bed occupancy rates for the hospital January to March 2015 had been 90.6%; this was above the recommended level of 85%. It is considered that bed occupancy above 85% creates a higher risk to patients. The Summary Hospital-level Mortality Indicator (SHMI) for April 2015 showed that the divisional position for medicine was within the expected range. Mortality was monitored in the Trusts Integrated Performance Report on a monthly basis. Any exception in the Trusts Mortality would be reported to the Governance Committee via the Safety & Risk Report. The mortality review process was reported in the Safety and Risk Meetings, we saw minutes for the October 2015 meeting which explained outcomes from the mortality review process and also noted outcomes from a General Medicine 'Deep Dive' review of 41 sets of notes.

Duty of Candour

- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have, occurred. The hospital electronic reporting system had a function for Duty of Candour for any incident of moderate harm and above which had to be completed. Any moderate or above incident alerted the Governance Manager for medicine who had responsibility to ensure that the Duty of Candour process had been undertaken.
- Staff at all levels were able to describe what the duty of candour involved and the actions required, even if they did not understand the terminology. Staff were also aware of the trust guidance and how to access this. More senior level staff, for example ward sisters and Matrons were very clear about the trusts responsibilities and how they were involved in the duty of candour. Staff provided an example following a patient injury. Staff

had followed the process and ensured the patient's family were contacted, informed, received an apology and an explanation for the following investigation process.

- Duty of Candour compliance is monitored through the Trust's Incident Review Group and Safety & Risk Committee. A quarterly report on closed incidents and compliance with the Duty of Candour requirements was presented to the group. In the period between 24th March 2014 and the 30th June 2015 there were 19 incidents that met the criteria for review. This compliance is also reported through to the Safety & Risk Committee and is included in the monthly Integrated Performance Report.
- The Trust did not have a formal training programme for Duty of Candour however the trust told us communication, openness; honesty and transparency are central themes running throughout many training programmes.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. This covers areas including falls, pressure damage, infection control, venous thromboembolism (VTE) and catheter associated urinary tract infections. For the medicine division this showed a low prevalence of falls with harm and catheter associated urinary tract infections
- The medicine performance dashboard showed that the trust scored itself a red rating for falls assessments completed from May to July 2015, we saw considerable work had been undertaken to improve falls risks for patients. Falls assessments had been completed and were followed up daily on the ward board round. Each ward undertook at least a daily ward discussion, centred on a patient's board which was updated during the discussion. Patients at high risks of falls had been cohorted into bays together and a 'tagging' system implemented. This meant staff stayed in that bay area so they could observe patients at all times. Staff told us that this had reduced falls and increased patient safety. We saw patients walking with non-slip socks on to further reduce falls injury.
- On Ashburn ward 28 patients were identified as at risk of falls, 19 of those patients had dementia or delirium. The ward was made up of six bays of four patients each. Staff told us a side effect of the falls 'tagging' was that call bell use had decreased.
- The performance dashboard showed that for venous thromboembolism (VTE), risk assessment targets had rarely been met and showed a red rating on a number of moths since December 2014. There have been months when the Division has been green. Additionally validation of results for some months the Division has been red has demonstrated that the Division is often above 95% compliance (Green). The Division has consistently achieved greater than 90% compliance.(October and December 2014) We saw ward rounds taking place which included staff checking VTE assessments had been completed for each patient. When not completed this was seen to be followed up by staff that day and confirmed on the next ward round.
- Information provided by the trust showed a low but persistent prevalence of pressure ulcers. Between February and July 2015 0.2% and 1.5% of patients had incidents of newly acquired pressure damage between level two and level three. Patients with skin damage caused by pressure had a body chart in place which highlighted the location and description of the skin damage. The medicine dashboard showed that assessments were completed consistently around 96% of the time from January to July 2015. A care plan was put in place for staff to follow to treat and monitor the wound. Staff used the Extra Pressure Risk Assessment tool (EPRAT) for patients seen as high risk. We saw that one patient had a wound that had not been graded or reported by the electronic reporting system.

Cleanliness, infection control and hygiene

- Wards and departments visited appeared visibly clean and tidy. Hand sanitising gel was located on each ward and department and there were adequate hand washing facilities. We observed staff used the hand gel during their duties and washed their hands in the correct manner in line with the control and prevention of infection guidelines. Personal protective equipment (PPE) such as disposable gloves and aprons, was seen to be appropriately used by staff. Sufficient signage

enabled staff and the public to be aware of when rooms were used for isolation of patients at risk of infection. We observed staff following infection control practice when entering and leaving isolation rooms.

- Observational audits were undertaken each month to assess the hand washing practices of clinical staff. The trust had set coloured coded targets (red, amber and green - RAG) with 85% being amber and 90% green and included all clinical staff working in the area at that time. Each ward recorded their scores, for example Yealm ward had 95% compliance. We did not see any ward with low scores.
- Staff training for infection control for the medicine division was RAG rated green with a score of 82% of staff having completed the training.
- We saw the infection control team working on the wards. They were checking on side rooms in preparation for the next patient. Staff confirmed this was done every day.
- An infection control operation group held monthly meetings which ensured results were feedback to relevant committees and Ward areas to highlight areas for improvement or celebrate good practice. Minutes noted action plans were put in place when needed.
- The trust told us that the hospital had no cases of MRSA bacteraemia for four years.
- The Patient Led Assessments of the Care Environment (PLACE) 2015 scored the trust at 100% for cleanliness compared to the England average of 98%.

Environment and equipment

- Medical equipment was serviced and maintained on an annual basis and stickers evidenced when they had been serviced and maintained within the last year.
- We visited some wards and departments which did not ensure the safe storage of solutions used for cleaning which would be hazardous to health (COSHH). Sluice rooms/dirty utility rooms did not have the facility to lock the door. Chlorine tablets and solutions for cleaning were easily accessible. Each room had lockable cupboards but the solutions and materials were not locked away for safety. On the AMU razors were also accessible to patients who may have mental health issues and be at risk of self harm, access to these chemicals and razors did not support their safety. We told staff members on the AMU on the first day of inspection about our concerns for these risks; we revisited on the last day of inspection and found them to still be accessible.
- Records showed resuscitation trolleys and equipment were checked regularly to ensure they were in a condition to be used at any time.
- Some equipment was under review for its repair or replacement. Some incidents were reported linked to issues around endoscope disinfection processes. This had impacted on procedures being undertaken. These issues were being addressed by the trust and remained on the trust risk register.
- Staff told us the Joint Advisory Group (JAG) previous accreditation had been withdrawn as a result of environmental work needed. JAG accreditation demonstrates a hospital has the competence to deliver against national endoscopy standards and measures. The trust told us that the endoscopy unit currently has JAG level C accreditation.
- Cardiology machines were also on the risk register and plans had been put in place to address any future need for replacement parts.
- The Patient Led Assessments of the Care Environment (PLACE) 2015 scored the trust at 94% for facilities, the England Average score was 90%.

Medicines

- The trust provided a medicines management policy for guidance and information to staff. We observed staff administering medicines in a safe manner. We saw ward medicine rounds and also the administration of intravenous and controlled drugs undertaken safely. However, we saw that on Wynard North ward the controlled drugs were not well managed. The record book did not match the stock levels and staff had not been aware of the discrepancy until we raised this with them. We have since been assured this issue was addressed. We noted two occasions on other wards when medicines trolleys were left unsecured and unattended which may have meant medicines could have been taken. We also saw one instance when medicine was left on a patient's locker; this was secured when staff were made aware. We saw that on the AMU some medicines placed on the side in the unlocked medicine room. This room was open to any patients on the ward. We told staff who ensured this was locked away.

- The storage of intravenous fluids was not secure. Within Medical wards and units treatment rooms where intravenous fluids and sodium chloride and water for irrigation were stored did not reflect the trusts medicines storage policy. These rooms often lacked a door frame, door and lock. The trust policy stated "A designated area for the storage of large volume fluids (e.g. intravenous, irrigation etc.). This should be a domestically clean area that is lockable". This was seen not to be the case.
- There were 10 risks on the pharmacy risk register undated but none were currently high risk. Staff explained some delays on the Cherrybrook unit for delivery of chemotherapy medicines; this had impacted on patients with them having to wait longer than expected for treatment.
- Patients with medicine allergies had this noted in their hospital notes and they wore a red wrist band to alert staff to the potential risks of an allergic reaction.
- We saw records which showed refrigerator temperatures were monitored daily and were within the range of temperatures to ensure the safe use of the medicines.
- Pharmacy take home medicines were not raised as a problem or reason for delays. Staff told us they arrived regularly to the ward.

Records

- Patient's records travelled with the patient from ward to ward and were in two files. The medical records were completed by the multi-disciplinary team and included all diagnostic results. For example blood results and X-ray reports and the nursing notes. Nursing notes included assessments of risks and a corresponding plan of care.
- A variety of risk assessment tools were in place to identify risks of thrombosis, pressure damage, moving and handling, nutritional risks and falls. In the 17 sets of notes reviewed, we saw records were mostly well completed and personalised to ensure any specific information to support the patient's choices and preferences were included. This included information about home circumstances, religious or spiritual choices and any issues which may specifically cause the patient concern.
- The management of patient records did not ensure patient's details were safe and that confidentiality was assured. We saw during the daytime and in the evening records were accessible to the public. Trolleys used for records storage were not secured or placed away from public access. We visited one ward in the evening and saw a patient's notes open on the nurse's station on a page describing their medical details. We were able to read these details without any staff being around to stop us.
- One patient's records were seen to have a missing audit trail of how decisions about treatment had been made. This patient was considered on one page to not have capacity to make decisions whilst on the next page were seen to be able to make informed decisions. Following staff discussion it was evident that discussions and decisions made by medical staff had not been recorded or communicated. This created a potential risk for the patient.

Safeguarding

- Staff were aware of the safeguarding policy of the hospital and could describe the process to follow to raise an alert. Training was available to staff as part of their induction and updated each year. Staff were aware of their own responsibility for the protection of vulnerable patients in their care
- All staff we spoke with were aware of the hospitals safeguarding procedures. Staff were confident about what constituted a safeguarding incident and the action they would take to keep patients safe.
- Compliance with training trust wide was recorded at December 2014 as 93%.

Mandatory training

- Most mandatory training was available to staff in an online electronic format for staff to complete whilst at work. Records provided showed 97% of staff had completed training in Equality and Diversity, 83% had completed fire training and 83% had completed moving and handling training. All were RAG rated as green. The Trust mandatory & statutory training target was set at 75% and recorded an overall achievement of 86% overall.
- Staff told us they felt supported, within staffing constraints, to attend training. The Comms Cell meetings were an opportunity to be informed of any specific training available.
- Advanced basic life support (ABLS) training was not included on the list of the trusts mandatory training. However, data showed that almost 80% of staff had completed some resuscitation training.

Medical care (including older people's care)

Assessing and responding to patient risk

- Systems were in place which identified when patients deteriorated and staff were confident to explain how the response process worked. Early warning scores (EWS) were used to identify deteriorating patients. Staff identified from a series of observations when a patient was deteriorating. The scores gave criteria for action and instructions for staff to follow. These scores were recorded in the patient's records, on the ward patient board and the white board system to monitor any change in condition. As part of Hospital at Night practice, EWS scores are added to the jobs list for the on call doctors. The site practitioners can see the EWS scores on this system. Should the EWS be seen to increase above a level of three a member of the hospitals bed management team would contact the ward to see what action was being taken. We looked at records and saw EWS were consistently completed and actions recorded when scores identified an increased risk. Governance minutes showed that EWS are reviewed as part of the medical division governance systems.
- Risk assessments for moving and handling, falls, venous thromboembolism (VTE) and malnutrition screening tools (MUST) were in place for patients. These risks were also noted on the ward boards and on each ward round were checked for updates. Following the board round the nurses would meet to ensure that any identified risk assessments not yet completed would be done.
- Patients admitted from the emergency department to Acute Medical Unit were seen by the medical doctor on duty, this included the AMU consultant and the consultant on duty for their specific medical need. Some consultants would visit the AMU daily to 'find' their patients to ensure they were seen promptly. These included the haematology consultants from Yarty ward.
- The Acute Care of the Elderly team (ACE) were part of the staff in Acute Medical Unit (AMU). The team were not as visible in the emergency department as AMU . The trust advised that patients were not transferred to the AMU if it was known discharge was possible.
- We saw from reported incidents that the medical division had three hypoglycaemic incidents reported between August and October 2015. This meant that on each occasion deterioration was noted for the patient's health caused by low blood sugar levels. Each of these incidents had an informal investigation.
- Patients admitted with mental health conditions and post suicide attempt were often transferred from the ED to the AMU. During this inspection we saw several patients who had these issues. The environment and staff training was not consistent to ensure that these patients had the support they needed. Staff did not receive specific training for mental health and had not received ligature training to support any risks of injury. We were advised by the trust that this training is planned for January 2016. There was a psychiatric nurse accessible in the AMU from the older peoples team but they did not become involved in patients post suicide unless they were elderly or to offer any advice if requested.
- The trust had a psychiatric liaison nurse available on call for when assessment was needed. Staff explained that when a patient with these risks was admitted they called the psychiatric liaison lead nurse who would then attend the AMU. This timescale could take several hours for the psychiatric liaison nurse to arrive. Staff told us that during that time no psychiatric assessment or plan of care was available for those patients. The trust confirmed that these patients will have undergone a psychiatric assessment in the Emergency Department unless they are medically unfit for assessment. Patients would be seen and assessed by the nurses and doctors in AMU so whilst they may not have been well enough to see the Psychiatry team in ED they would have medical plans in place. When needed one to one support of patients with psychiatric needs by trained or untrained nurses was made available. Staff tried to ensure the environment was as safe as possible, for example cables removed, but this was not always possible.
- These risks had been identified on the hospital risk register and there were plans in place to provide a specific assessment tool with a risk rating for AMU staff to follow, but this was not yet in place. Risk assessments of the AMU did not ensure the area was safe. We saw multiple ligature risks throughout the department and cleaning solutions, chemicals, razors and medicines were seen to be accessible. There was no specific room available for patients with psychiatric needs to be assessed. This meant that offices were used which were designated space for other work. At the time of the inspection there was a plan in place to develop a room specifically to meet the needs of psychiatric patients.

- On Culm East ward there was a respiratory high dependency unit. This bay was used to cohort patient's receiving non-invasive ventilation. These patients were considered to be Level One patients' only. This meant that they did not require admission to the critical care unit and whose needs could be met with advice and support from the critical care team. Should any of these patients deteriorate or their care needs increase, then staff would discuss this with the critical care team and they would be transferred to that unit. Some staff had the training and skills to manage level two patients and should this be needed in the short term this could be assessed to ensure staff skills were current. Because they were considered to have higher dependency both men and women were admitted at the same time in this bay. This was monitored carefully by staff to ensure privacy and dignity was maintained at all times.
- Staff were aware of the high risks of sepsis and the Sepsis 6 pathway to follow. The consultants had developed a sticker to decide who was septic so they could identify who needed antibiotics within one hour. Matron checked all the sepsis six steps were done and following up any areas not seen as completed.

Nursing staffing

- Staffing levels were reviewed regularly to inform and benchmark staff numbers and skill mix. Support was available from the clinical site team and clinical practitioners who responded to staff requests for help at busy times.
- A staffing tool was used to identify staffing levels needed. A review of the nurse staffing levels was undertaken every six months in all wards and departments. To inform this review a monthly safe staffing thermometer dependency tool is used. This tool measured if sufficient staff had been available to meet patient need. The information from the audits used was then benchmarked against National Institute for Health and Care Excellence (NICE) and Royal College of Nursing (RCN) safe staffing recommendations. The last review undertaken in May 2015 approved changes to Okement Ward to enhance the skill mix by converting 2.6 Band 5 posts to Band 6 to provide increased clinical leadership, but not an increase in staff numbers.
- The worst performance of staffing levels against NICE benchmarks was seen to be at night, with five wards (Avon, Bolham, Clyst, Culm East, Culm West). We visited each of those wards at night as part of our inspection. Staff told us that staffing levels could vary but when they raised a need for help with the bed management team, they were always supported by other staff or a clinical Practioner.
- We visited the hospital at night and saw that five wards were managed by band 5 nurses and supported by the bed management team. These wards included the cardiology, respiratory, renal and older people's wards. The nurses felt that this level of staffing was safe and they were supported by the bed management team when patients' needs increased or they felt the staffing levels may not be safe. The night before our visit, the renal ward had been very busy, on asking for support the bed management team found extra staff to support them and the clinical site manager had worked on the ward.
- During the time period May 14 – March 15 the highest bank and agency usage was on Culm (Respiratory, and four High-Dependency Beds) and Torridge wards (General Medicine). We did not have data for after that time to assess if the level of usage had improved.
- Where used agency staff were provided with an induction to the ward and were supported to understand the hospital policies and procedures.
- The trust was 90 whole time equivalent staff down on their planned staff. We were not aware of how many were specific to the medicine department. Staff from overseas had been recruited to work at the hospital and were currently being supported to complete induction at the hospital. We received comments from existing staff about the difficulties encountered due to language skills of some overseas staff. This was mostly about how this impacted on the existing staff and had increased the workload for them. They told us they had escalated their concerns but no staff were able to provide us with any feedback about manager responses to their issue. The trust advised that Clinical Practice Facilitators who work in the clinical setting supported overseas nurses in understanding the systems of working within the Trust and support the acquisition of clinical skills. There has also been a 'Transition to the NHS' focus within the preceptorship course to support the overseas nurses.
- Staff told us the time given to handover of information was sufficient to discuss each patient. We observed that each staff member had a handover sheet for their patients who included a diagnosis and any specific treatment areas.

Medical care (including older people's care)

Medical staffing

- The majority of the medical core services sit within the Medicine Services Division, although oncology and radiology sit within the Specialist Services Division. The medical cover is organised into speciality teams with all levels of doctors from junior to Consultant working within that team.
- Consultant cover is in place from 7am to 10:30pm in all areas with on call consultants out of hours. Consultant presence was available Monday – Sunday with the exception of gastroenterology and neurology which did not have ward or Acute Medical Unit presence at the weekends. Consultant cover for cardiology inpatients at weekends and out of hours was the minimum.
- Gastroenterology provided elective capacity (waiting list initiative) to see pre booked patients at the weekend. The Gastroenterology ward cover for weekends and out of hours consisted of a consultant Gastroenterologists on-call, this was not to be the same consultant undertaking the waiting list initiatives. Visits by a Gastroenterologist to the Gastroenterology ward were on an ad-hoc basis during weekends and out of hours , this meant patients did not have full time access to a gastroenterology consultant. At weekends and out of hours medical transfers from AMU to Gastroenterology wards are managed by the duty consultant physician because there was insufficient gastroenterology consultant availability.
- There is a 24 hour bleed rota in place to cover gastroenterology emergencies. This meant that any emergencies for the gastrointestinal team were referred directly to them for their urgent attention.
- The medical consultant cover for AMU was two consultants available on the unit from 08:00 to 12 midday, with a further one or two consultants on duty through the day to 11pm. Overnight a consultant was on call and could be contacted by staff when needed. Staff confirmed this system worked and the consultant was accessible. This cover was in place over seven days a week.
- For the non-consultant doctors there were two middle grade doctors available on duty 10am to 10pm, overnight there was one middle grade doctor (Registrar level) and that middle grade doctor also covered the wards but not including haematology and oncology. The ambulatory care had access to a junior doctor for first assessment then a consultant review as needed; this review did not need to wait for a ward round.
- On the wards there was a senior house officer available 9:30am to 9:30pm and a further three senior house officers, one covering the wards and the remaining two covering specifically haematology, oncology, renal, stroke and healthcare for older people. A junior doctor was on duty 5pm to 10pm and a further junior doctor on duty overnight. Out of hours there were consultants on call if required.
- The junior doctors answered 90 to 100 bleep calls each night. We spoke with a junior doctor who confirmed that they were very busy but rarely went home late assuring that the work load was manageable. Referral for admission was made overnight by junior doctors, sometimes this was done incorrectly, for example we saw when a patients was unnecessarily admitted to cardiology.
- Out of hours the medical team was supported by the hospital at night team - each night there are two band 7 nurses who provided support for clinical issues, deteriorating patients and responded to any general concerns from the ward teams.
- Medical handover operated separately although the trust was working towards implementing a shared medical and surgical handover.
- Within Medicine there was a formal medical handover which took place daily at 9:30pm in the MDT room and was attended by a site practitioner and at 8 .30am on the Acute Medical Unit (AMU).
- Supporting the hospital at night the trust had implemented a new electronic method of requesting and coordinating out of hour's doctors' tasks using an Electronic Doctors' Whiteboard, with bleeps being used only to notify doctors of urgent tasks. Each junior doctor carried a mobile tablet device which contained their patient lists and a real time list of their tasks requested for completion. The Site Practitioners had visibility of the totality of the doctors' ward workload and were able to monitor and reallocate tasks to other doctors or to themselves, to ensure timely patient care.
- Junior doctors told us they felt the support and learning from consultants was very good and met their needs. The trust had a similar percentage of foundation year doctors and higher percentage of consultants than the England average.

Medical care (including older people's care)

- We observed a doctors ward round and saw the doctors treating patients with dignity and respect. We saw patients were spoken to in a manner which they found to be informative and inclusive

Major incident awareness and training

- The board meeting for July 2015 confirmed that winter planning arrangements had begun for winter 2015. The trust had in place an Emergency Preparedness, Resilience and Response policy for staff to follow to meet unexpected pressures.
- To manage extra pressures on wards the matron's supervision time had been reduced on wards from 60% to 20%, this meant that they now spent more time on the wards working clinically and less time in a supervisory role.
- Phase 1 of the plan to manage winter pressures had been put in place with 18 extra medical beds being allocated on the gynaecology ward. These beds were specifically allocated for patients planned for 'Green to Go' Discharge. Green to Go criteria meant the patients were in need of further rehabilitation before discharge but no longer required acute medical care.

Are medical care services effective?

Good

Effectiveness in the medical services was rated as good. Patients received effective care and treatment that was delivered in accordance with evidenced-based guidance, standards and best practice. The trust participated in local and national audits and used the outcomes to improve services. Multi-disciplinary working was maintained and the trust was working towards seven day services.

Patients received their care and treatment from competent staff who were provided with appraisals and training, but staff training to support patients with learning disabilities was limited. Dementia training varied from ward to ward so staff skills varied.

Management of nutrition, hydration and pain relief were all effectively managed.

Evidence-based care and treatment

- The hospital provided staff with information and guidance through policies and procedures. These were accessible through the hospital intranet (IaN). The guidance used was routinely reviewed for compliance by the hospital governance teams to ensure it was in line with national guidance.
- The hospital contributed to national audits including the Myocardial Ischemia National Audit Programme, the National Diabetes Inpatient Audit, the National Cancer Patient Experience Survey and the Sentinel Stroke National Audit Programme. We saw that where recommendations were made, action plans were in place or being considered to take recommendations forward into practice.
- A stroke pathway was in place for patients needing acute stroke treatment and care. Patients suffering a stroke would be admitted through the emergency department but would not go to the AMU. Any scanning would be done in the emergency department and thrombolysis would be commenced either in the emergency department or on the Acute Stroke Unit. An acute stroke practitioner nurse would go to the emergency department and stay with the patient until they transferred to the ward. Out of hours and at weekends a nurse would be released from the ward to collect any stroke patients for transfer. Should any stroke patient be admitted to the AMU they were prioritised to be seen and transferred out as soon as possible.
- There was a clinical effectiveness committee meeting in March 2014 which looked at the National Audit of Dementia and identified areas of non-compliance, an action plan was formalised to address these areas. These areas included staff training and a review of the pathway. Timescales for completion were not included. There was no specific dementia lead nurse. The dementia care lead was away from the hospital for the next year and their role had been divided up across the division with no one person taking control to ensure the service was adequate and progressive to develop the service.
- The divisional risk register reported a risk regarding the capacity to treat acute coronary syndrome patients with myocardial infarction from a neighbouring trust within NICE recommended timeframes. It was unclear what the specific cause of potential non-compliance was and we were unable to ascertain this at inspection.

Medical care (including older people's care)

Pain relief

- Staff used a pain chart to measure patient's pain and a care plan was put in place to ensure pain was managed effectively. Staff were observed to check if patients had any pain and should pain not be managed then we saw staff speak with doctors to increase pain relief. Patients told us that should they have pain, staff responded quickly and also went back to check the pain relief provided had been suitably effective.
- Staff explained that tools used to measure pain included observation of body language or facial expression for those patients who were not able to speak or make their pain known. Staff emphasized how important an overall consideration of the patient's presentation was to establish if patients had pain.

Facilities

- Security at the hospital was managed by a hospital wide security team. Ward staff were not trained in restraint techniques to ensure their own and other patients protection. Security staff at the hospital had received appropriate training and were called by staff when needed. Staff confirmed they arrived promptly and managed situations on the ward well. Security staff provided customised training to ward staff to meet the needs of that ward.
- No mixed sex breaches were recorded by the trust in any areas including the AMU and the high dependency bays in the Coronary Care unit and Culm East ward. Staff on the AMU were very clear that mixed sex breach never occurred.

Nutrition and hydration

- The trust used the nationally recognised assessment tool, the Malnutrition Universal Screening Tool (MUST) to measure any food and fluid risks to patients. Each patient had a MUST assessment completed and this was checked during the ward board round to ensure it was in place. Any risks seen as a result of the assessment were managed with a care plan and if needed, further dietician support. A MUST audit was done on most wards which included an initial assessment score, an audit score and a food record chart score.
- On the renal ward a specific tool was used, the Renal Assessment Nutrition Tool (RANT). A dietetic consultant was available for those patients at high risk of malnutrition.
- Speech and Language therapists were available on the Acute Stroke Unit and ward to undertake swallow assessments on patients who may have suffered swallowing damage when having a stroke. Should therapists not be available, suitably trained staff on the ward would undertake an initial assessment to recognise swallow risks. This meant patients were not kept 'nil by mouth' until a SALT therapist was available. The SALT therapist told us that as soon as possible they would review those patients to undertake the full assessment and so continue the risk management of the patient.
- Housekeeping staff were involved in meal delivery. To support them they had attended nutrition courses and liaised with members of the Speech and Language (SALT) team to discuss any specific patient needs. One member of the housekeeping staff told us they reported their information to the nurse in charge. Housekeeping staff felt their support of patients was valued by nursing staff.
- Some wards had protected mealtimes to enable patient's time to eat in a calm and quieter atmosphere. Relatives of patients were allowed to visit during mealtimes to support the patient to eat and were made welcome by staff.
- The Patient Led Assessments of the Care Environment (PLACE) 2014 scored the trust at 93%, for food compared to the national average of 88%.

Patient outcomes

- In the Sentinel Stroke National Audit Programme (SSNAP) for January 2014 to December 2014, the trust's stroke services attained an overall score of 'C', on a scale of A to E with A being the best. The main areas identified which required improvement were occupational therapy, physiotherapy and speech and language therapy. Some progress had been made between October and December 2014 with regards to the provision of occupational therapy. Therapy staff confirmed that recruitment had recently been undertaken.
- The medical dashboard demonstrated that from January to March 2015 an improvement in the number of patients spending 90% of their admission on the stroke ward.
- There were mixed results in the 2013 heart failure audit: Results showed low input from specialist for inpatients practice. There was also lower than England and Wales

numbers for patients having received a cardiac echo diagnostic test. A consultant had been appointed to take the lead for heart failure and heart failure nurses had recently been employed.

- The data provided from the MINAP audit for patients referred for, or had an angiography were 97% compared to the England overall percentage of 77%. Cardiologist consultants were not accepting of the 97% data, they felt the data was incorrect and that 97% was too high a number. We were not made aware of any action taken by consultants to address what they considered a data error.
- The latest National Inpatient Diabetes audit (NaDIA) 2013, showed good performance compared to the national England average with the following exceptions; medicines, prescription, management and insulin errors. An average of 74.4% of patients, compared to the England average of 78.8% felt staff had the knowledge to answer their questions.
- Patients who moved between wards at night after 10pm were monitored. The highest numbers were seen to be from the AMU with information provided over the last 6 months showing numbers varied from the lowest 116 to the highest 217 each month. The medical wards numbers appeared to decrease over the last six months with the exception of Okemont which had not decreased.
- We saw some delays for blood results for patients with serious conditions, with four days being waited for a blood test result and the patient unaware of the outcome to the test.
- There was a low standardised relative risk of readmission for non-elective admissions at the hospital, particularly within care of the elderly. The trust has an average length of stay similar to the England average, the only exceptions being Clinical Haematology and Neurology. The clinical staff could offer no reason for this.

Competent staff

- Staff reported training was available for them to maintain their skills though electronic learning (eLearning) and some in house training. New staff starting at the trust had new starter packs and an induction to work through. For newly qualified staff a preceptorship period of training was provided. For overseas staff an extensive induction including educational support had been started.
- Dementia training was provided for most staff in the hospital. This was for one hour and had been provided for 6,000 staff. Staff on some wards including Ashburn ward told us they had a day long training session on dementia care. Staff received dementia care training as part of induction with longer day sessions available for some ward staff.
- For patients with a learning disability, staff training was not provided as mandatory. An e-Learning module was available should staff choose to complete it. We spoke with many staff, none of whom had completed this training.
- Some staff told us that the best training they had received was about Parkinson's disease which had enabled staff to better care for those patient's needs. Staff also said they felt supported to undertake training to develop their role.
- Trust wide staff appraisals showed that appraisals had been completed with consultants 100 %; nurse's band 5-6 81.2% and nurses band 7-8 75%. However, staff supervision data showed that in July 2015 only 13.2% of staff had received supervision and the trust RAG rated this as red. The trust have told us that various different approaches are in place to ensure staff receive the supervision and support they need.
- Nursing revalidation drop in sessions were taking place by the Practice Education team and were advertised through the Comms Cell meetings for trained nursing staff.
- Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. From April 2014 to March 2015, RD&E had an overall appraisal rate of 94%. Some areas were highlighted to be addressed and an action plan was being developed.

Multidisciplinary working

- There was evidence on all wards of multidisciplinary working. This working was onwards and between departments. Patients with complex needs were reviewed by a multi-disciplinary team and the required assessments undertaken and outcomes fed back at the MDT meetings and board rounds. There were two board rounds each day on the AMU. On the ward board rounds took place throughout the day to review patients and coordinate a plan of care. The rounds included the

multidisciplinary team including consultants, doctors, nurses, therapists, psychiatric support and discharge coordinators. The ward board rounds were used to identify each patient's plan of care, any outstanding treatment plans from all members of the multidisciplinary team and to agree what actions were needed. This was an opportunity to ensure all risk assessments had been completed and work towards a discharge date.

- The white board electronic system recorded patient care and treatment. We saw that the outcomes of the board meetings were included in the white board record system to provide an overview and an audit trail for all multidisciplinary staff to follow.
- Patients receiving rehabilitation on Bolham ward had a weekly multidisciplinary meeting.
- Stroke specialist nurses attached to the Acute Stroke unit were able to visit wards that had patients who may need acute stroke care and treatment. Staff on wards told us this happened and they found it supportive. Staff also told us they appreciated the support of the staff from the critical care unit who offered support and advice and from the site practioner who was available to help.
- There was a weekly opportunity for senior nursing staff across all specialities to meet, this time included discussion about patients who needed treatment and care across specialities. Staff told us that whilst multi-disciplinary working took place the staff were aware of which clinicians had overall responsibility for the patients care.

Seven-day services

- The trust told us they had completed the NHS Improving Quality 7 Day Services Baseline Self-Assessment and each division had undertaken a more detailed self-assessment against the relevant 7 Day Services Clinical Standards. They advised the medical services division was mainly compliant with the standards.
- The Trust was approaching the implementation of 7 day services on a staged basis. Progress was being monitored through a quarterly audit process against the Clinical Standards and reported internally through divisional governance processes.
- The medical triage unit was in place to assess patients and increase access through the hospital or home. It was open 10am to 6pm seven days a week.
- The National Stroke Strategy 'target' was for a 24 hour service for suspected high-risk patients who had experienced a trans ischaemic attack (TIA) to be available 7 days a week. At the time of our inspection the TIA clinic ran on five days a week, Monday to Friday. This issue remains on the trust risk register.
- Pharmacists were accessible by bleep at all times and were available midweek via the pharmacy service. Ward based clinical pharmacy services were not provided at weekends.
- Access to psychiatric input was available by telephone within working hours. This was about to be extended to 24 hours and seven day working was planned to commence from January 2016.
- X-ray, scanning and diagnostic testing was available 24 hours, seven days a week. Urgent blood tests could be available out of hours.
- Therapy access varied from ward to ward with some wards having therapists based on the ward. These included the AMU and the Acute Stroke Unit and Clyst ward. Out of hours and weekend access was available by an on call rota.
- Emergency endoscopy services were available 24/7. Out of hours endoscopies for emergencies were managed through the emergency theatre department.

Access to information

- On admission to wards, notes were requested from the hospital record system. Staff told us these were received within a good timescale.
- Patient's notes stayed with them if they moved from ward to ward. We saw that the nurse's observation records were stored at the patient's bedside and were accessible to them. The medical notes were kept in trolleys on the wards. Further information was available on the ward noticeboards which included the patients name and a series of coded indicators to enable staff to know at a glance any risk assessments which were in place or were needed and the current state of discharge planning.
- We looked at 17 sets of notes; most contained sufficient information to inform staff of the medical care needed by the multidisciplinary team and most were completed to an acceptable standard to ensure effective information communication.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Documentation relating to mental capacity and decisions about resuscitation were well completed. We saw that when a lack of capacity was established a mental capacity assessment was completed and best interest discussion used. Audits had been undertaken which showed an increasing level of successful completion. The wards and departments recognised the importance of full completion of the forms and each had their own scores for completion, the AMU had achieved 100% compliance.
- Deprivation of Liberty safeguards were put in place when hospital staff identified a need. The documentation was included in the patient's notes and also in the site manager's office. A record was maintained of when the safeguards were due to expire and the action decided. The safeguarding team oversaw the safeguards, audited the process and produced an internal audit review. Recommendations were made around the record keeping and monitoring processes of applications, an action plan included recommendations which were all noted as completed.
- Staff training for Mental Capacity Act and Deprivation of Liberty Safeguards was completed by 87% of staff which was RAG rated as green by the trust.

Are medical care services caring?

Good

Caring for patients in the medical services was rated as good. Patients and their relatives spoke positively about the care they received at the Royal Devon and Exeter Hospital. Patients were treated with respect and dignity and their choices and preferences taken into account when planning care and treatment. However, we saw two occasions when care was not always good and staff did not ensure patient dignity was maintained. Patients felt included in decisions about them and were clear about their plan of care and what was happening next for them.

Compassionate care

- We observed staff were kind, caring and compassionate. We saw examples of staff supporting patients and their relatives to understand the care and treatment being provided. We saw that a patient had asked a therapist if it was possible for her carer to be present to enable a continuity of care when the patient went home. The therapist immediately telephoned and arranged for this to happen. This prompt action was very much appreciated by the patient.
- We observed on all wards and departments visited that verbal consent was sought from patients before providing personal care. We observed all staff introduced themselves at the start of any conversation.
- The medical services used the Friends and Family test to seek feedback about the patients experience in the hospital. Data was provided from individual wards. We saw that the response rate varied between wards for the period of time July 2014 to June 2015, with the highest patient response coming from Yealm ward. The lowest response rate was from Yeo ward. Patient satisfaction varied from month to month and ward to ward but was generally at a high level. Some wards had cards and letters of thanks from patients; these were complementary and spoke of staff kindness and support.
- In two cases we saw care and treatment was not provided with dignity and respect. One patient was left exposed with staff walking past and not ensuring the patient's dignity until we pointed this out to staff. Another staff member was seen to raise their voice to a patient and other staff intervened to readdress the situation. The staff that intervened did so with great understanding, kindness and skill.
- The Patient Led Assessments of the Care Environment (PLACE) 2015 scored the trust at 90% for privacy, dignity and wellbeing. The comparative England average was 86%.

Understanding and involvement of patients and those close to them

- We spoke with approximately 50 patients who told us doctors and nurses had given them very clear and appropriate explanations of their plan of care and treatment. They told us staff took time to ensure patients understood what was happening and what the next stage of care would be.
- The Cancer Patient Survey for 2013/2014 showed that 19 out of the 34 questions had responses which placed the hospital in the top 20% of trusts. Only one area did not score well and that related to staff not advising patients of their access to free prescriptions.

Medical care (including older people's care)

- We visited the hospital Chapel and saw that multi faith support was available. We saw staff support patient's faiths providing space and privacy for prayer.
- Some patients voiced concerns about being woken at night by patients being moved. Other patients told us that their preferences were not asked or considered. A patient who preferred to get up at 8:30am was not offered that option and staff got them up when staff routine dictated. Another patient said that despite telling staff they did not like where they were sitting, staff ignored the patient's preference.

Emotional support

- Some staff went the extra mile to make sure patients were supported emotionally to be as comfortable as possible. One elderly patient was supported to speak to a relative overseas by telephone, the call was very important to this patient; the staff supported this patient to be able to access the call and supported them throughout. Another member of housekeeping staff explained that when a patient expressed a specific sporting interest, they had printed out pictures and facts to promote a discussion with the patient to stimulate their recovery.
- We observed a family discussion taking place with a doctor. A room for use was arranged, extra chairs found and the family escorted to the room in a supportive and caring manner. The door was closed to ensure a private discussion. This was all done in a manner which showed professionalism and a caring approach to sensitive discussion.
- For patients with levels of anxiety or depression a referral could be made to the psychiatric liaison services for counselling and support.

Are medical care services responsive?

Good

Responsiveness in the medical services was rated as good. Services were mostly responsive to patient's needs. Services were planned and delivered to meet the needs of the local population. Waiting list initiatives were needed to meet endoscopy demand.

The bed management team ensured flow through the hospital. Where areas of flow through the hospital were seen not to be as responsive, governance systems had highlighted this and action plans were put in place to provide additional bed capacity. There were some delays in discharge but wards and departments were working to ensure areas of delay were identified and plans put in place to improve discharge.

Complaints and concerns were responded to appropriately by the trust and staff received learning and feedback from the complaints.

Service planning and delivery to meet the needs of local people

- As part of the hospitals plan to meet the extra anticipated winter pressures a further 12 beds had been opened to medical patients. These newly opened beds were on the gynaecological ward and were called the 'Green to Go' beds. Patients with lower level medical care needs but who needed further therapy to be ready for discharge were transferred to this ward; often this was from other medical wards. This ward was led by a matron who was a therapist with support from band six nurses.
- The respiratory wards Culm East and West, provided a Wednesday Ambulatory Care Clinic for respiratory patients. This was to support patients who with a pleural effusion (a build-up of fluid between the layers of tissue that line the lungs and chest cavity) by attending the clinic to reduce their admissions to the hospital. A further ambulatory service was available in the acute medical unit.
- The endoscopy service was not responsive to the needs of patients and had to undertake waiting list initiatives at weekends. This did not mean this was a seven day service, the initiatives were in place to meet were needed waiting lists not met in the week. Currently one endoscopy theatre was being refurbished to meet JAG accreditation and so capacity was being met by the remaining two theatres. JAG accreditation is a national standard for endoscopy units to meet.
- Additional endoscopy and theatre space was being created to meet the increased patient demand for services. Fifty nine patients were waiting longer than 6 weeks as at the end of June for an endoscopic test. Plans to address capacity issues were continuing with works in place to have an extra procedure room in

endoscopy completed in December 2015. The trust planned to review and reapply for their JAG accreditation when the endoscopy works are completed.
- Seven consultants for cardiology undertook a rota to cover for 24/7 Percutaneous Coronary Intervention (PCi) service. This is a non-surgical procedure used for treating the narrowing of the arteries of the heart found in heart disease. A further three consultants and two registrars and junior doctors provided inpatient ward cover both midweek and weekends.
- The risk register for medicine noted there was a risk of cardiac dysrhythmia being undetected, this was dated 01/08/2011, but the register was not clear from the details given why this risk was rated so highly. A cardiac arrhythmia nurse had recently been appointed.

Access and flow

- Patients were admitted to the medical services through the emergency department, the medical triage unit or on occasion through ambulatory care. The medical triage unit and ambulatory care department had been put in place to manage flow and prevent some admissions to the hospital where patients could be seen and treated then discharge without the need for admission to a ward. The week before our inspection the ambulatory care department had seen 22 patients which some had prevented admissions. Staff told us they felt this was about normal for a week.
- Access and flow was managed and overseen by the bed management team who met three times a day to assess the flow and bed status of the hospital. They gathered data the day before and reviewed this to establish how the next day should be planned. Each morning at 08:45 a review meeting took place with senior nurses and heads of each department and the current bed position and status in the hospital was discussed. A further meeting took place at 12 mid-day with clinical leads to identify any escalation and flow issues and monitor the ongoing admissions and discharges. If the hospital escalated to red, following the meeting a call was made to external stakeholders such as the local commissioning group to update them and discuss actions which could be taken to address the increase in demand. A further follow up meeting took place at 4pm to review how the bed position had developed over the day and to review any further actions needed to enable patient flow through the night. Overnight the bed management team included one staff member managing bed flow and one practice manager available for support on the ward. Senior staff were on call overnight to be contacted if bed management escalated. The on call rota included a director, senior manager and senior nurse. The on call manager and senior nurse were updated at 8pm each evening.
- When patients could not be cared for on the right speciality ward for their treatment they were sometimes cared for on another ward. These patients were known as outliers. Generally these were patients who had already been treated and were planned for discharge or could be managed safely on an alternative ward. They were in two classifications, planned and unplanned outliers. The planned outliers were transferred to the 18 additional beds on the gynaecology ward which was opened to meet anticipated winter pressures. There were 16 unplanned outliers at the time of our inspection. These patients were receiving care and treatment on surgical wards. The site management team explained that outliers were rarely repatriated to the right medical ward for their care, as multiple moves were disruptive to patient wellbeing. Systems were in place to ensure that the planned and unplanned outlier patients were seen daily by their own speciality doctor and received nursing care by staff who had the appropriate skills to meet their needs.
- The discharge process started on admission with estimated date of discharge placed on the ward round board and electronic white board. If discharges were considered simple they were organised by the ward. If complex an electronic referral could be made via the white board system to the Onward Care Team, this team was in place from another provider and organised the community support needed to ensure the patient was cared for at home. At 9:30am a virtual bed meeting took place to identify beds available in the community. Staff told us the system worked well but there were never enough available beds in community hospitals which impacted on the length of patient stay
- A discharge checklist was in use on each ward for staff to complete at each stage of the discharge process. This ensured all aspects of care had been considered.
- All patients who had been in hospital ten days over their planned date of discharge were discussed at the 10 day plus stay review meeting each Friday. At the time of our inspection there were 243 patients who met these criteria on the hospital records.

- Delays to patient discharges and transfers of care were evident. On the first day of our inspection there were 73 patients considered medically fit for discharge but were delayed by access to the community. The trust had produced a work plan to address the challenges of delayed transfers of care.
- We saw an onward care waiting list summary for 23 October 2015. On that date 118 patients were waiting discharge
- Bovey ward had 11 patients awaiting discharge to nursing homes or placements. On Kenn ward 13 patients had discharge dates with nine of these patients aiming for home rather than onward care On Ashburn ward nine patients had delayed discharges and Yealm ward had six patients with delayed discharges.
- There was no discharge lounge available for medical patients which meant ward beds may not be available for new admissions until later in the day while those being discharged waited for transport or other aspects needed for them to be able to leave hospital. A small discharge lounge was operating for AMU only in the ambulatory care area to enable an efficient use of the unit.
- Hospital staff had been involved in 'Bay 6' which worked as a community housing aid project for patients who have no fixed abode. The project provided support and assistance to patients who didn't have anywhere to go when they were discharged and prevented unnecessary additional days in hospital.
- The Stroke Support Discharge team provided staff, patients and carers with support to facilitate discharge home. They organised equipment, and transport to get the patient set up at home and supported the patient with any questions they may had.
- We spoke with patients who had been moved to several different wards during their admission; we saw the number of moves varied. However, no patients felt this had impacted on their care. Information provided showed 59% of all inpatients admitted to the hospital between April 2014 and April 2015 experienced at least one ward move during their stay. 2% of all patients admitted to the hospital had experienced four or more changes of ward during their stay and 10% of patients three or more moves. Staff and patients did not raise any concerns about patients being moved at night and late night discharge was avoided.

Meeting people's individual needs

- There is a national operational standard that 90% of admitted patients should start consultant led treatment within 18 weeks of referral. We reviewed referral to treatment times which were available from NHS England. The referral to treatment times for cardiology, dermatology, gastroenterology, general medicine, geriatric medicine, neurology and rheumatology were all meeting the national standard.
- The trust had an Interpretation and Translation Policy available on the trust intranet site. Face to face interpretation and translation services were available for all languages other than English. Sign language was available and the Royal National Institute for the Blind (RNIB) for translation into Braille. For patients identified as having a transferable infection a modified hands free telephone was available. Staff showed us how they accessed these facilities and confirmed they worked effectively.
- The trusts website had the facility to translate into a range of languages. The site also had a facility to enlarge and enhance the font used to people who had a visual impairment.
- The chaplaincy centre was always open for prayer and reflection, with Sunday Christian worship broadcast throughout the hospital. We saw that a patient who needed to pray several times a day was provided with appropriate space to do this on the ward.
- Patients with a learning disability sometimes held a care passport. This was brought into hospital with them to enable staff to have a greater understanding and insight into the patient's choices, preferences and needs. The learning disability nurse would follow up with the patient's carers if a passport was not provided to ensure staff could support the patient. The learning disability specialist nurse would develop an assessment and care plan and would follow the patient through their journey. The plan would include any issues around equipment; advocacy and ensuring mental capacity and consent were considered.
- Patients with a learning disability were supported to be accompanied by their usual carer. The carer was enabled to stay on the ward with the patient and continue to be active in their care. We saw this to be the case. When the carer was not present staff would be required to undertake the patients care needs. Staff explained that most patients with a learning disability were admitted with their regular carer; however, we saw that this was not always the case and one patient did

not have any carer with them. We saw the staff were not engaging or interacting with this patient and the patient was left for periods of time unattended. Staff training for learning disability was not mandatory and should the learning disability lead nurse not be available, then the patients' needs may not be consistently met. There was only one learning disability nurse available and so the service was not available out of their working hours. There was no dementia strategy available however a strategy was in draft and would soon be available for staff. Ken and Bovey wards provided elderly care and were developing their service to meet the needs of patients with dementia. Activities were being provided including knitting, reading and discussion. The ward area itself was not dementia friendly but the staff had recognised the need to relieve patient boredom which may have resulted in patients challenging behaviour.

- We saw that younger people aged 17 were sometimes admitted to the AMU. Staff found this situation to be difficult to manage to meet the patient's needs as they were younger and the AMU was not always the most appropriate environment for them. Staff explained that the 16- 18 year age group varied in how they emotionally managed the environment. Each patient of this age was asked which admission route was appropriate for them. Staff told us that this was not always the case and sometimes transfers took place without this discussion. This was seen to take place during our inspection.
- Systems were in place to support patients with identified difficulties. Red trays noted patients who needed help to eat. Blue plates were in place for patients with dementia to enable them to see the food better. For patients with visual difficulties white plates with red edges would help them see the plate edge easier. Finger foods were available for patients who found that form of eating easier and pictorial menu boards were available on each ward.
- Staff were seen to be responsive to emergency situations. On two occasions the emergency call bell was rang. In both instances staff responded immediately with the resuscitation trolley and team in place.

Learning from complaints and concerns

- Information was seen on wards to inform patients on how to make a complaint. The trust said that in last 6 months 98% of complaints received an acknowledgment within 3 days but only 60% were responded to within 45 days (45 days being the trust target).
- We reviewed complaints received from the medicine division. We found 201 were received 2014/2015, making it the second highest area within the trusts three divisions for complaints. In July 2015, 12 were received and in June 2015, 16 were received. Themes for complaint included issues around communication, privacy and dignity, medicines and treatment.
- Patients told us they felt confident to raise a concern but at the time of inspection nobody had done so.
- We attended a Comms Cell meeting on the AMU. We saw that complaints were responded to by senior staff on the unit and a file was maintained for staff to review the investigation and outcomes for complaints about the unit. This was used as a positive learning opportunity for staff.

Are medical care services well-led?

Good

The medical services were rated as good for well led.

At ward level junior medical and nursing staff were clear about how to ask for help and how to escalate concerns; they had confidence in senior ward staff and found them to be accessible and supportive. Staff were aware of leadership at a divisional level. Some disconnect was noted at this level with staff not all staff sure how information provided was used once escalated. Staff had an awareness of the hospital board staff and told us they were accessible and approachable in the hospital.

Both medical and nursing staff told us the hospital had a family atmosphere and was a good place to work.

Vision and strategy for this service

- The trusts annual report 2014/15 identified their charter and values had been launched together with staff. The trust values were honesty, openness and integrity, fairness, inclusion and collaboration, respect and dignity. Staff explained their understanding of the trust vision "safe, high quality, seamless services delivered

with courtesy and respect" and said that the vision and values were discussed at interview to ensure a clear understanding from the beginning of the employment process.

- The medicine division had a strategy and operation plan 2015/2016. This included workforce priorities which included recruitment and development of the medicine service. Staff were aware of the medicine division's strategy generally for their own ward or area. They were aware of plans for the future for their area.

Governance, risk management and quality measurement

- When risks were identified at ward and speciality level these were verified by the divisional governance team. Any risk meeting the relevant score would be put onto local medicine divisional risk registers. These risks were reviewed at the monthly governance meetings, with an action plan being implemented and a review date planned. We saw that the cardiology department had been identified as having some areas for development around structure and management and an action plan implemented. Staff showed an awareness of issues included on the local risk registers.
- The governance structure for the medical division followed the trust set structure. Service line staff (such as medical, nursing and other professional staff) reported to the divisional business and governance meetings. Through divisional representation at this level information was passed to an appropriate committee, for example, the trust safety and risk committee or the patient experience committee. Information was then reported through the governance committee to the trust board of directors and executive directors.
- Minutes for the medical division governance group showed that specialities presented an overview of their service and areas of risk, complaints and concern were also raised. This was an opportunity for escalation of action. Action plans were produced which identified the actions to be taken and by whom.
- Some specialities held their own governance meetings which had minutes for reference; these included older peoples care, neurology and gastroenterology. The gastroenterology audit was three monthly, minutes recorded review of mortality and morbidity with case studies included to enable sharing and communication of learning.
- There was a medical services clinical audit programme which looked at both local and national audits for the medical division. Each audit had a named lead person and timescales for completion. Comments were included to provide an audit trail of actions taken.

Leadership of service

- The medicine division had five cluster groups to cover specific areas. These were, emergency department and acute medical unit, stroke and neurology, renal and dermatology, gastroenterology, cardiology and respiratory services. Each cluster group was led at ward level by a manager, senior nurse and clinical lead. Ward staff told us they had confidence in the management at this level and felt supported by the leadership in place.
- Senior nurses from each cluster group met each Tuesday with senior nurses from other divisional groups to discuss cross division working. This included discussion about any patients who required input from different divisions, for example surgical patients with medical needs. The clinical leads meet each Monday to discuss any issues or concerns.
- The medicine division cluster groups were managed at divisional level by three main roles. These were the Associate Medical director, Divisional Director and Assistant Director of Nursing. Staff at all levels understood how this management structure worked but not all were sure how management at this level used the information provided to them. For example, staff were unclear how concerns raised were escalated through the division to the board. These concerns included concerns raised about the recruitment of overseas staff and language issues impacting on current staff.
- Information travelled from the division to the executives and board and returned by the same route. Staff told us the Chief Executive and Chief Nurse were visible in the hospital and they felt able to raise concerns with them. Staff were keen to tell us that the Chief Nurse had developed leadership training which included a 'Care Matters' monthly programme .
- The trust had in place a whistleblowing policy which staff could access via the hospital intranet. Staff confirmed they would look at the policy and feel comfortable to raise an issue if needed

Culture within the service

- Staff told us that they were proud to work at the hospital. Staff were clear that the culture of the hospital was focused on the needs of the patients. Many staff described the 'family feel' to working at Royal Devon and Exeter NHS Foundation Trust and some staff told us they had left and then returned because they preferred the hospital.
- Staff told us they felt there was an open culture, where they could raise issues and put forward ideas for the development of their ward or department. Patients told us they found the hospital culture to be welcoming and supportive.
- Staff at the hospital had welcomed the use of 'Comms Cell' meetings to promote a learning culture. The meetings were undertaken daily with all staff groups encouraged to attend. Areas of discussion included updates, new learning and complaints. Staff confirmed that when used, the meetings were a positive learning experience for all staff.

Public and staff engagement

- Volunteers were seen to be assisting on wards and told us they felt involved in the hospital. Feedback boards were in place on wards with comments and cards seen to present positive comments and notes of thanks.
- We saw a report from a visitor to the stroke unit; this was to be presented at the stroke business meeting on a patient's behalf. This would enable the patients view to be heard.
- We saw that the hospital recognised staff performance and achievement. For example, the decontamination team in the endoscopy department were awarded the Extraordinary People awarded by the trust in October 2015 and the AMU and Medical Triage Unit had been award this also.
- The NHS staff survey results for 2014 showed one area of negative finding regarding the percentage of staff receiving job-relevant training, learning or development in last 12 months.
- Swartz Rounds were undertaken by the hospital to enable staff to share experiences and learn from each other. Staff told us this was an open invitation for all staff and we saw notices to remind staff when they were planned.
- The hospital had launched a hospital magazine for staff to share information and this magazine also recognised the achievements of staff.

Innovation, improvement and sustainability

- We saw areas where innovative practice had been encouraged by the hospital board. A memory walk and interactive garden were seen. Staff told us that in fine weather they escorted patients to sit in the garden. The dementia team and Quality Improvement Academy had been shortlisted for a health journal awards in the Compassionate Care and Patient Safety categories.
- The hospital had been shortlisted as a finalist for the Patient Experience Network (PEN) National Awards for compassion work.
- Within dermatology, there was an increase in the work that could be delivered through specialist nurses and the trust were in the process of delivering an innovative hub and spoke model of dermatology provision working in partnership with neighbouring acute providers and GPs with a special interest.
- The geriatrician service has commenced roll out and will support the continued expansion of an integrated model of care to support care of patients at home.
- We saw that on Kenn and Bovey ward a senior staff member had undertaken a piece of work looking at why patient's discharges were delayed and during which part of the patients journey the delays had started. As a result staff had identified some 'quick fixes' and some areas which needed further development. This work was ongoing and had led to other areas of development on the wards which would benefit patients.

Surgery

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

Information about the service

The Royal Devon and Exeter NHS Foundation Trust provides a broad range of adult surgical services to the population of Devon and a number of services to populations further afield, including Cornwall, Dorset, Somerset, Jersey and Guernsey.

Surgical specialties provided at Wonford Hospital include trauma and orthopaedics, general and thoracic surgery, ear, nose and throat (ENT), plastic, breast, ophthalmic (eyes), vascular, head and neck reconstructive and oral and maxillofacial surgery. The hospital also carries out interventional radiology: a process using minimally invasive image-guided procedures to diagnose and treat diseases.

The Royal Devon and Exeter Hospital has 11 main surgery wards which include two surgical elective admission units and one day surgery unit for ophthalmology (eyes) at its Wonford site. There are four theatre suites: the main theatres has 10 operating theatres, the Princess Elizabeth Orthopaedic Centre has five for elective orthopaedics, the West of England Eye Unit has two, and the Centre for Women's Health (maternity, gynaecology and women's surgery) three. We have reported separately on maternity and gynaecology services.

Interventional radiology is included in this report but the management and governance arrangements for the service come under the specialist services division and not the surgical services division.

On this inspection, we visited the surgery services on 4, 5 and 6 November 2015. We visited all the surgery wards, main theatres and the two recovery areas. We met the theatre stock team (they made sure all surgical equipment for operations was in available), visited the theatre admission unit and the day surgery units. We spoke with staff, including nurses and healthcare assistants, theatre managers, and staff from anaesthetics and recovery. We met the divisional surgical services management team, senior managers, ward matrons, ward sisters, consultants, and junior doctors. We also talked with pharmacy staff, housekeeping staff, and physiotherapists. The total number of staff we spoke with was 76. We met with 29 patients and six of their relatives and friends. We observed care and looked at records and data.

From January 2014 to December 2014, there were 35,200 operations undertaken at Wonford Hospital of which 48% were day cases, 26% elective surgery and 26% emergency surgery. Emergency operations performed for the same period were 17% ophthalmology, 21% trauma and orthopaedics 36% general surgery and 26% other surgery.

Surgery

Summary of findings

We have judged surgery overall as good.

Staff were open and honest about incidents and knew how to report them using the trust system. We saw evidence of learning from incidents and changes to practice that had taken place as a result. The trust encouraged an open culture. Staff were aware of the principles of duty of candour and always apologised to patients when things went wrong.

We observed good use of five steps to safer surgery that included the surgical safety checklist and briefing sessions, which all staff were aware of their roles and responsibilities. All the wards and units we visited were clean and staff followed infection prevention and control protocols. We heard high praise from patients for the domestic staff. The trust had no reported cases of hospital associated methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia since September 2011.

The hospital performed well in a number of national audits, including the Patient Reported Outcome Measures (PROMs) for April 2014 to March 2015 which is based on patients reporting to the hospital on their outcome following surgery for groin hernias, hip replacements, knee replacements, and varicose veins. The trust also performed well in national cancer audits, including those for lung and bowel cancer. A number of the surgical specialties were involved in national audits and were introducing new initiatives including a remotely led clinic for monitoring patients with prostate cancer.

There was a slightly lower risk of readmission for non elective patients compared with the England average. The average length of stay (LOS) for surgical patients within the hospital was the same as the England average.

All the feedback we received from patients and their relatives about their treatment by staff was positive. Patients gave us individual examples of where they felt staff 'went the extra mile' and exceeded expectations with the care they gave. Patients felt staff maintained their privacy and dignity at all times and provided them with compassionate care.

Between April 2013 and February 2015, the trust performed better than the England average for the percentage of admitted patients seen within the 18-week target time following referral. The number of operations cancelled at the hospital was below (better than) the England average until the months of October to December 2014. The percentage of patients not treated within 28 days of a cancelled operation was above (worse than) the England average for January to June 2015. This improved and, at the time of our inspection, the number of patients not rebooked in the 28-day time scale was below the England average.

Staff supported people with a learning disability and those living with dementia to improve their experience of hospital. Staff were kind and patient with people living with dementia and we observed one-to-one care taking place. A specialist team of nurses in the hospital provided support to patients living with a learning disability and staff caring for them.

The service leadership was good, and a cohesive clinical governance structure showed learning, change and improvement took place. Managers regularly reviewed the approach to risk management in the departments. A number of specialty meetings fed into the overall clinical governance and provided board assurance.

The trust used patient feedback to make changes to its services.

We found patient records were not being stored securely on the wards so unauthorised people potentially had access to them.

We found Patient Group Directions (PGDs), (written directions that allow the supply and / or administration of a specific medicine by a named authorised health professional to a well-defined group of patients for a specific condition) were being used without the correct trust authorisation and this potentially breaches the Human Medicines Regulations and this potentially placed both patients and staff in the West of England Eye Unit (theatres and the day unit) at risk.

The sickness rate for surgical services was also above the NHS national average.

Surgery

Are surgery services safe?

Requires improvement

We have judged the safety of surgery services as requires improvement.

Patient confidential medical records were left in unsecured trolleys, potentially allowing unauthorised people access to them.

The surgical services sickness rate was above the NHS national average.

We found in the West of England Eye Unit (theatres and day unit)that PGD were being used for certain types of medicines without the correct trust authorisation being in place which potential placed the member of staff and patients at risk of unsafe care.

However, staff were open and honest about incidents and knew how to report them using the trust system. We saw evidence of learning from incidents. Staff were aware of the principles of duty of candour and always apologised to patients when things went wrong.

There was good use of the surgical safety checklist and all staff were aware of their roles and responsibilities.

All the wards and units we saw were clean and staff followed infection prevention and control protocols. We heard high praise from patients for the cleaning staff.

Staff updated their mandatory training and met trust targets for levels of compliance with this.

There was a good range of safe and well-maintained equipment and there were records to support this. The majority of patient records were completed well. There was a clear and well-followed process for responding to acutely ill patients.

Incidents

- All staff we met were open and honest about reporting incidents. They told us all staff had access to the trust's reporting system. A senior member of staff told us the trust had included a feedback button on the incident reporting system so all staff were contacted by a manager once an investigation or review had taken place. Staff in the surgical services' governance team told us they tried to get staff to put their name on the incident report form so they could directly feed back to them, rather than reporting anonymously. The vast majority of staff we spoke with from theatres, units and wards said there were no barriers to reporting incidents. Staff said they were encouraged and reminded to report incidents by senior staff and received feedback. Junior doctors we spoke with told us they all knew how to report incidents using the trust's system. They told us there was an open culture for reporting incidents and errors. Staff from all areas within the surgical division told us they felt listened to by senior staff following any incidents and gave us examples of learning from these. We were shown by a senior member of staff, evidence of learning from an increase in surgical site infections for spinal patients. The trust had identified this and put actions in place. We saw the action plan, which included speaking to patients at their pre-operation assessment about showering and hair washing using a specialist skin preparation. The trust set up a working group to monitor the actions. At the time of our inspection, not all the actions were in place so the trust could not assess their impact.
- Staff on Otter ward told us about their learning and actions following two incidents. This related to incidents where skin grafts had failed following an operation. A new form was devised by the trust for recording the monitoring of skin grafts, with a senior registrar or above reviewing the grafts twice daily, seven days a week.
- The surgical services division reported four serious and moderate harm incidents to the Strategic Executive Information System (STEIS) for the year 2014/15. These included slips, trips, and falls, and poor patient care. We saw the trust discussed these in governance meetings and managers shared learning with staff in ward or unit meetings.
- We saw mortality and morbidity meeting minutes for urology, the acute surgical team, ENT, maxillofacial and anaesthetics. These varied in the details they contained. For example, ENT was about discussing individual cases where as urology included this and monthly audit review. Not all minutes contained an attendance list but we saw the urology meeting had input from the ward nursing staff.

- The minutes from the acute surgical team reported areas of good practice followed by key issues, audit results and recommendations following reviews of individual patient cases. Actions stated findings were to be fed back to the surgical services' governance team.

Duty of Candour

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2009. This related to incidents or harm categorised as 'notifiable safety incidents'. Staff were aware of the Duty of Candour regulation. All staff that we spoke with understood the principles of openness and transparency that are encompassed by the duty of candour. We were told that incident reporting system automatically alerts staff when an incident is subject to the duty of candour.
- The governance team for surgical services showed us details of how they monitored Duty of Candour incidents on a monthly basis. They showed us one incident as an example. This incident related to the death of a patient. We saw a letter sent to the patient's family. The trust had a standard letter but staff were able to change this if required, and this included an apology. We saw records of contact with the family and staff told us that more contact may have taken place but this was recorded elsewhere. The investigation was completed and a discussion with the family was planned to take place. The families were offered the opportunity to discuss this with the key staff involved in the care of their relative.

Safety thermometer

- As required, the hospital reported data on avoidable patient harm to the NHS Health and Social Care Information Centre each month. This was nationally collected data providing a snapshot of avoidable patient harms on one specific day each month. This included hospital-acquired (new) pressure ulcers (the two more serious categories: grade three and four) and patient falls with harm. The report also included catheter and urinary tract infections (UTIs) and incidence of venous thromboembolism (VTE). This information was on display in all the surgical wards. The data collected from July 2014 to July 2015 showed the surgical services division had a low occurrence of category 2-4 pressure ulcers and catheter-associated UTIs. They also had low occurrence of falls with harm, with none detected since November 2014.
- The trust monitored its VTE assessments using the definition of the national Safety Thermometer (this was if they had a VTE assessment in place) which was showed they were constantly above the 90% target and had been since September 2013.
- The surgical services performance overview for July 2015 stated they were at 98.5% for the absence of new harm free care. This was above (better than) the national threshold of 90%.
- There were public displays of the results of avoidable patient harm data on the wards.

Cleanliness, infection control and hygiene

- The operating theatre and recovery areas we visited were visibly clean, well maintained and organised. The wards and units were also visibly clean and maintained.
- Clinical waste was managed in line with 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.
- We observed staff washing their hands and using hand gel in between patients. All staff we saw on the wards, in theatres and in the units we visited were bare below the elbow and they had access to hand gel and hand washing facilities.
- The trust told us they had a central unit for the decontamination of powered alternating pressure relieving mattresses. We did not view this area.
- The hospital sterilisation and decontamination unit (HSDU) had clear procedures in place for the management of dirty and clean surgical instruments and equipment. Strict operating procedures existed to make sure patients were not at risk of cross infection. Staff in theatres told us they were able to turn around some equipment quickly if required and staff told us this had not led to any delays in theatre. The trust told us there was a programme of compliance audits for the HSDU including internal and external audits to ensure their compliance with the relevant bodies and standards.

- The trust reported there had been no hospital-attributed cases of Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia (blood stream infection) since September 2011. For the whole trust, they reported, 35 cases of Clostridium difficile (C-diff) against a target of 35 for 2014 to 2015. There had been four incidents of C-diff reported from January to July 2015 in the surgical services division.
- Compliance with screening for MRSA in elective and non-elective patients was audited for each speciality. The trust's target was 90%, with results from January to June 2015 showing for one month they had met this target but for the rest of this time they were just below their target ranging from 87% upwards.
- We saw the patient cleaning equipment audit results from May to July 2015 for the surgical services division. This included all the wards, theatres and day units. The trust target was 95%. All areas were compliant except for PEOC theatres for June when they scored 89%.
- The hand hygiene audits for the surgical division were just over 90% from April to July 2015 against a target of 85%. Capener ward was below the target, running between 60% and 75% for this period.
- The main theatres' recovery ward displayed their hand hygiene results for October 2015 achieving 100%. Main theatre scored below the trust's target. Actions had been listed for staff to follow to improve the score. For example, "staff to use hand gel after leaving zone 5".
- Patients recognised good cleaning. The hospital trust had scored well in cleanliness in the patient-led assessments of the care environment (PLACE) surveys in 2014 and 2015. In 2015, the trust improved its score to 97.5% from 96.35% in 2014. All patients we spoke with told us the standard of cleaning on the wards was very good.

Environment and equipment

- There was safe provision of resuscitation equipment. Trolleys and equipment including defibrillators in all areas were required to be checked daily, with records showing this was usually done. However, we did see in the main recovery area that there were some gaps in the recording of the checking of this equipment. A member of staff told us the main theatre staff were responsible for the checking of this equipment when we asked why gaps were present the member of staff did not know why. The trolleys were well located within wards, units and theatre areas so they stood out and were easily accessible. All the resuscitation trolleys were locked 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.
- Theatres and recovery rooms 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 may have required when caring for a patient. Emergency call systems were in place which we were told were tested regularly.
- All medical equipment in theatres, wards and units had been serviced and maintained in line with manufactures guidance. All equipment had a history log where all maintenance work and any breakdowns. All work was undertaken in accordance with the Medicines and Healthcare Products Regulatory Agency (MHRA) Guidelines for Managing Medical Devices (April 2014), manufacturer service recommendations, quality systems management and safety testing.
- The trust had targets in place for maintaining all equipment based on its rating priority of high, medium or low priority. The target for high-rated equipment was 95% and this was achieved for the year 2014 to 2015. Medium priority equipment had a completion target of 70% and had achieved 85% for the same period.
- A new tracking and tracing system for surgical equipment had been implemented. Staff in theatres showed us how they used this. All equipment used during any operation was recorded, including theatre instrument packs, implants and any other specialist equipment. Staff showed us how they scanned the bar codes into the computer system which automatically generated a record. Bar-coded stickers were also placed into patients' notes so that any equipment could be traced in case any issues were ever identified. The computer system was also used for ordering and monitoring of equipment used.
- The staff on the wards told us they were able to access equipment they required for a patient. For example, pressure relieving equipment. Staff were able to access equipment from the medical equipment library as required. Staff in recovery told us they ordered the equipment they needed for each day in advance, so it was available when patients came out of theatre.

Medicines

- Some medicine practices potentially placed patients at risk of unsafe care and treatment.

- We saw good recording of patient allergies on their medicine administration records on the all the wards we visited.
- The trust was monitoring its antibiotic prescribing. They looked at for example, how many patients were on antibiotics, the route they were being given (either orally or intravenously) and if they had a documented plan in place for their use within 72 hours. The trust had targets in place for points mentioned above. For July 2015 they had 39 patients in the surgery division on antibiotics, of these 80% had a documented plan in place for their use within 72 hours. This was below the trust target of 95%.
- We saw a patient, living with dementia on Lyme ward had been prescribed two medicines for agitation. These medicines were to be given as the patient required however there were no instructions on the medicine administration record or a care plan to inform staff when it should be used. Staff told us they knew the patient and when to administer the medicine.
- Staff in the main theatres' recovery checked the controlled drug medicines every day and records were maintained of this. This medicine was stored in appropriate locked cabinets.
- We reviewed the medicine arrangements in the West of England Eye Unit. We found outpatient prescriptions were stored securely and appropriate records were kept of these. The unit had a refrigerator for storing some medicines which staff recorded the temperature each day. Records we saw indicated the medicines refrigerator might have been running too cold as the fridge refrigerator thermometer indicated the temperature was outside of the recommended temperature range (-0.8C). We reported this to a member of staff, they were aware of this, and it had been escalated to senior staff.
- In the West of England Eye Unit (theatres and day unit), we found Patient Group Directions (PGDs these are written directions that allow the supply and / or administration of a specific medicine by a named authorised health professional to a well-defined group of patients for a specific condition) in use. Operating Department Practitioners (ODPs) are not listed as being a recognised group of staff in line the regulations governing these directives. ODPs in this unit were administering certain medicines. The trust had completed risk assessments detailing they were in breach of this legislation and this placed staff at risk. Whilst the trust had policies and procedures and processes to manage Patient Group Directions (PGDs) we have identified that some printed PGDs were not copies approved by them as required.
- We also reviewed some of the medicine arrangements on Tavy ward. To aid discharge of patients during the week discharge medicines were co-ordinated by the pharmacy medicines technicians rather than being sent to the pharmacy to be dispensed so this speeded up the process. Pharmacy medicines technicians also provided information to patients about their medicines.
- To Take Out (TTO) packs of certain medicines were available to aid patient discharges when pharmacy was closed.
- The storage of intravenous fluids was not secure. Within surgery wards and unit treatment rooms where intravenous fluids and sodium chloride and water for irrigation were stored did not reflect the trusts medicines storage policy. These rooms often lacked a door frame, door and lock. The trust policy stated "A designated area for the storage of large volume fluids (e.g. intravenous, irrigation etc.). This should be a domestically clean area that is lockable". This was seen not to be the case.

Records

- Patient records were not stored in a way that protected confidentiality and prevented unauthorised access. We found on all the wards we visited that patients' notes were stored on note trolleys but these were not secured or able to be locked. For example, on Lyme ward, we found they were stored opposite the main nursing station but the trolley was not secure as it had open slots where patients' notes were stored. The notes were placed in slots in the trolley and unauthorised people were able to gain access to these.
- There was a set format of documentation used on all wards for patients undergoing surgery. This included core plans of care for particular surgical procedures that staff personalised for each patient. Staff were able to write individual plans of care if a patient's needs were not covered by a core care plan, this enabled plans to be individualised as required. We saw this in place for one patient.
- A risk assessment had been completed for falls and one of the actions was to provide one to one care from a member of staff which we observed was in place.

- We reviewed the records of 18 patients and found all risk assessments and care plans for their assessed needs were in place. Some patients' nursing records were computer-based and we found access to these was restricted. We saw medical and nursing entries in notes were clear, dated and signed.
- Elective patients seen pre operation had their care planning documentation for surgery started by the nurses in the clinic. We also details of this assessment recorded in the patient's medical records if they had any tests undertaken, for example, blood tests.

Safeguarding

- Staff were up-to-date with their safeguarding training, which enabled them to recognise and respond to concerns about the safety of a vulnerable person. The training records for safeguarding vulnerable adults showed 87% of staff in the surgical services division were compliant with the training. That was above the trust target of 75%. For child protection training the majority of staff had completed this at the level appropriate to their role and interaction with children.
- Staff we spoke with were clear about reporting safeguarding. They understood their responsibilities and the trust's processes for reporting any suspected abuse. Safeguarding leads (staff whose roles were specifically to do with safeguarding) for the trust visited wards to provide advice and support for staff, and staff told us they knew how to contact them if required.

Mandatory training

- Mandatory update training was meeting trust targets. Staff were trained and updated in a wide range of statutory and mandatory subjects at various intervals. The training included a wide range of topics such as fire, infection control, equality and diversity and manual handling. Staff told us that some of this training was undertaken either face-to-face or via e-learning. The overall mandatory training completion figure for the surgical division was 89%, above the trust target of 75%.
- Staff told us they were mostly on target with their mandatory training. However, due to the recent increase in patients and demands on the service, some staff told us they could not complete their training.

Assessing and responding to patient risk

- Risks to patients who were undergoing surgical procedures was assessed and their safety monitored and maintained.
- The hospital had a policy for monitoring acutely ill patients, which was in the process of an audit for effectiveness. The hospital had implemented the Early Warning Score (EWS) system 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. We looked at 18 sets of patients' notes in all the surgical wards and units. We saw the EWS forms completed and used appropriately in the records we reviewed. Staff told us they knew what to do if the score was elevated, for example obtain medical advice.
- The trust had completed an audit of the use of EWS from December 2014 to July 2015. One of the areas reviewed was whether patients' EWS scores were correctly added up. Ninety one percent of records (136 out of 150) were correct. This showed overall that the EWS system was working well on the wards. If the score was elevated and the staff had a system to follow on what actions they took next.
- The hospital had a rapid response team (called the MET: Medical Emergency Team) to respond to emergencies around the clock. The MET team had specialists in resuscitation and emergency care. Following an incident on one of the surgical wards where an acutely ill surgical patient did not receive the correct care, a senior surgical doctor now attends these calls.
- Patients were assessed pre-operatively. The pre-operative assessment unit assessed day surgery patients (some by telephone) and most surgery inpatients. Assessments of patient general health and any medicine or other potential complication was considered before surgery could take place. Anaesthetists also provided patient assessment and consultation through the pre-operative clinics.
- The hospital was using the five steps to safer surgery, which included the surgical safety checklist (this is a tool for clinical teams to improve the safety of surgery by reducing deaths and complications) in all surgical procedures. 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. The

trust had a policy in place called 'Safer Surgery', dated August 2015. This provided staff with details about how to make surgery safe for all patients. It also included the responsibilities all staff had to undertake.

- We saw the five steps to safety checklist being used in interventional radiology. Audits of the use of the checklist undertaken by this department from May 2014 to September 2015 showed 15 out of 17 audits were compliant. Where issues were identified, actions were recorded to address these.
- The trust had completed an audit of their compliance with their safer surgery policy. This included the use of the surgical safety checklist from January 2014 to December 2014. For all their theatres and they had compliance rates of 98% to 100%. The trust made changes to their policy in November 2014 and had audited compliance with this from January 2015 to March 2015. This showed all theatres had compliance rates of 96% to 100%. The audit included staff training and the inclusion of information about the policy changes in local staff induction.
- An audit of the sign-out procedure for patients from two of the day surgical units found no concerns and demonstrated staff were following their procedures.
- We observed good practice in the operating theatres, with staff adhering to the relevant parts of the safer surgical checklist. All staff involved were present and included with no distractions during this process. We also observed practice which appeared 'natural' (not being performed for our benefit), and well embedded. We saw appropriate records being completed as part of this process, both paper-based and on the computer system. We also observed these checks in the West of England Eye Unit where the surgeon and other staff were seen to be checking the patients' identity and what operation they were having prior to the start of the operation.
- 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 was also recorded.

Nursing staffing

- There were high levels of nursing staff sickness on some of the surgical wards, however this did not impact on patient care.
- Eleven out of the 12 surgical wards were meeting their nursing establishment.
- The trust told us that every six months they reviewed all inpatient ward areas' nurse-staffing levels. The dependency tool used was a nationally recognised dependency tool that was based on NICE guidance. The last review being carried out in May 2015 and recommended adjustments to the skill mix on Lyme ward to allow for increased senior cover by increasing the number of band six roles. Otter ward had a vacancy rate of 5.2% or 0.98 Whole Time Equivalent (WTE). For Otter ward, the review recommended increased registered nurse cover at night Monday to Friday and an adjustment in skill mix to increase the number of band six nurses. These changes were going through budget setting at the time of our inspection.
- The sickness levels within nursing in the surgery services division were above the NHS national average of around 4%. Data we were provided for the last financial year showed for bands two to four it was 5.5%. For bands five to six it was 4.2%. For bands 7 to 8, it was below the NHS national average for the same period at 3.5%.
- During the period from May 2014 to March 2015 the median bank/agency use for the period was 7%.The highest usage of bank staff was on Otter, Abbey and Dart wards. Each had median bank/agency usage above 20% with Otter and Knapp wards peaking at 46% in March 2015. Otter ward was now up to full staffing establishment and they have no staffing vacancies.
- Bank/agency staff were given an induction into the ward or unit and this covered for example, fire exits and alarm points. They were included in handovers of shifts so they were aware of patient's needs.
- On the first day of our inspection in the main theatres' recovery unit, a member of staff was off sick. Cover was obtained from within the main theatres' department and staff told us they always tried to cover where they were short. Theatre staff told us they used the same three agency staff for the scrub area for continuity for the department.
- In main theatres, they had 15 whole time equivalent (WTE) vacancies across scrub and anaesthetics at band five. In the Princess Elizabeth Orthopaedic Centre (PEOC), they had one band 5 vacancy in anaesthetics. They told us recruitment of staff was on going.
- Handovers took place between each shift on the wards, units and theatres. Information about patient's condition was shared with all staff. We observed a

handover in recovery. The nurse in charge discussed with all staff the theatre lists that were taking place, who would be working where and about any patients that required extra support from them.

Surgical staffing

- Surgical staffing numbers meant patients received safe care and had access to consultant-led care. The hospital trust had a medical staffing skill mix similar to the England average. Around 46% of medical staff were consultant grade (England average 41%). Middle grade staff levels were 7%, below the England average of 11%. For the registrar group the trust was at the England average of 37%. For junior doctors the trust was just below at 10% compared to England average of 12%. The trust had identified on their risk register they did not have enough junior doctors for trauma and orthopaedics and they had employed trust grade doctors to supplement the rota to make sure they had enough numbers to cover all shifts.
- Nursing staff said they felt well supported by the medical teams. Although some of the wards did not have doctors based there, they usually came quickly when requested and did spend most of their time on the wards on weekdays between.
- Doctors and nurses across surgery reported excellent consultant presence and 7-day consultant working. Most specialties in surgery had daily consultant-led ward rounds, while some others were twice daily.
- Junior medical staff reported they were well supported by consultants in surgery and that they were always able to discuss issues with them.
- Use of locum doctors was reported by the trust to be relatively low in the surgery division. The median monthly percentage of wage expenditure on locums was 1.3% (range 0.0 – 3.3%) from April 2014 to March 2015.
- We observed a handover meeting between two teams of doctors, one team were finishing the on call and the other were taking over the on call. They discussed patients that had come in, their planned treatment, and any other patients assessed as requiring medical support.

Major incident awareness and training

- Staff told there was an e learning module for major incident training that all staff needed to complete. In case of a fire, each ward had a 'grab bag', which included equipment for moving patients urgently, patient name bands and medicine bags. Staff told us that this had been used when three wards needed to be evacuated due to a gas leak.
- Staff in theatres told us there was a procedure for them to follow if a major incident took place. All staff on duty would be given dedicated roles to undertake.

Are surgery services effective?

Good

We have judged the effectiveness of surgery services as good.

The hospital performed well in the Patient Reported Outcome Measures (PROMs) for April 2014 to March 2015. These patients reported to the hospital on their outcome following surgery for groin hernias, hip replacements, knee replacements and varicose veins. The trust also performed well in national cancer audits including those for lung and bowel cancer.

There was a slightly lower risk of readmission for non elective patients (readmission rates after surgery due to corrective measures or infections) compared with the England average. A number of the surgical specialties were involved in national audits. New initiatives, including a remotely led clinic for monitoring patients with prostate cancer was introduced as a result of audit review.

The average length of stay for surgical patients in the hospital was the same as the England average. In the hip fracture audit for 2013/2014 the length of stay for patients was better than the England average at 12.8 days when compared to 19 for the England average.

Staff managed patients' pain well, with access to and input from doctors, and nurses who specialised in pain management. Patients' nutrition and hydration was also well managed.

There was good multidisciplinary working among the staff.

Evidence-based care and treatment

- Policies and guidelines were readily available on the trust intranet. These were seen to be up-to-date. Care pathways complied with National Institute for Health and Care Excellence (NICE) guidelines.

- Staff on the orthopaedic ward and urology wards told us about an enhanced recovery programme they followed for patients after their surgery. Enhanced recovery is a modern, evidence-based approach that helps patients recover more quickly after having major surgery. For example, elective hip fracture repair patients. This had resulted in patients having reduced length of staff which was better than the England average. The trust performed better than the England average for patients seen by an orthopaedic geriatrician pre operation (70% compared to 51%). Staff on the elective trauma and orthopaedic ward said they had excellent support seven days a week from the orthopaedic geriatrician.
- All enhanced recovery patients for urology were followed up with a telephone call 72 hours after discharge. This was to follow up on their progress and to provide the patient with the opportunity to ask any questions etc.
- Patients were assessed for risks of VTE prior to surgery, in line with the NICE guidance. Pneumatic compression boots were worn theatre to reduce the risk to patients of VTEs (blood clots). There was evidence in patient records of the use of prophylaxis injections or tablets (proactive prevention) for VTE.
- VTE assessments were recorded on the medicine administration records and were clear and evidence-based, ensuring best practice in assessment and prevention. We saw these had been completed as per the trust's protocol

Pain relief

- Patients' pain was assessed and managed effectively.
- We saw a number of patients post-operation, one of who had an epidural in place to manage their pain**.** A member of staff told us about the information they monitored and recorded for patients with epidurals. For example, if the patient was hallucinating, this is a known effect of the medicine**.**
- Staff told us they routinely asked patients if they were in pain. We saw on patients' medicine administration records that they were given pain relief at regular intervals.
- Staff used a pain chart to measure patient's pain and a care plan was put in place to ensure pain was managed effectively.
- Patients told us they would ask staff for pain relief if required and they told us their pain was well controlled.
- The acute specialist pain team were available Monday to Friday during office hours. Staff told us they could contact the team during these hours and they routinely visited wards to see post operation patients as required. They would team review patients and the records staff made to assess the effectiveness of patients' analgesia. Outside of this time, an on-call anaesthetist provided support and advice.

Nutrition and hydration

- People's nutrition and hydration needs were assessed and met.
- The trust used the Malnutrition Universal Screening Tool (MUST) to assess patients' risk of malnutrition. If on assessment a patient was identified as being at risk, the computer-based system prompted the staff to put a care plan in place. On Otter ward, patients receiving nutrition by a nasogastric tube (a tube into their stomach) were considered as being at high risk of malnutrition. A dietician who specialised in head and neck patients assessed and provided support and guidance on how to meet their individual needs.
- We saw that the management of patients' fluid balance was good. Fluid charts were in place and those we reviewed for patients who had undergone major surgery, were very detailed and had totals for input and output. These also included measurements from any drains or other equipment they had in place.
- Patients told us they were offered medicines to prevent their nausea and vomiting post operation.
- Staff told us how a poor or deteriorating fluid balance was often an early indicator of possible problems to investigate. For patients able to take their own fluids, drinks were available and within reach. Staff on Dyball ward told us they were able to offer patients flavoured teas, for example lemon or peppermint, in addition to normal tea and coffee. This helped to encourage them to drink.

Patient outcomes

- The hospital performed well in the Patient Reported Outcome Measures (PROMs) for April 2014 to March 2015. These patients reported to the hospital on their outcome following surgery for groin hernias, hip replacements, knee replacements, and varicose veins. For groin hernia repair, hip and knee replacements, the trust scored above the England average. For varicose veins, the trust scored the same as the England average.

- Hip fracture performance for the year 2013 to 2014 was better than the England average in all audit measures. The average length of stay was 12.8 days when compared to 19 for the England average. In one other measure for pre-operative assessment by a geriatrician, the hospital performance had declined over the previous year, but was still better than the England average.
- The trust performed well in national cancer audits. In the lung cancer audit, the trust was better than the England average for discussing patients at a multidisciplinary level, and receiving timely surgery. In the bowel cancer audit, the trust was better than the England average for discussing patients at a multidisciplinary level, being seen by a clinical nurse specialist, and receiving a relevant scan. The trust was also above the England average of 87% for having well completed data in the bowel cancer audit. They scored 95%.
- The hospital complied with 16 out of the 29 measures for the first National Emergency Laparotomy Audit (NELA) 2014. This included pathways for the management of patients with sepsis and for the enhanced recovery of emergency general surgery patients.
- Patient readmission rates after surgery (due to corrective measures being needed or infections) were variable between elective (planned) and emergency surgery. When reviewing the data for all surgical specialities from December 2013 to November 2014 (in relation to how many procedures were performed) the trust was higher than the England average.
  - Urology had the highest elective surgery relative risk of readmission rate
  - For emergency surgery, the trust's relative risk of readmission was lower than the England average.
  - Ear nose and throat surgery was higher than the England average for the relative risk of readmission.
- The average length of stay for surgical patients within the hospital was the same as the England average. It is recognised as sub-optimal for patients to remain in hospital for longer than necessary and a barrier to other patients being admitted. The latest data produced for the trust by the Health and Social Care Information Centre covered 2014 with the following results:
  - For all elective surgery the length of stay was 3.1 days (England average 3.1 days.
  - For emergency surgery 4.5 days (England average 5.2 days).
  - Within elective surgery, there were longer stays than average in trauma and orthopaedic surgery (3.8 against 3.1 days).
  - In emergency surgery the top two specialities of general surgery and trauma and orthopaedic were below the England length of stay average.
  - Plastic surgery length of stay for emergency surgery patients was 2.9 days against the England average of 1.7 days.
- The trust's anaesthetics department had not been accredited by the Anaesthesia Clinical Services Accreditation scheme (ACSA). This is a voluntary scheme for NHS and independent sector organisations that offers quality improvement through peer review.
- The urology department had developed with the Macmillan Project Manager a Prostate Specific Antigen (PSA) tracker programme. This was for the management of patients with prostate cancer by using blood tests and the monitoring of these. An extra clinical nurse specialist had been appointed to help run this service.
- The breast care service had developed support groups for women and these included younger women with cancer, women with secondary cancer and reconstruction evenings.
- The breast care unit had an established portfolio of research and audits they took part in as members of the Association of Breast Surgery. These included an evaluation of outcome of implant-based breast reconstruction (iBRA) and mammographic surveillance in breast cancer patients aged 50 years or older (Mammo50). As these were on going at the time of our inspection, no data was available about the impact of these audits.

Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment to patients.
- Band 5 staff working in theatres for scrub and anaesthetics (called theatre practitioners) had to complete a competency assessment in each area and they rotated between each of the surgical specialities. Staff were able to transfer these competency assessment booklets to other providers if they left the hospital.

- Junior doctors told us they felt well supported by their senior colleagues. They were able to shadow their senior colleagues and knew who to contact if they needed advice and support. They also told us they had opportunities for teaching sessions.
- The ward staff told us they had link nurses for specific areas, for example, learning disability and older people and other staff on the wards were able to learn from them.
- The overall appraisal rate for the surgical services division was 77.7%, which was below the trust target of 80%. We saw the appraisal rates for main theatres and recovery and both of these were over the 80% target. Some staff told us they had not been able to have their appraisal due to the pressures of work. One matron said they were behind with the appraisals as they were now working as part of the ward team.
- Following the changes to the Nursing and Midwifery Council registration procedure for qualified nurses revalidation drop in sessions for nursing staff were taking place by the Practice Education team.
- Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. From April 2014 to March 2015, RD&E had an overall appraisal rate of 94%. Some areas were highlighted to be addressed and an action plan was being developed.
- Consultant appraisal rates were 80.3% above the trust target from April 2014 to March 2015.
- Dementia training was provided for most staff in the hospital. This was for one hour and had been provided for 6,000 staff. Staff received dementia care training as part of induction with longer day sessions available for some ward staff.

Multidisciplinary working

- We observed collaborative working from staff contributing to patient care. All staff we spoke with told us about the importance of working as a team when caring for patients. On several of the wards, they told us about their 'board rounds'. This was where members of the multidisciplinary team, including physiotherapists, occupational therapists and nurses, discussed each patient. Therapy staff told us they also attended ward rounds with the doctors to discuss patients' on going progress.
- We saw multidisciplinary teamwork in theatre in relation to the use of the World Health Organisation surgical safety checklist. Each member of the team had a recognised role.
- There was multidisciplinary input involved with all patient care. Patient records demonstrated input from therapists, including dieticians, speech and language therapists, and occupational therapists, as well as from the pharmacist team, the medical team, and diagnostic and screening services.
- There was evidence of a strong multidisciplinary approach from national cancer audits. In the 2014 bowel cancer audit there was 100% compliance for multidisciplinary discussion in the 285 cases reviewed. This was above the England average of 99%. In the 2014 lung cancer audit, there was 98.5% compliance for a multidisciplinary discussion in the 195 cases reviewed. This was above the England average of 95.6%.

Seven-day services

- Staff on Otter ward told us there were doctor-led ward rounds every day in the morning where all patients were reviewed. The urology ward staff also told us they had daily consultant-led ward rounds.
- Physiotherapy was available at weekends for patients assessed as requiring their input.
- Consultant cover was Monday to Friday and an on-call system was in place outside of these hours. For general surgery, ENT, plastics, urology, vascular, ophthalmology and orthopaedics a named consultant was on-call. Senior staff told us that the consultant on-call would undertake a morning ward round and an evening one if required.
- There was access to emergency theatre at all times to include weekends and out of hours. An operating list was overseen in the morning by the consultant who was on-call the day before, freeing up the consultant who was on-call that day to run the 'hot clinic'. The hot clinic was for newly admitted surgical patients who required scans and other investigations, and this was consultant-led. All theatre suites had a mixture of staff that were on duty or on-call to cover these areas. The emergency theatre was based in the main theatre suite and this was operational at all times.
- Pharmacists were accessible by bleep at all times and were available midweek via the pharmacy service. Ward based clinical pharmacy services were not provided at weekends.

- Access to psychiatric input was available by telephone within working hours. This was about to be extended to 24 hours and seven day working was planned to commence from January 2016.
- X-ray, scanning and diagnostic testing was available 24 hours, seven days a week. Urgent blood tests were available out of hours.

Access to information

- Staff had access to all the information they needed to deliver effective care and treatment to patients.
- Ward clerks told us they requested patients' notes from the hospital record system and these were received within a good timescale.
- Nursing staff told us when a patient was transferred to their ward from the critical care unit (CCU) records were maintained of their stay. These were stored in the patient's notes. Staff also said they received a verbal handover.
- Discharge summaries were promptly sent to GPs. We observed a consultant completing a discharge summary following an operation.
- Junior doctors told us they completed the discharge summaries as soon as possible to prevent the patient from having their discharge delayed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Processes were in place to make sure staff acted within the legal framework to safeguard patients.
- The trust had a number of different consent forms. Some were specific to operations patients were having and listed the complications that could arise, for example, some eye operations. Other consent forms included one for patients who did not have the capacity to sign or understand the operation or procedure they required.
- We saw the consent form for a patient on Lyme ward who was living with dementia. The trust had a specific consent form for patients who were not able to consent to operations. We saw this patient's relative had been involved in the decision for surgery and as they were an unplanned admission, the form stated it was in the patient's best interests due to their on going medical condition. We found this consent form had been completed in full as per the instructions and risks of the operation had been documented.
- Patients we spoke with told us they had signed consent forms prior to their surgery. They said the consultant or senior doctor had explained about the process and it was "discussed in language" patients said they could understand.
- Staff we spoke with had knowledge of Deprivation of Liberty Safeguards and when to apply them. The trust had provided training and guidance around what actions would amount to a deprivation of liberty and how to proceed to have the deprivation approved. Staff told us they knew whom to contact if they needed any advice for support and they knew how to make an application to deprive a patient of their liberty.
- Training figures for the surgical services division for Mental Capacity Act 2005 and Deprivation of Liberty safeguards was 89%, above the trust target of 75%. Staff told us they had training on the Mental Capacity Act and they knew about how to act in a patient's best interest if the lacked capacity to make a specific decision about their care.

Are surgery services caring?

Good

All the feedback we received from patients and their relatives was continually positive about the way staff treated them. Patients felt staff 'went the extra mile' and the care they received exceeded their expectations.

Patients and their family or friends were involved with their care and included in decision making. They were able to ask questions and raise their anxieties and concerns and patients told us the staff used language they understood.

There was access to chaplaincy services, and support from nurses and doctors with specialist knowledge.

Patients and their relatives told us they received a good standard of care and they felt well looked after by nursing, medical and allied health professional staff. Staff on the wards respected patients' privacy.

Compassionate care

- Patients were treated with dignity, respect and compassion when they were receiving care and support from staff.

- Patients spoke overwhelmingly of the kindness of the staff. All the feedback we received was very complimentary, and we had no negative feedback. One patient told us they travelled a long way for treatment at the hospital. This was due to feedback about the way staff cared for patients. Examples of feedback we received included: "very good and caring" and "nothing too much trouble"
- Another patient told us they observed staff sitting with a patient who was alone without relatives and upset. The staff had spent time with the patient, talking with them, listening, and answering their questions. The patient who observed this said the "staff are fantastic".
- We observed all staff paid good attention to patient dignity. Any patients we observed in the operating theatres were fully covered in all preparation and recovery rooms, and when returning to the ward areas. A patient operation we observed demonstrated dignity was maintained at all times, including when repositioning the patient. On wards, curtains were drawn around patients, and doors or blinds closed in private or side rooms when necessary.
- The NHS Friends and Family Test results for nine of the surgery wards showed excellent results. Patients were asked to say if they would recommend the ward to their family and friends. From July 2014 to June 2015, the percentages of patients who would recommend the ward to their family and friends ranged from 93% to 100%. The response rate (where patients had returned their survey) ranged from 17% to 61% for the same period.
- The trust scored well in privacy and dignity in the PLACE (patient-led assessments of the care environment) surveys in 2014 and 2015. The results, which were much the same as the England average in 2014 at 87.03% and this had improved in 2015 to 89.60%.We observed good attention from staff to patient confidentiality. Voices were lowered to avoid confidential or private information being overheard as much as possible.

Understanding and involvement of patients and those close to them

- Friends and relatives of patients were kept informed and involved with decisions when appropriate. Relatives and close friends of patients we met said they were able to ask questions and could telephone the wards and departments when they were anxious or wanted an update. One patient told us they were anxious before their operation. On their return to the ward, they found a member of their family waiting for them following a call from a nurse. The patient said they felt much less anxious and were overwhelmed with the kindness of the staff.
- One patient told us that the visiting times had been altered for their relative due to issues with transport so they could visit out of the listed times.
- Another patient told us the "ward round was very effective, I felt listened to by all the staff and I had everything explained to me".
- Patients we spoke with on all the wards and units told us the nurses and doctors gave them time to ask any questions and relayed the answers in language they understood.
- Patients were actively involved in their care and treatment. Staff were fully committed to working in partnership with them. Patients were given time to ask questions about their treatment and could make the decision to refuse. We observed patients' individual preferences and needs were always reflected in how their care was delivered.

Emotional support

- There was access to a multi-faith chaplaincy for patients and their relatives and carers. The chaplaincy team were available in working hours and then on-call 24 hours a day all year round. There was a chapel in the hospital for people to use, whatever their religion, and this was open at all times.
- There was support for patients with cancer from the palliative care team based at the hospital. They had a large resource of knowledge and experience to draw upon to provide advice and emotional support. Staff were also able to contact and obtain support and advice from social services to further support people where this was needed.

Are surgery services responsive?

Good

We have judged the responsiveness of surgery services as good.

Surgery

The trust-wide Admitted Adjusted Referral to Treatment (NHS England consultant-led referral to treatment time targets of within 18 weeks) performance was better than the England average and above the standard between April 2013 and February 2015.

The number of operations cancelled at the hospital was below (better than) the England average between October and December 2014. The percentage of patients not treated within 28 days of a cancelled operation was above (worse than) the England average for January 2015 to June 2015. This had since improved and the amount of patients who were not re-booked in the 28-day time scale was below the England average.

Patients enjoyed the food and said they had access to drinks. Staff supported people with learning disabilities to improve their experience of hospital. Staff were kind and patient with people with dementia and we observed one-to-one care taking place.

Complaints were dealt with, as required, either by Patient Advice and Liaison Service (PALS) staff or by the ward teams. Complaints were used by the trust to provide learning and produce changes to improve care and patient experience.

There were few facilities on the wards for patients living with dementia, such as easy-to-read signage and dining areas to help frail and confused patients.

Service planning and delivery to meet the needs of local people

- The trust worked with commissioners to plan for, and meet, the needs of the local population. There were regular meetings and an open relationship between them and other stakeholders. The surgical services division management team told us when they planned services they looked at a number of areas, including what they were already providing and how changes and improvements to series could be made. For example, how many operations could be performed balanced against demand and contracts. At the time of our inspection they were looking at how to increase the number of operations they performed at community hospitals to reduce the pressure at Wonford Hospital.
- The trust was working hard to meet the backlog of cancer wait time for urology patients. This had resulted in extra theatre time with three lists per day in the week and at weekend. The trust trajectory was to catch up with the backlog by December 2015.
- The surgical services divisional management told us they also worked with other NHS providers to look at where it was best to provide some services, for example one site to have an area of excellence rather than several sites where the expertise may not be as high. For example bariatric surgery.

Access and flow

- The trust performed better than the England average in most of the national audits they provided data for.
- The trust-wide Admitted Adjusted Referral to Treatment (NHS England consultant-led referral to treatment time targets of within 18 weeks) performance was better than England average and above standard between April 2013 and February 2015. However, the Standards were not met between March and May 2015. The latest data (September 2015), published per surgical speciality by NHS England, showed three out of the seven surgical specialities were not meeting the referral to treatment time of 18 weeks. This was just under the 92% NHS operational standard.
- The number of operations cancelled at the hospital was below (better than) the England average between October and December 2014 (quarter three).
  - In quarter four of 2014/15 (January to March 2015) the hospital cancelled 227 elective operations (operations meeting the NHS cancellation criteria).
  - In quarter one of 2015/16 (April to June 2015) the trust cancelled 110 operations.
  - The percentage of patients not treated within 28 days of a cancellation was above (worse than) the England average for quarter four of 2014/15 and quarter one of 2015/16. The surgical services divisional management told us they had since improved this figure and the amount of patients who were not re-booked in the 28-day time scale was very low.
- The Trust regularly reviewed its theatre utilisation. The focus of 2016 will be community theatre utilisation. A project was going to involve a review of day surgery services provided at community hospitals and how these could safely increase their capacity. This project would also review how patients were booked in for operations because each speciality within surgery had a

different way of doing this. The trust's theatre utilisation figures for July 2015 for the main theatres was 94%. For the Princess Elizabeth Orthopaedic Centre (PEOC) it was 99%, and for the West of England Eye Unit it was 88%. These figures were either the same or higher than the previous month and demonstrated mainly good use of theatres in these areas.

- There was a daily 'hot clinic' run by the on call consultant. The purpose of this clinic was to review all new patients admitted as emergencies and to undertake any tests required on that day. For example, scans and to obtain the results quickly so patients had a prompt diagnosis and then treatment.
- Staff on the wards told us if they had any medical outliers (these were medical patients being cared for on surgical wards due to lack of medical beds) on their wards, a dedicated team of medical doctors visited them daily, along with a consultant three times a week. They said they all knew how to contact this team. At the time of our inspection staff on the wards felt this was not influencing patients who were admitted for operations.
- There was round-the-clock provision for emergency surgery, as recommended by the National Emergency Laparotomy Audit 2014. A specially reserved and dedicated emergency theatre was used.
- The main theatre recovery area had reported 12 occasions (no time frame was given) where patients had to stay in recovery overnight before returning to the ward. This was due to bed pressures within the wider hospital.

Meeting people's individual needs

- Patients' were having their individual needs assessment and met by staff.
- The trust's website had a video called 'Just ask' for patients to watch about coming into hospital for planned surgery. This provided information for patients about what to expect during their stay and encouraged patients to ask questions of staff.
- The trust website also had a leaflet called 'Coming into hospital', which was available in other formats and languages. It told patients about what to bring with them and about leaving valuables at home. It also had information about using a service called 'justvisiting.com', the online visiting room for patients to stay in touch with their family and friends.
- Staff in recovery told us how they cared for patients with a learning disability. They said that staff in the pre-admission clinic would inform them when a patient with a learning disability was due to come in for an operation. They would have a staggered admission time and their family or carer was able to stay with them on the ward and in recovery once they had woken up from their operation. The hospital trust had a team of nursing staff who specialised in supporting patients with learning disabilities. Members of this team would be available to come to a ward or unit to help staff provide support for a patient with a learning disability.
- For patients living with dementia the recovery department told us they had 'twiddle muffs'. These were knitted muffs with lots of different materials secured to them so patients could touch and hold them while they were recovering. These were used to help keep patients living with dementia occupied and to reduce their anxiety of being in an unfamiliar environment. We saw it documented in a patient's notes on one of the surgical wards that these had been used by the patient while in recovery. On one of the surgical wards, a patient living with dementia had one–to-one care from staff 24 hours a day because they were at risk of falling, as they liked to walk around. We also observed a member of staff from another surgical ward take a patient who was living with dementia on a walk through the hospital, looking at all the photographs as they walked along. However, the surgery wards did not provide any specific prompts or enhanced signage to assist people living with dementia. For example, there were no dementia-friendly signs around the wards to help people with orientation. There were no places for people to sit other than by their bed. Patients were not able to sit at a table to eat; it has been recognised this would often be a trigger to encourage confused patients to eat and drink.
- A risk assessment had been completed for falls for patient who was assessed as being at risk and one of the actions was to provide one to one care from a member of staff which we observed was in place.
- The PLACE survey regarding dementia for 2015 scored 83%.
- The PLACE score for food was 88 % for 2015, which was a reduction from 2014. The England average was 94%. Almost all the patients we met had enjoyed the food.

- There were facilities for providing patients who were delayed in leaving the recovery area with something to eat and drink. The manager of the recovery teams said staff were able to arrange for patients to have food and drinks brought up.
- Translation services were available and had been well used. There was a telephone translation service provided for general or urgent translation needs. There were also translators available to visit the unit to provide either one-off support for a specific situation, or a planned longer-term service.

Learning from complaints and concerns

- Patients' concerns and complaints were used to help improve the quality of care.
- The hospital provided a Patient Advice and Liaison Service (PALS) to deal with concerns and complaints. There was no evidence to suggest these were not well managed and to the satisfaction of the complainant. There were leaflets about the service available in wards, units, and relevant areas for patients or their relatives/ friends. This included how to raise a concern, who to contact and when they were available. The leaflet was available in different formats on request.
- None of the patients we spoke with had any complaints about the service they had received. All comments we received were very positive.
- Senior staff on the wards/units told us all complaints about their ward or unit came to them to investigate and to formulate the response to the complainant. Senior staff also told us they were able to meet with the complainant if they wanted to. They also told us that any learning from complaints was shared with the team staff via meetings or electronic communications. For example, on one ward the relatives of patient complained about their care after they had died as they had not understood how ill the patient was. The learning from this was to make sure all staff gave better explanations and checked with the relatives their understanding of what was said.
- Complaints were discussed as part of the clinical governance meetings for the surgical services division.
- As of July 2015, the surgical services division had 72 complaints and of these 18 were overdue for a response. They told us this was due to a number of reasons, for example, being able to access the patients' notes.

Are surgery services well-led?

Good

We have judged the leadership and governance of surgery services as good.

The leadership of the service was good, and there was a cohesive clinical governance structure demonstrating learning, change and improvement. The approach to risk management in the department was under regular review by managers. There were a number of specialty meetings held, and these fed into the overall clinical governance arrangements and provided board assurance.

Interventional radiology had its own governance systems that fed into its management structures.

Serious risks were shared by the surgical services divisional management team with the executive team as required.

Staff told us that if incidents took place, they wanted to be open and transparent with patients about any failings. The culture of learning from incidents was promoted by managers among staff, and they told us they were encouraged to report incidents.

A theatre use programme was under way to improve the use of operating theatres at Wonford Hospital and other community hospitals. A range of clinical audits were undertaken with results being reported to the divisional board.

There was good leadership and local-level support for staff. All the staff we met showed commitment to their patients, their responsibilities and one another.

Vision and strategy for this service

- The surgical division management team had a vision and strategy to deliver continuous improvement of the services they provided integration of care pathways from community through to acute care and back out to community again and specific service expansion. For example, they plan to redesign their emergency and elective care pathways to improve patient care. They told us this was part of the whole trust's strategic plan. Each surgical specialty had development plans. These included growth of their specialties to meet local and

wider demand, and working with other providers. For example, to become a regional centre for urology and pelvic cancer. Surgical division managers kept these plans under review.
- Staff we spoke with were aware of the trust's values, which included fairness, honesty, openness and integrity.

Governance, risk management and quality measurement

- An effective governance framework was in place to monitor performance and risks and to make sure the executive board were aware of these via the trust wide governance reporting.
- The surgical services divisional had a risk register in place. We saw some entries had been open a long time, and on going actions were recorded. At the time of our inspection, the urology waiting times were included on the trust-wide risk register as part of a wider picture. The surgical services division had an on going plan in place to reduce these waiting times and completion of this being planned for December 2015.
- We saw minutes of the clinical effectiveness committee. This was a trust wide group and in the minutes, we saw they discussed the results of two audits relating to surgery. These were the National hip fracture database and National Emergency Laparotomy Audit (NELA). Areas of compliance and non-compliance were discussed and actions were in place on how they planned to meet non-compliance. Where required issues were escalated to governance committee.
- The surgical services division had their own governance team and part of their role was to monitor incidents that had occurred. We were shown records of incidents that were on going and how they monitored these. Minutes of meetings at which incidents were discussed were shared with us, along with the robust action plans.
- The surgical services division also had monthly divisional business meetings where they discussed a number of areas, including financial and capacity issues. Where any challenges were identified actions were put in place to address these.
- Interventional radiology had its own governance systems that fed into its management structures. Serious risks were identified on their risk register and shared with the executive team when required.
- There was a programme of audit within the surgical services division and we saw in the minutes of the surgical service division clinical governance meetings discussions about some of these. The surgical services division risk register had identified areas where NICE guidance was not being met and actions were in place on how to address this.

Leadership of service

- The leadership within the surgical services division reflected the visions and values of the trust, which promoted good quality care.
- The surgical services divisional management team consisted of three senior members of staff and two of these were new to the team. These were the Associate Medical director, Divisional Director and Assistant Director of Nursing. This team recognised they had to deliver a programme of change and development, some of which might be difficult and challenging due to financial constraints. Staff at all levels understood how this management structure worked but not all were sure how management at this level used the information provided to them
- Junior doctors told us they felt well supervised by consultants and other senior doctors
- The majority of consultant surgeons were visible and regularly seen on every ward, seven days a week. Staff on the wards told us they were approachable.
- Matrons (ward managers) were visible on most wards and often they were involved with direct patient care, leading by example. Staff said their matrons were always visible and available.
- Senior staff also told us their ideas for changes to the service were listened to by divisional and executive level managers and some actions were taken. However, they sometimes would come to a full stop without explanation.

Culture within the service

- Staff 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 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.
- There was strong camaraderie and much flexibility in many departments. Two areas that specifically stood

out were the main theatre team and the West of England Eye unit department. The teams all worked well together and covered any gaps in the rotas so patient care was not compromised.
- On the urology ward, all staff had a weekly newsletter to keep them up-to-date with any new developments.
- Staff told us about the 'Comms Cell' meetings to promote a learning culture. The meetings were undertaken daily with all staff groups encouraged to attend. Areas of discussion included updates, new learning and complaints. Staff confirmed that when used, the meetings were a positive learning experience for all staff.

Public engagement

- Patients were encouraged to give their views on the services provided to help improvement and with the planning and shaping of future services.
- Patients were able to feed back their views on the ward via the Friends and Family Test. They were asked whether they would recommend the ward to their friends and family. We saw results of these on display in the wards. The overall response was the vast majority of patients recommended the wards. For example, the nine top scoring wards in the surgery division for June 2015 had scores ranging from 95% to 100%.
- We were shown the results of surveys that were sent to oral and maxillofacial patients dated July 2015. Of those who responded, 99% said they would recommend this department to a friend. Where issues were highlighted there was not any action recorded on how they would address these.
- We saw on the notice boards outside of the wards where patients had left comments both positive and negative. Where a negative comment had been made the ward sister or matron had added a response to this on how they were addressing/had addressed the issues raised.
- Patients took part in PLACE (patient-led assessments of the care environment), although the results did not relate to named wards or the surgery services specifically. The results, which were mostly above the NHS averages, were encouraging for staff, patients and the hospital trust.
- The colorectal team held a coffee morning for a selection of cancer patients to gather feedback on the service they had received. The feedback was all very positive and an action plan had been put in place regarding dietary advice and support following surgery.
- The breast care service had developed support groups for women and these included younger women with cancer, women with secondary cancer and reconstruction evenings.

Staff engagement

- Staff were encouraged to give their views on the services provided to help improvement and with planning and shaping future services.
- Staff were encouraged to share their views at their team meetings and staff told us these took place regularly.
- The trust had a number of ways to reward staff, for example long-service awards and extraordinary people nominations. This was where peers could nominate each other or teams for awards due to their good work.
- The trust board cascaded information and news items to staff by email and within electronic alerts and newsletters.
- The results of the 2014 NHS staff survey showed the trust was within expectations. They scored better than the England average regarding staff experience of bullying, stress, pressure to work and equal opportunities.

Innovation, improvement and sustainability

- There had been innovation within surgery services. This had included the Prostate Specific Antigen (PSA) tracker programme for the management of patients with prostate cancer by using blood tests and the monitoring of these. An extra clinical nurse specialist had been appointed to help run this service. This service was designed to save time and cost for all involved by reducing the need for attendance at the hospital for follow-up consultations and check-ups.
- The trust had purchased a robotic machine to improve the surgical outcomes for patients, including a reduction in the length of stay and blood loss.
- There was a theatre utilisation programme being implemented to improve the use of all the operating theatres and how they could increase the use of community hospitals' theatres. The aim being to provide more day surgery in these units to release theatre space at the Wonford Hospital site.
- The surgical services division management team told us they had to make efficiency savings but they had to balance these to make sure they benefitted both the patients and trust.

Surgery

- Following feedback from junior doctors and other staff about out-of-hours working, the division had recently introduced a new handheld 'whiteboard'. This helped reduce the burden of out-of-hours bleeps as staff could write on to this board any jobs they needed and it provided a system for recording the duties junior doctors performed. As this had only been in operation for a few weeks, there was no official feedback about its impact.

Critical care

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

Information about the service

The Royal Devon and Exeter Hospital provides a critical care service to adults and children who need intensive care (described as level three care) or high dependency care (described as level two care).

Patients were admitted to the critical care unit following complex and/or serious operations and in the event of medical and surgical emergencies. The unit provided support for all inpatient specialities within the acute hospital and to the emergency department.

The critical care service was located within a single unit. The unit had 15 bed spaces to accommodate both level three and level two patients, with one bed being used for children when needed. Bed spaces were a combination of single occupancy rooms and curtained bays.

The service was led by a consultant intensivist with support from the critical care consultant team and senior nurses.

In the three months from January to March 2015, around 20% of admissions were elective (planned) patients and the remaining 80% were unplanned (emergency) patients. The number of patients treated has fluctuated over the past five years, but was usually between 200 and 250 per quarter, with just over 900 patient admissions per year.

The critical care unit (CCU) contributed data to the Intensive Care National Audit and Research Centre (ICNARC: an organisation reporting on performance and outcomes for around 95% of intensive care units in England, Wales and Northern Ireland). This is reflected in some of the statistical data used in this report.

As part of our inspection we visited the critical care services on Wednesday 4, Thursday 5, Friday 6 and Tuesday 10 November 2015. We spoke with a range of staff including consultants, doctors, trainee doctors, nurses, healthcare assistants, administrative support and the housekeeping team. We met with the consultant clinical lead for the service and the senior nurse who ran the critical care nursing team. We spoke with physiotherapists, a pharmacist and a dietitian. We met with patients who were able to talk with us, and their relatives and friends. We checked the clinical environment and equipment, observed care and looked at records and data.

Critical care

Summary of findings

We have judged the overall critical care service to be outstanding. Caring and leadership were outstanding. The safety, effectiveness and responsiveness of the service were good.

Treatment by all staff was delivered in accordance with best practice and recognised national guidelines. There was a holistic and multidisciplinary approach to assessing and planning care and treatment for patients. Patients were at the centre of the service and the overarching priority for staff. Innovation, high performance and the highest quality care were encouraged and acknowledged. All staff were engaged in monitoring and improving outcomes for patients. They achieved consistently good results with patients who were critically ill and with complex problems and multiple needs. The whole service had a collaborative approach with a multidisciplinary attitude to patient care.

Patients were truly respected and valued as individuals. Feedback from people who had used the service had been overwhelmingly positive. Staff went above and beyond their usual duties to ensure patients experienced compassionate care and that care promoted dignity. People's cultural and religious, social and personal needs were respected. Innovative support for patients, such as the development of patient diaries, was encouraged and valued. Staff took the time to ensure patients and their families understood and were involved with care plans.

The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. All the senior staff were committed to their patients, their staff and their unit with an inspiring shared purpose. There was strong evidence and data to base decisions upon and drive the service forwards from a clear programme of audits and national evaluative studies. Staff, patients and their families were actively engaged with to identify areas of good practice, as well as areas that could be improved. There was a high level of staff satisfaction, with staff saying they were proud of the unit as a place in which to work. They spoke highly of the culture and consistently high levels of constructive engagement. The leadership drove continuous improvement and staff were accountable for delivering change. Innovation and improvement were celebrated and encouraged, with a proactive approach to achieving best practice and sustainable models of care.

There was a good track record on safety, and lessons were learned and improvements made when things went wrong. This was supported by staff working in an open and honest culture and by a desire to get things right. There were reliable systems and staff received training to keep people safe from abuse. The environment did not meet all the requirements for modern critical care units, being an older unit, and this was recognised by the trust. The unit was generally clean and well organised. Staff adhered to infection prevention and control policies and protocols. There were good levels of nursing staff meeting the Core Standards for Intensive Care Units (2013) to keep patients safe. However, overnight medical cover did not meet the recommendations of the core standards and there were times when a doctor was not present on the unit because they were attending a medical emergency call elsewhere in the hospital.

The critical care service responded well to patients' needs. Communication aids, including translation services, were available for patients who could not otherwise communicate easily or effectively. There were bed pressures in the rest of the hospital that meant about 50% of patients were delayed in their discharge from the unit, but the numbers of these incidences were below the NHS national average. Very few patients were discharged onto wards at night and there was a very low rate of elective surgical operations being cancelled because a critical care bed was not available. The facilities for patients, visitors and staff in critical care were good. There was quick input from consultants and nurses when new patients were admitted. Patients were treated as individuals, and link nurse roles were used to support specific aspects of patient need.

Critical care

Are critical care services safe?

Good

We have judged the safety of critical care services to be good overall.

There was a good track record on safety, and lessons were learned and improvements made when things went wrong. This was supported by staff working in an open and honest culture and by a desire to get things right. There were reliable systems and staff received training to keep people safe from abuse that reflected national guidance and legislation. Incidents were reported, but staff accepted they did not necessarily recognise all events as reportable incidents.

The environment did not meet all the requirements for modern critical care units, being an older unit, and this was recognised by the trust. However, it was not on the risk register and there were no firm plans to address this.

The unit was generally clean and well organised. Staff adhered to infection prevention and control policies and protocols.

Medicines were stored securely in accordance with trust policy and legislation, and equipment was well maintained. However, emergency medicines for resuscitation were stored in trolleys that were not tamper-evident.

There were good levels of nursing staff meeting the Core Standards for Intensive Care Units (2013) to keep patients safe. However, overnight medical cover did not meet the recommendations of the core standards and there were times when a doctor was not present on the unit because they were attending a medical emergency call elsewhere in the hospital. There was a daily presence of experienced consultant intensivists and doctors, and rarely any locum cover was needed or used.

Mandatory training completion rates were variable between staffing groups and topics, but the majority of staff were up to date.

Incidents

- The critical care unit (CCU) had a strong focus on patient safety and incident reporting. There was a positive culture amongst all staffing groups to report incidents, including near misses and low harm incidents. Managers encouraged and supported staff to raise incidents. Managers and staff recognised the importance of incident reporting as a learning tool to maintain and improve safety, and were aware of their responsibilities to ensure incidents were reported.
- Staff did raise incident reports as required in the majority of instances; however, there were a few occasions where this was not the case. For example, when patients accidentally removed a medical device, such as an intravenous line, this was not always reported as an incident.
- Incident reporting was accessible and staff knew how to use the system. The trust used an electronic incident reporting system. This was available on computers throughout the CCU and staff were able to access this easily. Staff were provided with training and guidance on how to use the system, and they told us they were comfortable using it.
- There had been no serious incidents or never events recorded by the unit in the last 12 months, and safety performance over time compared favourable against similar services.
- Learning opportunities were recognised and shared with staff. Once an investigation had been completed, the investigator provided the reporter with individual feedback where this had been requested. All incident reports were discussed at the unit's governance meetings and minutes of these were shared with all staff. Specific learning points were communicated to all staff by email and during daily safety briefings, and trust-wide learning points were shared through a regular newsletter.
- Mortality and morbidity meetings were held regularly and ensured learning was shared. Monthly consultant-led mortality and morbidity meetings looked at all patients from the previous month to review the care provided and identify any areas of learning. The unit's senior nurse was a member of the group, as were the unit's lead physiotherapist and pharmacist. All staff in the department were invited to attend, and minutes were circulated to ensure everyone had access to the cases discussed. Incident reporting against each case was checked and where an investigation had not been completed but further details were needed a retrospective investigation was started. Where

necessary, information was shared with other departments to ensure a full-service review took place; however, we were told it was sometimes difficult to get a response back from other departments.

Duty of candour

- There was a culture of openness and transparency in the unit. Staff understood their duty of candour to be open and transparent in their practice, and to give an explanation and apology if an error was made that caused harm requiring it to be reported. Staff were supported to speak up about errors, and managers were supportive when things went wrong.
- The incident reporting system included a mandatory section to record compliance with the duty of candour and we saw this was being used when incidents were reported.

Safety thermometer

- The CCU participated in the national safety thermometer performance and achieved consistently positive results. During the 12 month period July 2014 to July 2015 the department had reported no falls resulting in harm, no catheter-acquired urinary tract infections and only three pressure ulcers.
- Results for the safety thermometer were displayed in the waiting room and staff room so visitors and staff were able to see them.

Cleanliness, infection control and hygiene

- Staff adhered to infection prevention and control policies. Staff were observed to be 'bare below the elbows' and observed good hand cleaning procedures before and after each patient contact. Appropriate personal protective equipment, for example gloves and aprons, were used in accordance with guidance.
- Equipment and the environment was mostly found to be clean. We checked two empty bed spaces on our first day and found loose dust and hairs in a corner in both rooms. One bed also had a layer of dust on its base. We informed the senior nurse of our findings and the rooms were immediately re-cleaned and all other bed spaces were checked. On the remaining days of our inspection, including our unannounced visit, we checked several bed spaces and found all were visibly clean.
- There were no cleaning checklists being used in the unit. There was no audit sheet for staff to sign when a bed space had been cleaned or checked, which meant it was not possible to evidence when an area had last been cleaned or checked. However, staff had good vision of the unit and could therefore see where the cleaners were working and had already been, and there was good communication between the staff and cleaners to identify when a bed space had been cleaned.
- Regular infection prevention and control audits were undertaken. There was a mix of nursing-led and cleaning supervisor-led audit, including hand hygiene. Results showed that overall compliance was good at around 90%, with hand hygiene being mostly at or above 90%, with only two months of 13 dipping to 85%. Areas of concern were raised appropriately and rectified promptly.
- The unit had isolation facilities available. Within the CCU there were a number of side rooms, of which four had negative pressure isolation facilities. Two of these rooms had separate access via a small lobby area where staff could perform necessary infection control procedures before entering the patient's room. Negative room pressure allows air to flow into the isolation room but not escape from the room, preventing contaminated air from circulating amongst other patients in the unit.
- The CCU had a consistently low rate of unit-acquired infections. There had been one case of unit-acquired methicillin-resistant Staphylococcus aureus in the unit between July 2014 and October 2015, and no cases of Clostridium difficile or bloodstream infections during the same period.

Environment and equipment

- The CCU was secure and safe for patients. The unit had access cards for staff, and an intercom system with CCTV for visitors. Staff in the unit could answer the intercom and view the CCTV remotely, allowing them to check who was at the door before allowing access.
- The nurses' stations had monitors displaying live observations from the patients' monitors, allowing remote monitoring should a staff member need to leave the bedside. Single occupancy rooms had windows (with curtains) to allow remote observation from the neighbouring room if required.
- Resuscitation and difficult airway equipment was readily available, but these were kept together in the same trolleys which were not tamper-evident. There were two emergency trolleys in the unit, both of which contained the equipment needed in the event of

a cardiac arrest (including emergency medicines) or to manage a difficult airway. Both trolleys were checked daily, and evidence that these checks had been completed was located with the trolley. We checked both trolleys and found all the required equipment was available and in date. Neither trolley had a means of identifying if the resuscitation equipment and medicines had been used or tampered with, and one of the trolleys was sometimes unobserved by staff. We were told the trolleys were not sealed because they were regularly used for difficult airways and resealing them every time was time consuming.

- There were clear waste and clinical specimen disposal arrangements and these were followed by staff. The unit had separate dedicated areas for clean and dirty equipment, linen and specimens, with clearly marked standard waste and clinical waste bins. Sluice facilities were contained in the dirty utility and items that had been cleaned and sanitised were labelled as such. Waste was regularly removed from the unit.
- The unit had immediate access to regularly used specialist equipment, and could request other equipment not held locally. Equipment in the unit included machines capable of haemofiltration (a process where a patient's blood is passed through a machine where waste products and water are removed. Replacement fluid is then added and the blood is returned to the patient) and haemodialysis, syringe drivers and a portable x-ray machine. Additional equipment, for example bariatric commodes and hoists, were available centrally if required.
- Equipment in the CCU was regularly maintained. The trust had a medical equipment management (MEM) department who were responsible for the management of all equipment in the hospital. There was a central asset management database that recorded all equipment and its location in the hospital, along with service schedules, priority levels and service history. Compliance with equipment service intervals was good, with 95% of high priority equipment having been serviced in accordance with the required intervals in the last 12 months and 85% of medium priority equipment being serviced. Trust targets for service compliance were 95% for high priority and 70% for medium priority equipment.
- The unit did not comply with current Department of Health building standards. The current Health Building Note HBN 04-02 for critical care units was published in 2013 as the standard to be met when a new critical care unit was built. The existing CCU was built in two phases, adhering to the building standards at the time. National guidance from the Core Standards for Intensive Care Units (2013) recommends non-compliance with existing building standards should be entered on the risk register with a timescale for when the standards will be met. However, we were told the risk register had not been updated because a risk assessment against the gaps did not identify a significant risk requiring this level of escalation. We reviewed the risk assessment and found it only related to four beds, did not risk assess the areas of non-compliance individually and did not provide a timescale for when standards would be met. Some ways the unit did not comply with the current building standards included:

- There was not a separate entrance for visitors. Patients, staff and visitors had to share the same entrance and exit, with the exception of patients going to/coming from theatre. Access to theatres was via a separate door.
- There were no ceiling-mounted hoists.
- None of the bed spaces had clocks capable of showing elapsed time.
- There were not 28 unswitched sockets available at every bed space.

Medicines

- Medicines, including intravenous fluids, were stored securely. All medicines and intravenous fluids were stored inside locked store rooms. Each member of staff authorised to access the room had an individual access card registered to them. All access to the store room was therefore recorded and could be audited in the event of an investigation.
- Controlled drugs (CDs) were stored safely and managed in accordance with legislation and policy. CDs were kept in locked cupboards and locked refrigerators inside the locked store rooms. The only exceptions were the refrigerated emergency medicines, which were kept in an unlocked refrigerator. Keys to the CD cupboards and refrigerators were held by two nominated nurses, identified to all staff at the beginning of each shift. All CDs were audited on a weekly basis, with evidence of these checks being recorded in the CD registers. We completed a check of several CDs, comparing the register to the stock levels and checking expiry dates. We also cross-checked register entries against patient's

prescription charts and found records were being accurately maintained. We found two tramadol tablets in blister packs that had been separated from the rest of the blister pack and as a result did not have expiry dates printed on them. We informed the matron who then took action to check the stock.

- Patients' own medicines were stored securely. Medicines arriving in the unit with patients on admission were stored in a small locked medicines cabinet in the bed space. Patients' own controlled drugs were stored in the CD cupboard and entered on a dedicated CD register.
- The unit was using an electronic prescribing system, which was keeping people safe. The electronic prescribing system had been specifically created for use in the CCU and we were told it "works well". We were told the system was reliable and saw evidence that since the system had been introduced there had been fewer medicine errors reported. We observed paper prescription records from the wards had been entered onto the computer when patients were admitted. We reviewed both the paper and electronic records and found they were accurate. On discharge, the prescriptions were printed for handover to the wards. The system was easy to use, allowed the pharmacist to access records remotely and enabled easier auditing and quality checking.
- Allergies were clearly recorded in the majority of cases, and systems prevented medicines being prescribed if a patient was allergic to them. Of the 11 electronic prescription records we checked, nine had the patients' allergy information documented as required. There was a dedicated field at the top of the prescribing system, with allergy information being recorded in red to make it visible. If an allergy to a specific medicine was recorded on a patient's prescription document, the system would not allow that medicine to be prescribed.
- Antibiotics were administered in accordance with local microbiology protocols. The CCU had access to microbiology protocols and we saw these being used. Of the six records we checked where antibiotics had been administered we saw input had been gained from a microbiologist and appropriate treatment plans started.
- Patients who were not given a prescribed medicine, or who had this delayed, did not always have a reason for this recorded. We checked 11 prescription records and found two of these showed a medicine dose had been missed or delayed, but no reasons had been documented.
- Refrigerator temperatures were regularly monitored and maintained in accordance with trust policy. Staff checked and recorded the refrigerator temperatures twice a day, ensuring they had been operating within the required temperature range. Guidance was included on the check sheet for the action to take when a refrigerator was out of range. We checked the records and noted several occurrences where one of the refrigerators had been out of range (high) over several checks. The pharmacist had been informed as required and additional checks were completed. It was found that the refrigerator was being accessed regularly because it contained the emergency medicines, and therefore the maximum temperature was 'peaking' for a short time while the refrigerator was open. Action was taken to reduce the amount of stock held in the refrigerator to minimise the risk of a large amount of stock having to be destroyed.

Records

- Records in the CCU were held securely, were legible and up to date. The unit used an electronic records system, which was password protected and accessible only to those who needed access. Records were typed and therefore legible, and updated by the multidisciplinary team in a timely manner.
- Risk assessments were completed and clearly recorded. We reviewed 11 records and found they all contained appropriate risk assessments and care plans, including for falls, venous thromboembolism and pressure ulcers.

Safeguarding

- The majority of the CCU staff group had completed safeguarding training. In total, 93% of staff had completed mandatory adult safeguarding training in the last 12 months (90 out of 97) and 99% had completed child protection training (95 out of 96).
- There were processes and guidance documents available to support staff in managing safeguarding concerns. Policies and procedures relating to safeguarding were easily accessible on the trust's intranet system. Staff showed us how they would access

these and explained the processes they would follow to make a safeguarding referral, including informing the nurse in charge who would then complete a safeguarding referral.
- Staff were aware of their obligations with regard to safeguarding. Staff we spoke with were able to tell us what would constitute a safeguarding concern and told us they would report any concerns immediately to the nurse in charge.

Mandatory training

- There were varying rates of compliance with mandatory training topics in the CCU, with overall compliance at just under 90%. In the last 12 months, administration staff had complete 100% of the required mandatory training. 85% of medical staff had completed all the mandatory training topics, but there were some sessions where only half the team were up to date, including manual handling and conflict resolution. 89% of registered nursing staff were fully compliant, with dementia & delirium training being the lowest attended session at just 59%. Unregistered nursing staff were 94% compliant overall, with several areas being at 100% compliance, including child protection, safeguarding adults and the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Mandatory training was delivered through online tools and taught/practical sessions. Staff told us they were able to access the online training easily, and found all training sessions were appropriate to their needs. Topics included:

- Bullying and harassment
- Conflict resolution
- Dementia and delirium
- Fire training
- Infection prevention and control
- Information governance
- Manual handling
- Waste management
- Child protection
- Falls, slips and trips
- Mental Capacity Act and Deprivation of Liberty Safeguards
- Adult safeguarding

Assessing and responding to patient risk

- Risk assessments were available and being used to develop care plans. The CCU had a range of risk assessments available, including for pressure ulcer, venous thromboembolism (VTE) and falls. The unit's performance for completing pressure ulcer and VTE risk assessments in June and July 2015 showed varied compliance (VTE 92% and 67% respectively, and pressure ulcer 100% and 86% respectively); however, in all the care records we reviewed there were appropriate risk assessments and care plans being used.
- A hospital-wide early warning score (EWS) system was being used to identify patients at risk and clear escalation processes kept patients safe. The EWS process was led by the resuscitation officer and their team. Although the scoring system was not used in the CCU, it helped identify when critical care review and advice to a patient on a ward was required. The use of the EWS was regularly audited and between August 2014 and July 2015 the medical and surgical divisions consistently achieved 100% compliance.
- The CCU did not have an outreach team; however, there was a medical emergency team based in CCU who provided the response and advisory function of a traditional 'outreach' team to ensure critically ill patients on wards outside of the CCU were provided with early critical care input to keep them safe.
- In response to an elevated EWS at a given trigger point, ward staff made a call to the hospital's medical emergency team (MET). Critical care attended these calls 24 hours a day, seven days a week. Attendance to a MET call was usually by an intensive care registrar with at least six months' anaesthetics training, but sometimes an intensive care consultant would attend.
- Training in the management of deteriorating patients was provided by the CCU. Working with a local university, an undergraduate competency-based training package had been introduced for ward staff. The course, Care of Critically Ill Adults in Non-critical care Acute Areas, received positive feedback from those completing the course. The package included taught sessions, research and practical exercises, as well as competency-based assessments. In addition to this formal course, occasional informal simulation training was provided on an ad-hoc basis by the CCU team.

Nursing staffing

- The numbers of nursing staff in the CCU kept people safe. Although the unit was not using a formal acuity

tool to calculate the numbers of nursing staff required, a review of nursing ratios based on the Core Standards for Intensive Care Units was completed regularly throughout the day. The unit was commissioned to provide 13 level three (intensive care) beds and rotas were designed to provide cover for this. Generally there were fewer level three patients than this, but a number of level two (high dependency) patients also on the unit. Level three patients require one to one nursing, whereas level two patients require one nurse to two patients. Therefore, by regularly providing 13 nurses the department was able to adequately support all the patients in the unit almost all the time.

- The unit had one senior nurse who assisted the lead consultant with running the unit. The senior nurse was supported by three matrons and each shift had a supernumerary band six shift coordinator. Three healthcare assistants were employed by the unit to assist with essential nursing tasks, for example basic care.
- The unit did not have a full establishment of nursing staff. In July 2015 the unit had 4.3 whole time equivalent vacancies, equating to a 6% vacancy rate in this staff group. Gaps in rotas were being filled by agency nurses, and recruitment had recently been completed to cover the vacant posts permanently. The unit had recently employed three nurses. The new staff were subject to a six week supernumerary induction period during which time they were familiarised with the department and given training on the equipment and processes in the unit. This was supported by the practice development team. In June 2015 the average fill rate for day shifts was 105% and for night shifts was 97%. In July 2015 the day shift fill rate was 101% and the night shift fill rate was 98%. Staff told us they were “very, very rarely” understaffed.
- Between May 2014 and March 2015 7% of shifts had been covered by agency nurses. Agency nurses new to the unit were given an induction at the beginning of the shift, including familiarisation with the layout, processes, equipment and IT facilities. The induction process was formalised, with a checklist ensuring all agency staff received the same important information.
- The nursing handover followed a structured format. Every day at 7.30am and 7.30pm the day and night shift nurses in charge handed over to each other in the office. They reviewed every patient on the unit and discussed pertinent information, including safety considerations such as allergies, and plans for the shift ahead (for example, discharge arrangements or follow-ups). Staffing numbers were confirmed and any safety briefing topics discussed. At 8am and 8pm, the nurse in charge then briefed the nursing team in the staff room, allocating nurses to patients and covering the key items from the nurse in charge handover. The nurses then went into the unit and took a further handover from the off-going nurse at the patient’s bedside, including events overnight and current clinical observations.
- The CCU was supported by a critical care pharmacist and adequate physiotherapists to ensure patients received adequate safe treatment.

Medical staffing

- Medical staffing in the critical care unit met recommended standards during the day, but overnight this was not the case. The Core Standards for Intensive Care Units (2013) recommend a resident doctor to patient ratio of one to eight, and a consultant to patient ratio of one to 15. During the day there was sufficient medical cover to achieve this, with at least two consultants and two doctors on duty. After 5.30pm, however, there was only one registrar in the unit caring for up to 15 patients. The unit had identified this shortfall and in May 2014 it was recorded on the risk register. The clinical lead had submitted a business case to increase medical staffing numbers so the standard could be achieved but funding had only been agreed in part and therefore the standard could still not be met. Further funding was going to be requested for the next financial year, but this was not guaranteed and without it the recommended staffing levels would not be met.
- The overnight resident doctor was also responsible for attending the hospital-wide MET calls, which resulted in times where no doctor was present on the CCU. There were alternative mitigating arrangements in case of an emergency, for example contacting another doctor from elsewhere in the hospital or calling the on-call consultant, but these did not provide an immediate response. There was also an arrangement with the anaesthetic department to respond to some medical emergencies in the hospital to release the critical care doctor, but we were told this was "patchy". Three incidents had been reported internally that had been impacted upon by overnight medical cover. One of these incidents, in January 2015, reported a patient

being kept sedated overnight due to insufficient medical cover. Another incident in February 2015 raised concerns that a patient in the resuscitation department had intubation delayed because the overnight intensive care and anaesthetic doctors were both junior and not confident to undertake the procedure. The third incident, in July 2015, reported there being no doctor immediately available to manage a patient's airway because the intensive care doctor was committed on a MET call and the backup anaesthetics doctor was committed with another patient. Although none of these incidents resulted in actual harm, there was a risk to patients in the event of an emergency requiring immediate medical intervention, particularly advanced airway skills.

- The unit was able to have a consultant on site within 30 minutes during the on-call period. We were also told the consultants had a low threshold for coming in to support the unit, and staff therefore felt comfortable calling them when support was needed.
- Although there were some gaps in the medical staffing establishment, these were covered internally. The CCU had not used any locum cover for any medical grades in the last 12 months.
- A nurse consultant was included in the medical staffing establishment. An advanced critical care practitioner (ACCP) role had been piloted in the unit and had become a permanent position within the medical rota. The role provided additional support for trainee doctors, managing their induction and shadowing their first on call periods, and brought a unique nursing insight into the medical field.
- New doctors working in the department were inducted and well supported. A comprehensive induction programme existed for new doctors, supported by the consultants and ACCP. This included departmental familiarisation and a period of shadowing nursing staff.
- There was a structured handover process in place for medical staff. The medical handover was office-based and in the morning involved the night doctor handing over to the oncoming doctors and consultant(s), and in the evening involved the night doctor taking a handover from the off-going doctor. Each patient was reviewed in turn and safety issues were discussed.
- There were two consultant-led ward rounds every day of the week, once in the morning and again in the afternoon. The morning ward round was used to set treatment goals for the day, and the afternoon ward round reviewed progress against these goals and discussed any additional plans needed to ensure safe care and treatment for each patient.

Major incident awareness and training

- The trust had a major incident plan, which included action cards with specific instructions for critical care staff to follow. Copies of the action cards were readily available in an emergency bag in the matrons' office, and staff knew how to use these in the event of a major incident. The unit's senior nurse was also a member of the emergency prevention, preparedness and response group.
- The unit was involved in major incident training exercises. We were told of a recent table top major incident exercise, which the CCU had participated in. Staff had not been specifically trained in major incident response, but were aware of their responsibilities should a major incident occur.
- The hospital had the ability to temporarily increase its capacity to care for critically-ill patients in a major incident such as a pandemic flu crisis or major incident. Plans existed to utilise theatres and recovery areas with critical care staffing and equipment being used to care for patients in these areas.
- The CCU had received a certificate in the trust's 'New Year's Honours' celebrations recognising their preparedness for Ebola.

Are critical care services effective?

Good

We judged the effectiveness of the critical care service to be good.

Treatment by all staff, including therapists, doctors and nurses, was delivered in accordance with best practice and recognised national guidelines. There was a holistic and multidisciplinary approach to assessing and planning care and treatment for patients.

Patients were at the centre of the service and the overarching priority for staff. Innovation, high performance and the highest quality care were encouraged and

acknowledged. All staff were engaged in monitoring and improving outcomes for patients. They achieved consistently good results with patients who were critically ill and with complex problems and multiple needs.

Staff were proactively supported to obtain new skills and share best practice. Trainee doctors were well supported by the consultant team and the advanced critical care practitioner. The nursing staff were supported by a strong and professional practice development team. The majority of nursing staff held a post-registration qualification in critical care nursing, while others were working towards this.

The whole service had a collaborative approach with a multidisciplinary attitude to patient care. All staff were treated with respect and their views and opinions heard and valued.

Consent practices were embedded in the care and treatment provided to patients. Staff spoke of always acting in the best interests of patients while protecting and supporting their rights. There was individualised care and support provided to both patients and those close to them. Patients and families understood what was happening and were fully involved in decisions and plans of care.

Evidence-based care and treatment

- The critical care unit (CCU) was compliant with all the Core Standards for Intensive Care Medicine (2013) relating to patient care and treatment. The unit had completed a risk assessment against the core standards in March 2015 and identified one area regarding patient treatment that was not being met; however this had since been resolved.
- The Core Standards for Intensive Care Units (2013) recommend all patients should have their rehabilitation needs assessed in within 24 hours of admission to critical care. In the unit's risk assessment against the Core Standards in March 2015 it was identified that this standard was not being met. Since then work had been completed to ensure this was now being met in most cases. The lead CCU physiotherapist joined the nursing handover daily and then worked with the wider nursing and medical teams to draw up daily rehabilitation plans for each patient. An audit of a four-week period in October 2014 was completed in August 2015 and found 67% of eligible patients had their rehab needs assessed within 24 hours, 89% within 25 hours and 100% within 28 hours. The physiotherapy team provided cover in the unit seven days a week, although at weekends this was a reduced service, and were confident that the vast majority of patients now received assessments within 24 hours. The unit had also employed a band three rehabilitation technician six days a week. Their focus was to ensure all patients were mobilised in accordance with their rehabilitation goals.
- When patients were discharged from the CCU to the wards rehabilitation goals were formulated to ensure ongoing mobilisation and rehabilitation support. Although a formal rehabilitation prescription document was not in use, plans and goals were written into the discharge section of the electronic patient record. On discharge from the CCU these were printed and travelled with the patient to the ward so that a patient's rehabilitation continued. An audit of a four-week period in October 2014 was completed in August 2015 and found 95% of patients had their rehabilitation prescription goals handed over (63/66). A further audit of more recent data was being planned but had yet to be started.
- The CCU was using national best practice guidelines and research from relevant groups to ensure care and treatment was effective. Policies and practices were based on guidance from the royal colleges, National Institute for Health and Care Excellence (NICE) (for example NICE 83 'Rehabilitation after critical illness' and NICE 50 'Acute illness in hospital') and critical care groups, for example the Faculty of Intensive Care Medicine. Additionally, the unit held a weekly journal club where it considered recent articles and research impacting on critical care, and considered its implications for the unit.
- The CCU was using critical care bundles to ensure compliance with national best practice. Care bundles ensure key aspects in the general care of a critically ill patient were regularly identified and checked. One care bundle being used was the 'FAST HUG', covering Feeding, Analgesia, Sedation, Thromboembolic Prophylaxis, Head of bed elevation, stress Ulcer prevention and Glucose control.
- Patients were safely ventilated using specialist equipment and techniques in accordance with national best practice. This included mechanical invasive ventilation to assist or replace the patient's breathing using endotracheal tubes (through the mouth or nose into the trachea) or tracheostomies (through the

windpipe in the trachea). The unit also used non-invasive ventilation to help patients with their breathing, using masks or similar devices. All ventilated patients were constantly reviewed and checks made and recorded hourly.

- The unit had participated in a self-review against the recommendations of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) 'On the right trach' report. This report was focused on improving the care provided to patients who had a tracheostomy as part of their treatment. The unit was compliant with the majority of the recommendations. Areas that weren't being met had been identified and actions put in place to reach the standards. The vast majority of the actions had been completed and a re-audit against the recommendations was planned for February 2016.
- Patients who had acute respiratory distress syndrome (ARDS) were treated in accordance with national guidelines from the ARDS Network, with a dedicated care bundle being available to support staff. We reviewed the care of one ARDS patient who was in the unit during our inspection and found the care bundle was being used appropriately.
- Patients were sedated in accordance with national best practice. The unit had a sedation policy in place with an assistive flowchart for staff to follow. Sedation holds (a daily period where sedation is paused to limit drug medicine accumulation, promote a more awake state and permit further assessment of a patient) were completed every morning.
- The critical care unit met best practice guidance by promoting and participating in a programme of organ donation led nationally by NHS Blood and Transplant. One of the experienced consultant intensivists was the clinical lead for organ donation, supported by a specialist nurse who directly supported the organ donation programme. The specialist nurse role was split between two hospitals, with half their time being spent in each location.
- Between 1 April 2014 and 31 March 2015 there had been 29 patients eligible for organ donation. Of these, 13 families were approached to discuss donation. Eight of these families (62%) were approached with the involvement of the specialist nurse, against a national average of 30%. Evidence has shown there is a higher success rate for organ donation if a specialist nurse is involved with discussions with the family. Ten patients went on to be organ donors and 34 people received organs as a result. The average number of organs donated per donor was 4.5, which was above the national average of 3.4.
- Patients were being screened for delirium using a nationally-recognised risk assessment tool. The confusion assessment method for intensive care units (CAM-ICU) was used in the unit to assess patients for delirium. Patients in a critical care setting are at high risk of psychological effects resulting primarily from the medicines used to treat patients (for example, heavy sedatives). The Core Standards for Intensive Care Units (2013) recommend all patients are screened for delirium.

Pain relief

- Patients' pain was well-managed. Regular assessment of a patient's pain using assessment tools took place, and plans to manage any pain were quickly started. Pain scores were recorded on patients' observation charts at hourly intervals.
- None of the patients we spoke with were in any pain and there was evidence of pain assessments, both verbal and non-verbal, and administration of pain relief in all records we reviewed.

Nutrition and hydration

- Patients' nutrition and hydration needs were being met. The unit monitored and responded to their patients' hydration needs using fluid balance charts to regularly monitor and manage hydration. Patients' nutritional intake was recorded and monitored daily, with dietitians being asked to review patients where specialist input was required. We reviewed nine care records and found they all contained regular records and observations. A diet kitchen was available seven days a week to provide support to patients with specific diet or cultural needs, with the CCU receiving a priority service.
- Patients were supported to eat and drink. Patients who were able to feed themselves were given the time and opportunity to do so. Food and drink was placed near the patient so they could easily reach it. Patients who required assistance were helped by nurses or healthcare assistants. Hot food was only brought to the unit on request when a patient was ready to eat it, meaning it did not risk going cold and uneaten. Patients who were unable to eat, for example because they were sedated,

were fed using a tube and liquid food. Standard feeding protocols were available for staff to follow to ensure these patients received adequate nutritional intake before a dietitian reviewed them.

- Patients in the unit were regularly reviewed by dietitians to ensure their nutritional needs were being met. A critical care dietitian attended three times a week on a Monday, Wednesday and Friday. If additional support was required on a Tuesday or Thursday the dietitian could be contacted as needed. The dietitians shared an office with the speech and language therapists (SALT) and had a good working relationship with this team. The SALTs were available when needed and we were told they provided a prompt response when requested.

Patient outcomes

- Patient outcomes were routinely captured and monitored against those achieved nationally. The CCU had contributed data to the Intensive Care National Audit and Research Centre (ICNARC) for at least the last five years, allowing national and regional benchmarking. Mortality rates in the unit were exceptionally good, with data showing consistently lower (better) mortality rates when compared nationally. Just under 2% of patients were readmitted within 48 hours, which was slightly higher than the national average. A higher number of patients were discharged 'early' when compared with regional and national units (just under 6% against an average of about 3%), which may have been a reason for some of the patients being readmitted within 48 hours. A review of these patients had not been completed to see if there were any lessons that could be learned.
- In addition to the national ICNARC programme, the unit had also participated in the South West network benchmarking exercise and completed a self-audit against the NCEPOD 'On the right trach' recommendations, all of which showed positive results for patient outcomes.
- The unit had an audit calendar to ensure patient outcomes were reviewed and action plans put in place to address any identified learning points. In addition to the regular ICNARC programme, the unit also participated in a national NCEPOD pancreatitis study and the International Multicentre Prevalence Study on Sepsis (IMPRESS). Local audits, including a central line audit and phlebitis cannula audit were also being completed. The diary showed these were being completed regularly and recorded progress against any learning actions that had been identified.

Competent staff

- Staff appraisals were not always completed on time. Appraisal compliance rates for the surgical services division (which included CCU) showed varying results across the different staff groups. For example, only 30% of allied health professionals had completed an appraisal within the last 12 months, whereas 88% of admin and clerical staff had had an appraisal. Compliance information specific to the CCU was not available. All staff we spoke with had completed an appraisal within the last 12 months and told us they felt their appraisals were useful, relevant and supportive. We were told that agreeing developmental objectives at the appraisal meeting meant that training courses were made available to achieve those objectives. Competencies were also reviewed at the appraisal meeting and supportive training or mentoring put in place for areas that needed strengthening.
- Doctors and registered nurses were supported to revalidate with their professional bodies. A list of all registered nurses was displayed in the staff room along with their revalidation date. Doctors' revalidation was electronic and dates were held on the computer system. Although individuals were responsible for revalidating with their professional body, they were reminded this was required and supporting documentation was approved by appropriate managers.
- Practice development for nurses had been recently introduced to ensure training and competency was appropriately managed. Earlier in the year it was identified that a number of staff members would be retiring and therefore a cohort of new staff would be coming into the department. The senior nurse recognised the impact this would have on existing staff if they had to assist the new staff, and also wanted to comply with the Core Standards for Intensive Care Units (2013) which recommend a full time practice educator should be in post. Therefore a business case was made and four part-time nurse practice educators were appointed, covering two whole time positions. These roles started in April 2015 for a fixed term period of one year, at which point their impact would be reviewed. We received positive feedback from all the staff we spoke

with. We were told they felt "well supported" with the practice educators providing mentoring and support to new nurses and to any existing nurses working towards their critical care CC qualification.

- Staff competency was assessed and supportive programmes put in place where staff needed additional experience to achieve competency. New staff received a competency document outlining all the areas they needed to be proficient in before being 'signed off' as competent. These were regularly reviewed and supported by the practice development nurses. Yearly self-assessments were mandatory for all staff using equipment in the CCU. These allowed staff to identify additional support they needed in the use of specific equipment. Only 73% of the CCU staff had completed their self-assessment in the last 12 months.
- The CCU had sufficient numbers of nurses who held a post-registration critical care award. The Core Standards for Intensive Care Units (2013) recommend at least 50% of the nurses working in intensive care hold a post-registration award in critical care. Of the 84 nursing staff employed in the CCU, 46 (55%) held such an award.
- Staff development was available and encouraged. Nursing staff were split into four bands on the rota based on their competence and experience. New nurses joining the unit without any critical care experience started as preceptors and were supported through their initial unit competencies. Once they were deemed competent they were encouraged and supported to start their critical care qualification training, at which time they moved into the next group. After completing the critical care course and training in haemofiltration they moved up another group and were encouraged and supported to complete a course in caring for a child in the critical care setting. On achieving this they would reach the last group where they were supported to develop further to enable them to become a sister.
- The unit held monthly mandatory training, which was a mix of theory and simulated scenarios. Additionally, junior doctors received weekly training from one of the consultants. Consultants were supported to maintain paediatric skills through roadshows, yearly updates and the opportunity to spend time in a paediatric intensive care unit at another hospital.

Multidisciplinary working

- There were good multidisciplinary working arrangements in place. Pharmacy, physiotherapy and dietetics were regularly visible in the department, attending appropriate meetings, handovers and ward rounds. Microbiologists attended ward rounds at least once a week, but often twice a week.
- There were good links with the end of life care team and staff worked closely with them to strengthen support to patients and their families at the end of a patient's life.
- Working relationships in the department were excellent. The unit had a real 'family' feel to it with all staff, regardless of role or grade, being included and respected. Visiting staff, whether agency or specialty, were welcomed and valued. At all times we observed staff checking and challenging each other, asking questions and making sure things were being done in the patients' best interests.
- There were clear discharge arrangements, including a formal handover process; however, follow up of patients following discharge was limited. We tracked two patients who had been discharged from the unit to a ward. We found in both cases that relevant and pertinent information had been handed over to the ward staff, including treatment escalation plans, physiotherapy rehabilitation goals and medicine prescriptions. Handovers were recorded and signed by the receiving ward. A new hospital at night team had been established and was responsible for reviewing patients overnight who had been discharged from the CCU during the day. However, there was no formal follow-up process of patients by the CCU on a regular basis. Only patients who had particularly complex conditions were followed up on an informal basis.

Seven-day services

- Consultants were available 24 hours a day, seven days a week. When the unit's consultant was not on site, they provided a thirty minute response on an on-call basis.
- There was good access to services seven days a week. Physiotherapy, imaging, pharmacy and microbiology were all available seven days a week, with out of hours' access available where required through an on-call system.

Access to information

- Patient records were accessible at all times. Every bed space had a dedicated computer for accessing patients' care records. Relevant sections of paper care records were copied onto the electronic system when a patient was admitted to the unit. There were multiple sections

within the electronic care records for different specialties to record relevant information. This made it easy to find information about a patient's care and treatment.

- When a patient was moved out of the unit, for example discharged to another ward, all relevant notes and records required to support their ongoing care were printed from the electronic system and travelled with the patient to the ward.
- Test results, for example X-rays and blood tests, were communicated and made available promptly. Tests and results were prioritised, which ensured the most urgent information was available at the earliest opportunity.
- Policies, procedures and other supporting information were readily available when required. The trust's intranet system had a library of policies, procedures and other useful information. Additionally, the unit had a number of task-specific folders available, including safeguarding and Deprivation of Liberty Safeguards.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had good working knowledge of the Mental Capacity Act 2005 (MCA). The MCA was included as a topic in mandatory training and most staff in the CCU were aware of their role and responsibility in applying the act to keep people safe. The electronic care record did not have a dedicated section for recording MCA assessments or best interest decisions; however, we were shown these were recorded within the nursing or medical notes when required.
- Patients who had the capacity to make their own decisions were supported to do so. Staff took the time to explain treatment options with patients, helping them to understand the consequences of agreeing to or denying treatment. Communication tools were used for patients who were unable to communicate verbally.
- There was limited understanding of the Deprivation of Liberty Safeguards (DoLS) and the use of restraint. Although DoLS was included as a mandatory training subject, most staff we spoke with were not aware of their responsibilities with regard to restraint and gaining authorisations. One manager advised us that there was currently work ongoing with the local safeguarding board and the court of protection to clarify some points and requirements for CCUs to apply for DoLS. They told us they could not remember any DoLS authorisations being applied for in the unit.

Are critical care services caring?

Outstanding ☆

We judged the care given to patients as outstanding.

Patients were truly respected and valued as individuals. Feedback from people who had used the service, including patients and their families, had been overwhelmingly positive. Staff went above and beyond their usual duties to ensure patients experienced compassionate care and that care promoted dignity. Staff got to know patients and built relationships with those who stayed for short or long periods, and with their families and those close to them.

We found many examples of staff going 'above and beyond' to support patients emotionally, and to make the environment as comfortable and welcoming as possible.

People's cultural and religious, social and personal needs were respected. Innovative support for patients, such as the development of patient diaries, was encouraged and valued.

Staff took the time to ensure patients and their families understood and were involved with care plans.

Compassionate care

- Patients and visitors were treated with compassion at all times. Patient care was truly at the forefront for everyone working in the unit and staff interactions with patients and visitors were exemplary. All staff from the multidisciplinary team took the time to talk with patients, even when they were sedated, explaining what they were doing and having friendly conversations. Visitors were welcomed into the department and staff made sure they took the time to talk with all visitors in a caring manner.
- We saw examples of staff 'going the extra mile' for their patients. One patient who had been extubated the previous day (the tube that had been used to help them breath had been removed) wanted to use their mobile phone but the battery had run out. Because the patient's charger had not undergone a portable appliance test (PAT) they could not use it in the sockets provided in the room. The nurse caring for the patient spent a long time tracking down someone in the hospital who could complete a PAT on the charger, who

duly visited and allowed the charger to be used so the patient could use their phone. The same patient told us the staff caring for them had been "extraordinary" and gone to another ward overnight to get them some biscuits because they were hungry.

- We saw one patient struggling to send an email on their mobile phone being assisted by a nurse. Another patient who was on a sedation hold (a daily period where sedation is withheld) had become quite agitated. The nurse caring for the patient was reassuring, calm and supportive. When it was decided to sedate the patient again the nurse kept talking to the patient, even after the sedation had been completed.
- We were shown photographs of a birthday party that had been held on the unit for one patient, and were told about children being supported to visit loved ones. Small pets were permitted to visit on the unit for longer stay patients and this was arranged with support from the trust's infection prevention and control specialists to ensure it was done safely. Patients who were able to be supported to go outside were accompanied by staff to provide additional stimulation, and beds in the unit could be turned to face external windows so that patients who were awake could see outside.
- Feedback from patients and visitors praised the caring nature of the staff. The unit had feedback forms that asked visitors to record what had gone well, and what could be made better. There were no negative comments about the care being given, only praise for the staff. Additionally, the unit had participated in the national Family Reported Experiences Evaluation (FREE). This independent study spoke with 370 relatives of 209 patients between June 2013 and June 2014. It asked them to give feedback on their experiences in the CCU. The report was overwhelmingly positive about the care provided, with comments including:
- "Excellent care – my husband was in very good hands"
- "I cannot praise the care…highly enough."
- "The ICU provided…compassionate care…"
- "…one could easily imagine each nurse was a family member."
- Privacy and dignity was maintained at all times. The majority of bed spaces were single occupancy rooms with window blinds and closable doors. There were some bed spaces in curtained bays, with four bed spaces in a square arrangement (two next to each other and two opposite). At all times we saw curtains being drawn and doors close to maintain privacy and dignity. In the four-bedded area staff tried to place the same sex patients opposite each other but where this was not possible curtains were kept closed to prevent patients overlooking each other.
- Staff and systems promoted patient confidentiality. All care records were electronic and computers were password protected to prevent unauthorised access. Discussions with patients were at a volume that allowed the patient and anyone else in attendance to hear, while limiting the risk of neighbouring patients and visitors overhearing.

Understanding and involvement of patients and those close to them

- Patients and their relatives were informed about, and involved with, patient care. We saw staff talking with patients and visitors, explaining in understandable terms what was happening and giving them the opportunity to ask questions. One patient's relatives told us they felt "well informed and involved in decisions." Other comments received as part of the FREE study included:
- "I feel I was well informed…"
- "Always told me what they were doing and why."
- "They...would take time to answer any questions."
- The unit led on, and participated in, organ donation programmes. The clinical lead for organ donation explained how a specialist nurse for organ donation would be available to assist staff with initiating discussions with relatives around organ donation, although may not be present at every discussion. It was generally the nurse in charge who would start a conversation about organ donation in the absence of a specialist nurse, and they had received some guidance on how best to do this. We were told that family members were given time to understand what organ donation involved and how it could benefit other patients. Families were then enabled to make an informed decision about organ donation and would be supported by the staff throughout.

Emotional support

- The unit had good support mechanisms for patients and their friends and families. Patient diaries were used for all patients who were in the unit for more than 48 hours, with good results. The diaries were contributed to by staff and visitors and encouraged entries to be

personal and relevant to the patient. Research has shown how patients sedated and ventilated in critical care suffer memory loss and often experience psychological disturbances post discharge. Patient diaries have been shown to provide comfort to patients and their relatives, both during the stay and after discharge. They provide an opportunity to fill the memory gap, and have also been found to be a caring intervention which can promote holistic nursing. We saw patient diaries that were in use. We read comments from staff about what the patient had been experiencing that day, and from relatives filling in news about loved ones, pets, the weather and other items of interest.

- The unit was also using a 'This Is Me' form for all their patients. This included information about the patient, such as the name they preferred to be known by, who their friends and family are, their hobbies and interests and any spiritual or religious beliefs they held. This enabled staff to provide emotional support to patients that recognised their individuality.
- Family feedback as part of the FREE study included:
- "The nurses hugged me when they saw I needed comfort."
- "…their genuine concern for families is humbling."
- "The hugs went a long way – thank you ICU nurses."
- Spiritual support was available from the multi-faith chaplaincy. The chaplain visited the unit at least once a week, and more often if a patient or their family requested.
- The unit had a number of volunteers who gave up their time every afternoon, with the exception of a Saturday, to greet visitors when they arrived at the unit. These volunteers provided a friendly and caring presence at the entrance, and ensured visitors were comfortable and being supported.
- Patients who showed signs of depression or anxiety could be referred to a psychologist to promote emotional recovery, and counselling services were also available. Additionally, a multi-faith chaplaincy service was available 24 hours a day, seven days a week.

Are critical care services responsive?

Good

We have judged the responsiveness of critical care to be good.

The critical care service responded well to patients' needs. Communication aids, including translation services, were available for patients who could not otherwise communicate easily or effectively.

There were bed pressures in the rest of the hospital that meant about 50% of patients were delayed in their discharge from the unit, but the numbers of these incidences were below the NHS national average. Very few patients were discharged onto wards at night and there was a very low rate of elective surgical operations being cancelled because a critical care bed was not available.

The facilities for patients, visitors and staff in critical care were good, although as it was an old unit not all of the modern critical care building standards were met. There was a good response from consultants and nurses when new patients were admitted. Patients were treated as individuals, and there were strong link nurse roles for all aspects of patient need, including learning disabilities, dementia and end of life care.

The unit did not provide a follow-up clinic. However, funding and cover arrangements were being put in place to ensure this was reintroduced.

There were no barriers to people who wanted to complain. There were, however, few complaints made to the department. Those that had been made were fully investigated and responded to with compassion and in a timely way. Improvements and learning were evident from any complaints or incidents.

Service planning and delivery to meet the needs of local people

- The service had been designed and planned to meet people's needs. The unit was located within the hospital to enable staff to respond to emergencies either within the critical care unit or the operating theatres. The emergency department was on the floor below the unit and easily accessible. Despite issues with access and flow due to bed pressures in the hospital and elsewhere

in the health economy, the unit was responsive to emergency admissions and was very rarely unable to provide a critically unwell patient with a bed and the care and treatment they needed.
- There was good provision of facilities for visitors to the unit. A comfortable and bright waiting room was available just within the entrance to the unit and away from the main the clinical area. Feedback from visitors that the room was too hot had been taken on board and fans were now available in the room.
- Overnight accommodation was available on the hospital site. Allocation of the accommodation was on a first-come, first-served basis with the CCU being prioritised. In the event that accommodation was not available, there was a list of local bed and breakfasts and hotels available in the waiting room.
- The unit had a dedicated consultation room where staff could talk to relatives in a comfortable environment away from the ward. If the room was not in use and visitors wanted somewhere quiet to sit, they were allowed to make use of the consultation room.
- The CCU had equipment to meet patient's health needs that could be unrelated to their critical illness or condition. This included, for example, haemofiltration and dialysis machines to provide treatment for patients with kidney failure which might be unrelated to their critical illness.
- It was recognised that the CCU was a 'mixed sex' environment and did not meet all the gender separation rules. However, the Department of Health guidance recognised that gender separation was difficult to fully manage in the critical care environment and staff made best use of the available space and equipment to ensure privacy and dignity with this regard. Like many intensive care units nationally the CCU had no provision of separate gender toilets or washing facilities to meet the element of the same-sex rules. The Intensive Care National Audit and Research Centre (ICNARC) data showed about 49% of discharges from critical care to a ward were delayed over four hours. This meant the unit often breached the same-sex rules as they related to providing washing facilities and toilets.
- The unit operated a 'stabilisation before retrieval' service for children under the age of 16 requiring level 3 (intensive) care. Children requiring high dependency care were usually cared for in the dedicated children's high dependency unit in the hospital. Children requiring intensive care were initially treated in a dedicated children's bed space in the unit before a team from a children's specialist hospital arrived to retrieve the patient. In a few cases, children had been admitted to the unit for continuing treatment on advice from, and on close liaison with, the specialist children's centre. At least one nurse who had completed a course in caring from children in an intensive care setting was on duty at all times in case a child was admitted.
- The unit did not have a follow-up clinic. The Core Standards for Intensive Care Units (2013) recommend that patients discharged from intensive care should have access to a follow-up clinic. The unit had been running a follow-up clinic for several years but this had been unfunded and was not sustainable. A project was being completed to review the provision and gain adequate funding so a formal follow-up clinic could be introduced. We were told that some patients were still being seen on an ad-hoc basis following a referral from their doctor, and these cases input from clinical psychology was available if needed.

Meeting people's individual needs

- The unit had access to, and good relationships with, learning disability and dementia specialist nurses. There were link nurses in the unit who were able to advise other staff on best practice and we saw supportive processes in place to help staff respond appropriately respond to these patients' needs. On one feedback comment we read that staff had been "excellent with mental/learning difficulties."
- Interpreting services were available through an external provider. We were told this was primarily telephone based, but an interpreter could attend if notice was given. The need for interpreter input was minimal in the unit, but we were given one example of a Polish patient requiring an interpreter where the telephone translation service was used until a face to face interpreter could be found. Another example we were given was of a patient's relative who was Indian and spoke little English. The unit was able to provide a nurse who spoke the same dialect as the patient to aid communication with this family member.
- The unit had some communication aids for patients who were unable to speak, and were raising charitable funds to purchase new equipment. 'Low tech' communication aids, such as letter boards and coloured charts, were available to assist patients who were not verbally communicative. The unit wanted to purchase

some new technology to improve these aids and had worked with a long-stay patient and their family to create a recipe book to raise money to fund this, with recipes being collected from staff, celebrities and local restaurants.

- All patients we reviewed had treatment plans with clear timeframes and objectives. We saw documentation was clear and concise. Records contained assessments, diagnoses and plans for treatment with rationalised objectives and achievable timescales for tasks and reviews.
- Information was readily available to support patients, their relatives and friends. The unit had a printed leaflet for relatives and friends with useful information about the care provided in a critical care unit. It explained the visiting times in the unit, the availability of waiting rooms and accommodation, contacting the unit, and spiritual support. Additionally, there were multiple information leaflets on a wide range of subjects available in the waiting room, including the Patient Advice and Liaison Service.
- A psychiatrist was available if required. During our inspection we saw a psychiatrist on the unit working with one patient who had a possible mental health-related condition. We were told this service was available and provided good support to the unit.

Access and flow

- The trust had a clear admissions policy and guidance flowchart for admission to the CCU. The flowchart was broken down into pathways for elective admissions, emergency admissions and 'other' admissions (for example, requests from other hospitals). All admissions were discussed with the CCU first, and in the rare event of a CCU bed not being available when needed qualified staff from the CCU would be expected to care for that patient outside of the unit until a bed became available. In practice this usually meant the supernumerary shift coordinator would take over a patient's care in the unit to release a nurse to attend recovery.
- The biggest challenge facing the unit's access and flow was patient discharge. In 2014/15 just under 50% of discharges were delayed, although this was below (better than) the national average of about 60%. We were told the main impact on this was bed availability in other areas of the hospital, which meant patients could not be discharged to a ward at the earliest opportunity. Out of hours discharges were rare. The CCU performed better than the national average for the number of patients discharged from the unit out of hours. It is recognised that patients discharged overnight are at increased risk of deteriorating. Best practice is therefore that overnight discharges are limited; however, this can have an impact on inflating the numbers of delayed discharges.
- In 2014/15 the unit transferred fewer patients to CCUs in other hospitals for non-clinical reasons (for example, lack of bed space) when compared to the national average.
- The unit's bed occupancy levels were below (better than) the national average for eight out of the 16 months between April 2014 and July 2015, and above for seven. The remaining month was in line with the national average. The Royal College of Anaesthetists recommend maximum critical care bed occupancy of 80%. Bed occupancy figures for April 2014 to July 2015 showed occupancy levels were above 80% half the time (eight out of 16 months). On one occasion, in February 2015, the unit reported 100% bed occupancy. More recently, in June and July 2015, average adult occupancy levels were 78% and 83% respectively. Bed occupancy levels generally increased due to a lack of a ward bed into which to move a discharged patient, and, as with the national picture, due to an increasing demand for critical care beds which was not meeting rising demand.
- Since January 2015 there had been five incidents where elective surgery requiring a CCU bed post-surgery had been cancelled because a CCU bed was not available. These all occurred in January and February at a time when the trust and wider health economy was experiencing unprecedented demand for services.
- Bookings for elective surgery patients potentially requiring a CCU bed were managed centrally and were limited to two patients a day. In some cases it was agreed that three patients could be booked, but it was always made clear that the least urgent operation may be cancelled in the event of a surge in demand. Elective admissions were recorded in an electronic calendar and copied into a paper diary on the unit, which was checked daily.
- Very rarely patients were nursed in the theatre recovery area due to a lack of beds on the CCU. There had only

been one reported case of a patient being nursed in recovery in the previous 12 months (January 2015), and three in the previous 15 months. These cases were reported as incidents for investigation and analysis.

Learning from complaints and concerns

- The CCU had not received any complaints in the last 12 months. We reviewed the last complaint they had received and found good multidisciplinary involvement in the investigation and good communication with the complainant. Records were clear and lessons learned recorded and effectively disseminated.
- The Patient Advice and Liaison Service (PALS) was advertised in the waiting room, with leaflets about their services available for relatives to take away. Staff told us that should a patient wish to make a complaint they would attempt to resolve any concerns within the unit first before involving the PALS team.

Are critical care services well-led?

Outstanding ☆

We judged the leadership of the critical care service to be outstanding.

The leadership, governance and culture on the unit were used to drive and improve the delivery of high-quality person-centred care. All the senior staff were committed to their patients, staff and the unit with an inspiring shared purpose.

There was strong evidence and data to base decisions upon and drive the service forward from a clear programme of audits and national evaluative studies. There was accountability for driving through actions and improvements.

Staff, patients and their families were actively engaged with to identify areas of good practice, as well as areas that could be improved.

There was a high level of staff satisfaction, with staff saying they were proud of the unit as a place in which to work. They spoke highly of the culture and consistently high levels of constructive engagement.

Staff were actively encouraged to raise concerns through an open, transparent and no-blame culture.

The leadership drove continuous improvement and staff were accountable for delivering change. Innovation and improvement were celebrated and encouraged, with a proactive approach to achieving best practice and sustainable models of care.

Vision and strategy for this service

- The CCU had a local vision to increase its capacity and modernise the unit in order to provide the safest and most effective care possible. Although initial draft plans had been drawn up earlier this year, the vision had not been put into a strategy due to financial constraints and other priorities within the division and hospital. However, staff, managers and executives were all aware of the need to review the delivery of critical care services with increasing demand.
- The divisional strategy document for 2014/15 to 2016/17 included a plan to increase CCU staffing to match the demand from the previous year (2013/14). The strategy included a timeframe for achieving this goal and provided progress updates for the board. It had been developed based on staff feedback and analysis of demand profiles.

Governance, risk management and quality measurement

- There was a clear and effective governance framework and structure in the CCU. The unit had a consultant lead for governance who oversaw and managed the governance processes for the unit. Regular meetings were firmly embedded in business planning and reporting structures between the unit, division and trust were in place.
- The unit held monthly departmental governance, mortality and morbidity meetings with representation from all staffing groups. Attendance at the meetings was encouraged, and minutes were circulated to all staff promptly after each one. The unit's lead pharmacist and physiotherapist attended and contributed to the meetings on a regular basis. Safety performance, reported incidents and subsequent learning, quality indicators and the unit's risk register were all standing agenda items. The risk assessment against the Core Standards for Intensive Care Units (2013) had also been presented at the governance meeting, ensuring required actions were discussed with the multidisciplinary team and monitored closely.

- The unit participated in the monthly divisional performance review meeting and kept the CCU staff up to date. The meeting was regularly attended by the CCU's consultant governance lead, with the senior nurse and lead consultant attending occasionally. Items including safety performance, finance and staffing were reviewed. Details and actions from this meeting were captured in minutes, which were circulated to attending members. Unit managers communicated important safety performance issues back to staff during the daily safety brief, or at team meetings. We saw evidence of this in the minutes of team meetings. Additionally, performance data was displayed on the noticeboard in the staff room.
- A clinical audit programme existed and a dedicated audit lead had been appointed in the consultant group. The audit lead focussed on ensuring important and relevant audit programmes were completed, for example the Intensive Care National Audit and Research Centre (ICNARC) data returns. Other audits included the International Multicentre Prevalence Study on Sepsis, the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) pancreatitis study, and two local audits around central lines and cannulation. The clinical lead translated audit results into meaningful reports for staff and items were discussed at governance meetings to ensure appropriate actions were recorded and monitored.
- The unit had a risk register, which was linked to the divisional and trust risk registers at certain trigger points. There were two items on the risk register, both of which were recognised and understood by the managers and staff in the CCU. The two items were:
- Capacity versus rising demand – this had been placed on the risk register in March 2015. The risk had been escalated to the divisional risk register and control measures, including effective management of elective admissions, had been identified. There were no progress updates against this risk.
- Overnight doctor cover. This had been placed on the risk register in May 2014. The risk had been escalated to the divisional risk register and control measures were in place to contact another doctor from elsewhere in the hospital or call in the on-call consultant. There were no progress updates against this risk.
- The lead consultant was aware that the overnight doctor cover did not meet recommended standards, placed this as a risk on the department's risk register and escalated it to the divisional risk register. A business case was presented to increase the numbers of staff to allow for sufficient overnight cover, however this was only agreed in part. Work was ongoing to review the consultant rota and doctor rota to see how adequate cover could be provided, but this was proving challenging without further financial investment. We were told a further case for additional funding would be made for the new financial year, but without this funding there was little the unit managers were able to do to improve overnight medical cover.

Leadership of service

- The leadership of the service by the lead consultant and the team of experienced staff was strong and committed. There was a genuine commitment to achieving an excellent service, with good clinical governance helping to deliver a consistently safe, effective, caring and responsive service. The nurses we spoke with had a high regard and well-earned respect for their medical colleagues and the allied health professionals, and vice-versa.
- The nursing leadership of the service was strong. The matron and senior nursing staff demonstrated a strong commitment to their staff, their patients and one another. They were visible on the unit and available to staff to assist with patient care at times of high demand, or if staff needed to talk something through. The consultants we spoke with had a high regard and respect for the nursing team, and the allied health professionals. The nursing team was described by several consultants and doctors as "fantastic". Staff told us managers were "supportive and approachable", and they were visible in the unit.
- Managers had good foresight, recognising emerging issues and responding to them before a problem arose. For example, the lead nurse had recognised an upcoming change in the skill mix of the team as a result of a number of staffing coming up to retirement which meant new staff coming into the department. In response to this, two full time practice education posts were created and recruited into in order that new staff could be adequately inducted and supported without impacting on the existing staff group.

- Each shift was coordinated by a supernumerary nurse in charge. The nurse in charge of the shift very rarely had direct patient care responsibilities, allowing them to oversee the smooth running of the unit. When required, for example in times of high demand or to cover staff breaks, the nurse in charge would take over patient care with the unit coordination being supported by all staff.

Culture within the service

- Staff worked collaboratively in a culture that promoted safe and effective patient care. All staff, regardless of grade or position, were encouraged and given the opportunity to talk openly with each other, and felt safe doing so. We saw doctors asking nurses for their thoughts on patient treatments, and saw nurses asking questions of doctors when they were unsure about something.
- The CCU team were praised by visitors and patients as being "cohesive" and "genuinely putting the patient first". Staff told us they loved the team work, with comments including: "This is the nicest team I've worked with in 30 years" and "Best team in the hospital for support". Volunteers told us they felt included and valued as part of the wider team.
- Staff were respected and valued as part of the CCU team. All grades of staff told us they felt valued and respected by others, including management. We saw evidence that staff were included in important discussions, for example rota reviews and being encouraged to suggest ways things could be improved. We also saw day to day relationships in the unit promoting a respectful culture, with all staff appearing to be a on a 'level playing field', regardless of seniority or role.
- Staff at the hospital had welcomed the use of daily communications meetings (known as the 'Comms Cell') to promote a learning culture. The meetings were undertaken daily with all staff groups encouraged to attend. Areas of discussion included updates, new learning and complaints. Staff confirmed that when used, the meetings were a positive learning experience for all staff.
- Staff wellbeing was an important consideration in the CCU. Managers and colleagues took a genuine interest in the wellbeing of staff in the unit. Being a strong team working closely together we found that day to day conversations always considered others' wellbeing. There was a section dedicated to staff wellbeing on the staff noticeboard, including numbers for the trust's counselling service. Additionally, a survey was established and carried out in April and May 2015 to identify key stressors for unit staff from January 2015. Working with a local university, the practice developers looked to identify areas where they could have a positive impact. The survey was planned to be repeated in early 2016 to see if any impact had been made, and how further work could be completed.

Public and staff engagement

- Visitors and staff were encouraged to give feedback to help identify what was going well and where things could be done even better. Visitors were asked to complete a simple form asking the two questions "What went well?" and "Even better if…?" The unit's volunteers helped to promote this. Comment cards were displayed in the waiting room, with responses and updates about suggestions for improvement located alongside. One example of feedback from visitors was the high temperature in the waiting room. In response, the unit had purchased fans to help keep the waiting room cooler and the feedback card was noted to reflect this. Another example of visitor feedback having a positive impact was a suggestion that visitors could be used to welcome people when they arrive at the unit. This was taken forward, with volunteers working six days a week and recruitment being continued to try and cover the remaining day.
- The unit had also taken part in the national Family Reported Experiences Evaluation (FREE). This independent study spoke with 370 relatives of 209 patients between June 2013 and June 2014. In response to a comment about a quiet room being available for visitors who needed some time alone, the consultation room was made available when it was not already being used.
- In the staff room there was a section on the notice board dedicated to service improvement. Staff were encouraged to complete feedback in the form of problem solving, what went well and what could be done better. Responses to suggestions were recorded, and progress for any changes updated. This was visible and accessible to all staff and was being well used.

Innovation, improvement and sustainability

- Staff were encouraged to make suggestions about how services could be improved. Feedback from all staff,

including agency nurses, was sought by the unit managers. In addition to a dedicated feedback area on the staff noticeboard, a book on the nurses' station was also available for staff to write about any suggestions. We saw evidence of managers responding to these, and progress against that were being taken forward was regularly updated.

- On the 'Problem Solving : 3Cs' (concern, cause, countermeasure) section, we saw the following:

- Nursing handovers were taking too long. In response, a new handover process had been trialled and subsequently rolled out, with progress being marked as complete.
- There was a lack of computer desks in the unit, with computers being stored on inappropriate trolleys. A trial of alternative desks had been completed and new desks purchased and introduced. This action was marked as complete.
- The keys to the medicines cupboards were not always easy to locate. A new swipe card access to the store room had been introduced, and two people in the unit were nominated every day as key holders so staff knew who to go to when they needed the keys. This action was also completed.
- There had been an issue with agency nurses not being able to access the computer systems. A solution had been agreed with the IT department. A number of temporary username and passwords were going to be issued for allocation to agency nursing staff on a shift-by-shift basis. This item was still in progress.

- Some items on the 'What went well?' section included:

- A debrief that had been set up for staff following the death of a patient on the unit who subsequently went on to be an organ donor. All staff had been able to attend and found it supportive and reassuring.
- A ventilated patient had been taken home overnight, accompanied by unit staff to keep them safe.
- All staff in the unit had been nominated for an Extraordinary People Award in the Excellent Care Award category.

- And in the 'Even better if…' section we found:

- More cables for TVs would be advantageous because there were only three, which limited the number of patients who could watch television. This had been resolved.
- TV signal was often poor in the unit, with patients not always being able to watch what they would like as a result. This had been resolved.
- Accommodation was not available for visitors to stay overnight. This had been resolved with the wider hospital, with accommodation now being available.

- An innovative role in critical care started in the Exeter CCU before being rolled out nationally. An Advanced Critical Care Practitioner (ACCP), or nurse consultant, worked full time in the unit, bridging the gap between the medical and nursing staff groups. They worked as part of the medical rota, undertaking a number of traditionally-medical tasks, including responding to the medical emergency team call-outs. The individual was the only non-medical member of the Faculty of Intensive Care Medicine's board and worked nationally to promote and further develop the role. The benefits of the role had been evaluated by unit managers and funding had been agreed to introduce a further two ACCPs to the unit.

Maternity and gynaecology

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

Information about the service

Royal Devon and Exeter NHS Foundation Trust provided a range of antenatal, perinatal and postnatal maternity services in Wonford Hospital and the community. Maternity and gynaecology services were managed within the specialist services division of the trust's services.

The consultant led unit was located within the Centre for Women's Health and provided care for women with high risk and/or complex pregnancies. There were 10 delivery rooms on the labour ward, one of which had a birthing pool for women in labour to use. Alongside the labour ward there was a theatre suite which comprised of three theatres. One was used for obstetric surgery, one for gynaecology and one for gynaecology day surgery.

Antenatal and postnatal care and treatment was provided on a 43 bed ward. This was divided into the following areas;

- eight postnatal beds allocated to the co-located birth centre,
- four bed bay for women requiring induction of labour,
- four transitional care beds,
- eight antenatal,
- eighteen postnatal and
- four flexible beds located in two side rooms which were used dependent on need.

There was a co-located midwife led unit at the hospital for women who were assessed as low risk. We were told women were encouraged to deliver their babies here or within the community unless there was an identified risk or complication that required them to deliver in the consultant led unit. Women were assessed against strict criteria to determine the level of risk.

There were three midwife led birthing centres located in Honiton, Tiverton and Okehampton. We did not visit the midwife led birthing centres during this inspection as they were registered as separate locations. Women were also assisted to give birth at home when assessed as safe to do so.

The trusts internal reporting system showed a total of 4,102 births between April 2014 and March 2015. We were provided with data which showed the Exeter midwifery led birth centre had delivered 630 babies, Honiton birthing centre 51, Tiverton 74 and at Okehampton birthing centre 51 were born during this time period. 102 women had been assisted to give birth at home. The remaining births had been in the obstetric led unit. The numbers of multiple and single births were comparable to the England average.

Gynaecology care and treatment was provided on Wynard South, a 14 bed ward, located in the Centre for Women's Health. This ward also had an attached 10 bed day surgery unit. The ward had recently been divided providing medical care on Wynard North and gynaecology care on Wynard South.

Outpatient facilities and services were available for women and included antenatal clinics, screening clinics, fetal and maternal assessment unit, ultrasound clinics, ambulatory gynaecological care and treatment, early pregnancy assessment unit, fertility and colposcopy services. A

termination of pregnancy service was provided. This was for medical and surgical terminations and between April 2014 and April 2015 a total of 129 medical terminations and 474 surgical terminations were carried out.

During our inspection we spoke with 19 patients and five relatives, who all made positive comments about the service they had received. We received 34 comment cards from patients who had attended the birthing centres.

We spoke with 49 members of staff including consultants, junior and middle grade doctors, senior managers, matrons, ward sisters, registered nurses, midwives, supervisors of midwives, student nurses, student midwives, midwife support workers, nursing auxiliaries, housekeeping and administration staff. We reviewed seven patients' healthcare records. Before, during and after our inspection we reviewed the trusts performance information.

Summary of findings

Overall we rated safe as requires improvement. We judged the maternity and gynaecology services were effective, responsive and well led. We rated the maternity and gynaecology services as outstanding for caring.

We have judged safety in the maternity and gynaecology services as requiring improvement. Some medicines and cleaning chemicals were not secured at all times which meant they could have been accessed by visitors or patients on the ward.

Patient's confidential and personal information was not stored securely at all times on the wards and in the clinics. This meant it was accessible to others.

The staffing levels on the maternity unit were affected when cover was required in the labour ward to ensure women received 1:1 care. At times this meant other areas were left staffed below the planned establishment level. The midwife to patient ratio was worse than recommended levels set by the Royal College of Obstetricians and Gynaecologists (RCOG 2007) Safer Childbirth Minimum Standards for the Organisation and Delivery of Care in Labour. The RCOG recommends there should be an average midwife to birth ration of 1:28 but at this trust in September 2015 the ratio peaked at 1:34. The average midwife to birth ratio was 1:32.

Nursing and midwifery staff were encouraged to report incidents and robust systems were in place to ensure lessons information and learning.

The maternity and gynaecology service were responsive to the needs of women living locally and those further away from the hospital. Services were provided in the areas where women lived for example, ante and postnatal clinics. Women had access to maternity and gynaecology emergency clinics seven days a week.

All wards and departments we visited were visibly very clean and hygienic in appearance. We saw staff adhered to the trust policies and procedures regarding infection control. However, audits conducted by the trust showed inconsistencies amongst staff regarding hand hygiene.

Maternity and gynaecology

Care was delivered in line with the Royal College of Gynaecologists and Obstetricians standards and the National Institute for Health and Care Excellence (NICE) guidelines

It was clear that staff worked well as a cohesive and effective team across the maternity services and gynaecology speciality as well as with other departments of the hospital. The culture of the hospital was inclusive, supportive and staff spoke often as being part of a large family when at work. This cascaded to the patients who spoke of a warm and caring environment.

Women received their care and treatment from trained and competent staff who were supported by their line managers to provide an effective service. Consultant, nursing and midwifery leadership was described as good, with practical examples given by staff to support their experience.

These were overwhelmingly positive and complimentary about the care and service provided with the exception of one comment where the patient felt they had received conflicting information. Patients all said they were treated with respect, their dignity promoted and that staff were kind and helpful.

We observed patients were treated with respect, their dignity promoted and they were involved in discussions about their care and treatment. Patients felt they were listened to and their choices and preferences respected.

The organisation welcomed feedback from staff and there was a culture of listening to staff and learning from incidents. Clear evidence was available to support that the services were well led at a local level. Staff were able to meet with their managers regularly and approach them for support and guidance. Staff all commented they felt proud to work in the trust and felt they were a cohesive dedicated team who were well supported in their roles.

There were comprehensive risk, quality and governance structures and systems in place though some risks had been on the risk register for a considerable length of time.

Are maternity and gynaecology services safe?

Requires improvement

We judged the safe domain as requiring improvement for the maternity and gynaecology services. Staffing levels on the maternity services were at times below the planned establishment levels. This was due to sickness and staff being moved to other areas to ensure women received 1:1 support in labour. This caused staff concern at times when units were busy and left without a full staff team.

The maternity and gynaecology wards did not ensure the safe storage of medicines. We saw medicines unattended in areas that were accessible to the public and patients.

Patients records were not stored securely which meant their personal and confidential information could be accessed by others.

The clinical areas appeared tidy, clean and hygienic. Audits of infection control procedures were carried out. The hand hygiene audit for the maternity services found that some areas did not meet the trust compliance target but there was no evidence to support the action taken in response to this.

The maternity and gynaecology services encouraged staff to report incidents. Staff said they felt encouraged and empowered to report incidents and received feedback regarding this. Learning was taken from incidents and staff were informed of action plans put in place to reduce the risk of the incident happening again.

Incidents

- Staff were encouraged to report incidents through the trust electronic reporting system. Staff told us they felt able to report incidents and received feedback following such a report.
- Information and learning from incidents was shared with the staff teams at team meetings and within the maternity and gynaecology newsletters to reduce the risk of similar situations reoccurring.

- A log was kept which evidenced how learning from individual incident reports and investigations had been provided to staff. This ensured staff were aware of actions which had been put in place to reduce the risk of the incident happening again.
- The trust provided managers with a 'grading matrix' to use to assess the risk to the service from actual and potential consequences of the incident. The matrix provided a colour coded risk rating which corresponded with guidance on when to take action and/or escalate the incident within the trust.
- We were provided with information and documentation regarding one incident which had been fully investigated by the trust. The outcome was escalated to the trust governance team and an action plan put in place to ensure learning from incidents and to reduce the risk to patients in the future.
- The Supervisors of Midwives (SOM) were made aware of reported incidents which had involved midwives. The SOM provided support to midwives they supervised and another SOM would be tasked to carry out an investigation into the incident and report to the Head of Midwifery.
- Between August 2014 and July 2015 the trust reported a total of five incidents through the national Strategic Information Executive Information System (STEIS). These were all regarding newly born babies who required unexpected admission to the neonatal unit. The incidents met the criteria for reporting as determined by STEIS prior to March 2015.
- The guidance for reporting serious incidents was amended in March 2015 and the trust has followed the Department of Health serious incident framework guidance (March 2015). This states each incident must be considered on an individual basis against a revised description of incidents. Each reported incident since March 2015 was reviewed by the Head of Midwifery, discussed at the midwifery managers meeting and forwarded to the trust board where it was considered whether any action/treatment could have been improved upon. This information assisted the Director of Nursing and senior managers when making decisions on whether the incident was reported to STEIS. No never events had been reported for maternity or gynaecology. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. NHS trusts are required to monitor the occurrence of Never Events within the services they commission and publicly report them on an annual basis.
- Perinatal mortality and morbidity meetings were held every other month. We were provided with minutes from the trust of recent meetings held. The meetings followed a set format during which case studies were presented and actions decided upon.

Duty of Candour

- During November 2014, a new regulation was introduced to providers of NHS patients who were required to comply with the Duty of Candour Regulation 20 of the Health and social care act 2008 (regulated activities) Regulations 2014. This related to incidents termed as 'reportable patient safety incidents'. These were any unintended or unexpected incidents occurring to a patient leading to death, severe, moderate or prolonged psychological harm. This regulation requires staff to be open, transparent and candid with patients and relatives when things had gone wrong.
- The electronic incident reporting template used by the trust prompted staff to consider Duty of Candour when completing following an incident. Any incident rated moderate or above regarding risk to patients, triggered information being sent to managers within the maternity and/or gynaecology services and the wider trust. The governance manager for the division had a responsibility to make sure the Duty of Candour process had been undertaken.
- We saw a detailed investigation report following a reported incident which identified the patient was provided with information and an apology for their experience. One patient's records we looked at showed Duty of Candour was adhered to when potential patient safety incidents were reported.
- Staff we spoke with demonstrated an understanding of Duty of Candour principles although some staff were not aware of it by name.
- Duty of Candour training was provided as part of the ongoing annual update training for maternity and gynaecology staff.

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. Wynard South (gynaecology)

participated in the NHS safety thermometer and collected information each month in respect to patient falls, catheters, urinary tract infection and pressures sores. Results of the safety thermometer reported 100% harm free care from May 2015 to October 2015. Staff we spoke with informed us that if the service provided less than 98% harm free care an investigation into the incidents would take place.

- The Maternity Dashboards (both a local dashboard and the South West Strategic Maternity Network Dashboards) recorded activity and clinical indicators to gather information and data regarding the outcomes for women and their babies. This included perineal and/or abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. In addition the department identified any babies who had an Apgar score of less than seven at five minutes and/or those who were admitted to a Neonatal Unit. The Apgar test is designed to quickly evaluate a newborn's physical condition and to see if there is an immediate need for extra medical or emergency care.
- Women admitted to the maternity unit were assessed on admission for risks relating to venous thrombosis. We saw from patient records these were consistently completed.

Cleanliness, infection control and hygiene

- All wards and departments we visited were visibly very clean. Equipment appeared clean and ready to use. Some equipment, such as commodes, had stickers attached which informed when it had been cleaned and who by. However, this system was not consistently followed and some equipment did not provide this visual evidence that it was clean and ready for use.
- The CQCs Survey of Women's Experiences of Maternity Services 2013 found that the trust compared the same as other trusts regarding the cleanliness of the ward, bathroom and toilets provided.
- Data from the trust showed that emergency admissions admitted to the gynaecology ward rated as amber for screening for methicillin-resistant Staphylococcus aureus (MRSA) with between 74-81% of patients screened. We did not see evidence of any action taken to increase the incidence of screening.
- MRSA Screening of elective admissions was higher with between 91 and 96% of patients admitted to Wynard South being tested. We were informed that a high number of patients admitted for planned surgery had a pre-operative assessment and checks were completed in the gynaecology clinic prior to the day of their admission. As this was part of the preoperative assessment process staff felt this increased the compliance with testing for MRSA.
- Wynard Ward displayed excellence awards that had been presented to the ward in January 2015 showing they had no catheter related bacteraemias for six months, no MRSA bacteraemia for three years and no ward acquired MRSA in 2014.
- We saw staff adhering to the trust's infection control policy. Hand gel was placed at each patient's bedside and we saw staff using this. Information was displayed in clinical areas to remind staff about correct hand washing procedures. We observed staff were bare below the elbows and long hair was tied back.
- Monthly audits of hand hygiene took place on Wynard Ward. Between September 2014 and August 2015 audit results showed 100% of nursing staff and 99% of housekeeping staff complied with procedures.
- The audits taken from the antenatal and postnatal ward identified that since July 2014 seven out of the 12 monthly audits completed identified staff did not follow procedures relating to hand hygiene with the ward not meeting the trust target of 90%. The hand hygiene audits displayed on the labour ward showed staff had not met the trust target with 75% compliance in September and 85% compliance in October. There was no information provided on any action that was being taken to address this.
- The theatre staff had an infection control link nurse who updated the staff on issues around infection control. Two members of staff in the department observed hand hygiene procedures and fed back any identified issues to the member of staff concerned. However, no formal audit was carried out in theatre regarding effective hand washing.
- Staff were informed and knowledgeable about promoting the control of infection and we observed one patient being nursed appropriately when they had a communicable illness.
- The Patient Led Assessments of the Care Environment (PLACE) 2015 scored the trust at 100% for cleanliness compared to the England average of 98%.
- The labour ward and co-located birth unit enabled women to labour and deliver in a birthing pool. We noted that records were maintained of the routine daily cleaning of the birthing pool. The pool was also cleaned

after every use and a sticker used to identify this had been carried out. The taps were set to run automatically at intervals, to reduce the risk of Legionnaires disease. Legionnaire's disease is a form of pneumonia that is spread chiefly by water droplets which contain the bacteria legionella. Flushing water through the pipework and water outlets reduces the risk from legionella.

- We found the Control of Substances Hazardous to Health (COSHH) regulations were not complied with. COSHH is the law which requires employers to control substances that are hazardous to health and requires employers to know what the health hazards are and to have adequate procedures to ensure safe storage of such substances. We found chemicals for cleaning purposes were not secured and were accessible to patients and visitors to wards and departments. For example on the labour ward the housekeeper's room was unlocked and chemicals such as chlorine sanitizers, detergents, glass and floor cleaners were accessible. Sluice rooms on the antenatal, labour and Wynard South were open and contained chlorine sanitizing liquids and tablets which were not secured. These posed serious risks to patients and visitors as staff were not following COSHH regulations.

Environment and equipment

- The maternity and gynaecology services were located in a purpose built centre for women's health. The building had been built in 2007 and was modern, light and spacious.
- Equipment was maintained and serviced by the medical equipment department. All medical equipment was recorded on a central asset management database. Each piece of equipment was assigned a unique identification number which enabled the equipment and its' service record to be accessed while in use.
- Stickers were placed on equipment to clearly identify to staff that the equipment had been serviced and was ready to use. Equipment we checked had been serviced within the last twelve months.
- The staff had access to a range of medical equipment for monitoring women and their babies. For example; cardiotocography (CTG) machines, foetal blood analysers and foetal heart rate monitoring
- Wards and departments had access to emergency resuscitation equipment and this was checked regularly and a record maintained to show it was ready to use. The labour ward carried out a monthly audit of the resuscitation equipment and included a review of the daily checks carried out by staff. However, records showed this had last been carried out in August 2015. The matron for the labour ward was aware of this and assured us action would be taken to ensure compliance.
- Resuscitaires were in place on the labour and post-natal ward for use when babies required emergency medical care and treatment. These were checked daily and records showed they were ready for use.
- Emergency medicines and equipment for the management of post-partum haemorrhages were available in all birthing areas.
- Emergency evacuation equipment was in place to assist women out of the birthing pools where necessary. On the labour ward there was overhead tracking for the use of a hoist in addition to the nets which were located in the room with the birthing pool. The co-located birthing unit had nets attached to the birthing pools to enable midwives to access them promptly. Staff were trained in the use of the nets and hoist.
- Four scanning machines were used for anomaly scans in the clinic. An anomaly scan enables staff to check the baby is developing normally. The scanning machines were serviced and maintained according to the manufacturers guidelines. An older style ultrasound machine was also available in the clinic in a separate area for use by clinicians for dating scans. We were told this machine was not suitable for anomaly scans and staff were clear that due to the location of this machine it would not be used for this purpose.
- The trust employed the services of security personnel through an external agency. This person was on duty from 8am to 8pm for six days a week and sat at a desk at the entrance to the maternity wards and the neonatal unit. At other times, the desk was covered by a hospital porter. CCTV cameras were monitored from this desk which viewed entrances into the building and external views. Security measures were in place and entry into the unit was through a buzzer system. Women who were going home with their babies were escorted to the exit by a midwife. If a person with a baby asked to leave the unit without a midwife, the safety of the baby was established by the porter or the security personnel telephoning the ward to request the attendance of a midwife before the person left.

Medicines

- Medicines were not always manged safely. The labour ward had a medicines refrigerator which we observed to be full of medicine for injections. This refrigerator was unlocked and placed in an unlocked store cupboard. This did not ensure the security of the medicines. The temperature of the refrigerator was checked to ensure the medicines were stored at the correct temperature to ensure its safe use.
- The storage of intravenous fluids was not secure. On Wynard South the rooms/cupboards where intravenous fluids were stored were not locked. This did not comply with the trusts medicines storage policy. The trust policy stated "A designated area for the storage of large volume fluids (e.g. intravenous, irrigation etc.). This should be a domestically clean area that is lockable".
- Staff on Wynard South had access to medicines for patients to take home which they dispensed from the ward following written instructions from the doctor. We saw three packets of medicines had been left unsecured and unattended in the medical notes trolley. We were told this had been prepared for the patient to take home. Nursing staff on the ward told us that the pharmacy porters delivered medicines to the ward and placed these in an open box on the nurse's station. They said they were not always aware that medication had been delivered until they checked the box. The nurse's station was accessible to patients and visitors to the ward. We observed that at times there was not always a member of staff present in this area. Whilst staff told us they secured the medicines as soon as they observed it had been delivered, the medicines were not at all times stored securely. This posed risks of medicines being accessed by other patients or members of the public.
- Wynard South ordered medicines for individual patients and ward stock using a carbon copy order book when necessary. This enabled the ward to maintain a record of all medicines ordered and was signed off when received onto the ward.
- Controlled drugs were ordered using the same system but in different order book. Controlled drugs are classified (by law) based on their benefit when used in medical treatment and their harm if misused and additional procedures apply to their storage and administration. Controlled drugs were handed to a trained nurse by the pharmacy porter and a signature obtained.
- Controlled drugs used in the theatres were stored securely in a suitable cupboard. During the day the operating department practitioner (ODP) held the key and at night the keys were secured and the on call staff had access to them.
- We checked the controlled drugs registers and stocks of controlled drugs on the labour ward and Wynard South and found these were accurate and balanced.
- Systems were in place to safely return to pharmacy or dispose of medicines which were no longer required on the ward. Medicines no longer required were placed in a locked cupboard and collected by pharmacy. Individual tablets which were not required were disposed of in a sharps bin.
- The medicines used on Wynard South were secured in the treatment room in locked cupboards which was also used by Wynard North.
- On Wynard South, medicines which required cool storage were securely stored in refrigerators specifically for this purpose. Staff regularly checked that the temperature was at a safe level.
- A risk assessment was completed when patients wished to self-administer their medicines. If the patient was deemed to be safe to administer their own medicines they were asked to sign a declaration they took responsibility for this. We saw these completed in patient's records.
- We observed the administration of medicines on the antenatal and postnatal ward. We observed that the midwife used a medicine trolley to safely transport the medicines to the patient's bed. Checks were carried out prior to administering the medicines. For example, checking the patient's identity band against the medicine record and asking the patient to confirm their name. The midwife wore a tabard which advised people they were carrying out the medicine round and asking to not be distracted during this process.

Records

- Patients records were not stored securely on Wynard South, on the antenatal and postnatal ward and in the clinics. We found records left unattended on trolleys and in offices which were not locked. This did not ensure the safe storage of the records and compromised patients' private and confidential information.
- The patient care needs were assessed using the trust's electronic patient record system. Following the assessment, a care plan was generated and printed and

placed in a file that remained at the patient's bedside. Some of the generated care plans required staff to identify further information. For example the falls care plan. We saw two falls care plans which had not been personalised to indicate the assessed level of risk to the patient.

- The electronic system highlighted when areas of the care documentation had not been completed. When reviewing the system for patients who were on Wynard South, we saw four patients had not had their VTE assessment information completed on line. Staff explained that the doctor completed this on admission, recording the outcome on the patients medicine record and then nursing staff entered the information into the electronic record. The staff member was going to follow this up for the four patients concerned to ensure their electronic records were accurate and up to date. Three patients had the dementia needs icon flashing. Staff were unable to explain this as the patients concerned did not have dementia care needs. The staff member we spoke with was going to follow this up with the information technology department.
- We reviewed the nursing and medical records for five patients on Wynard South. The medical records were up to date and contained clear information regarding the patients' medical care and treatment plan. All records identified clear signatures and dates indicating when medical staff had reviewed the patient.
- Systems were in place in the gynaecology clinic and ward to ensure that appropriate documentation regarding termination of pregnancies as required by the department of health were completed and reported on appropriately. We reviewed the records for seven patients who had attended the hospital for termination of pregnancy and found all paperwork completed in full.
- Specialist teams, for example the stoma nurse specialist or the oncology team, recorded their review and treatment plan for the patient in the medical notes.
- Women carried their own records during their pregnancy and took them to appointments. We saw patients attending the clinic and labour ward who brought their notes with them. The notes provided a detailed record of their pregnancy and their choices, preferences and wishes.
- We reviewed ten sets of records on the antenatal and post-natal ward. We saw the records were completed appropriately including risk assessments and care plans were in place. Medical records were up to date and provided detailed information on the women's care and treatment, screening and birth plans. Baby notes on the postnatal ward were up to date and provided information on skin to skin contact following delivery, the first feed had been observed and documented, first assessment completed and a management plan completed.
- Patients' medical records were provided to the nurses, midwives, doctors and consultants when women were booked into the maternity and gynaecology clinics. Concerns were raised by staff that when notes were taken out of the area, for example to the ward or another speciality within the hospital they were not traceable. This meant staff spent a long time looking for notes prior to the women's next appointment.
- Theatre staff completed the World Health Organisation (WHO) Safe Surgery Checklist. The checklist identified three stages of an operation. In each phase, a checklist coordinator must confirm that the surgery team has completed the listed tasks before it proceeds with the operation. We reviewed the medical notes for 12 patients who were recovering from surgery and saw the checklist was completed for each patient.
- Staff recorded the count of needles and swabs which took place before and after the procedure of suturing the perineum following childbirth.

Safeguarding

- Safeguarding policies and procedures were in place for staff to follow regarding safeguarding adults in vulnerable situations and safeguarding children. They informed staff on the action to take if they suspected any safeguarding issues including female genital mutilation and child sex exploitation. Staff we spoke with had a clear understanding of their responsibilities. Staff attended training according to their role. Senior staff had all attended Safeguarding level 3 training which included guidance on female genital mutilation, honour based violence and child sex exploitation. Records showed staff were compliant and up to date with this training. Staff were advised by email of when their training was due to be renewed.
- The trust had a safeguarding team available within the hospital to provide support to staff regarding any suspected safeguarding issues. Staff were positive about their availability and response to requests from wards and departments. Staff knew who the lead nurse and doctor who dealt with safeguarding issues were within

the trust and how to contact them. We reviewed two sets of records on Wynard South which clearly evidenced staff had identified possible safeguarding issues and taken appropriate action. Staff on the maternity and gynaecology wards asked each patient on admission if they had any concerns regarding domestic violence as this was a prompt on the admission assessment documentation. Staff we spoke with were clear they would only ask the patient when they were alone to enable them to speak freely. We saw records which showed appropriate action had been taken following information provided by one patient.

Mandatory training

- The trust had a programme of mandatory training modules which staff were required to complete. The content of mandatory training varied according to the person's job role. Maternity and gynaecology staff received an email informing them of which modules they were required to complete and when their training was due to be updated. Information was also placed on staff notice boards advising when individual staff members were required to update their training.
- The training and development lead for maternity and gynaecology reviewed the mandatory training compliance rates each month and provided a monthly report for the senior managers meeting. The report from October 2015 showed the trust target for compliance was 90% over the year. The report showed that at the time of the inspection not all staff had completed their annual mandatory training; with the exception of the midwifery support workers. The nursing auxiliaries had not reached the trust target for mandatory training relating to information governance with 81% completed and 89% having completed the mental capacity act and deprivation of liberties training. The midwives had not all met the target regarding infection control with 87% having completed the training, 84% fire safety, 85% information governance, 82% venous thrombo prophylaxis, 89%mental capacity act and deprivation of liberties and 70% dementia. Consultants were not meeting the mandatory training with 87% completed mental capacity act and deprivation of liberties, information governance, manual handling and fire safety training. We spoke with the training and development lead for maternity and gynaecology staff who was aware of the gaps and requirements for this training to be completed within the year. Training sessions were booked for some staff in the near future and would be checked to ensure the staff members attended.
- All staff who worked on the maternity unit, including medical staff, midwives, midwifery support workers and nursing auxiliaries were required to attend three days of training in addition to the trust mandatory training program each year. The study days included neonatal and obstetric emergencies and mandatory training such as infection control and manual handling. The study days were repeated throughout the year to enable all staff to attend. Training records showed 88% of midwives, 94% of midwife support workers and 96% of nursing auxiliaries had completed this training. With remaining staff booked to attend forthcoming study days.

Assessing and responding to patient risk

- Risk assessments were in place for women who were pregnant and were put in place during the initial antenatal appointed and reviewed and updated as necessary throughout the pregnancy. The risks assessment process included checking and screening for venous thromboembolism, pre-eclampsia (a condition which occurs in pregnancy causing high blood pressure and protein in the urine, which if left untreated can cause poor outcomes for the mother and/or baby), diabetes in pregnancy, female genital mutilation and domestic abuse.
- The risk assessments were used to ensure women delivered their baby in a safe environment. For example, women who had identified risks were strongly encouraged to give birth in the consultant led unit and others with no or low risk factors could choose to give birth in the co-located midwife led unit, stand alone units or at home.
- Each individual patient who wished to deliver their baby in a birthing pool had a risk assessment completed by the midwife allocated to their care. Women who were deemed as high risk were not able to use the birthing pool.
- Staff on the maternity wards monitored the health and wellbeing of women and their babies before, during and after birth. Records were maintained and concerns escalated to medical staff or senior midwives when

necessary. During our inspection we observed staff consulted the matron on the labour ward with concerns relating to the slow progress made of one woman in labour.

- The consultants, middle grade and junior doctors had a high presence and visibility on the wards during the day and we observed nursing and midwifery staff had no hesitation in raising issues or concerns with them either in person or by telephone if they were not on the ward.
- The obstetric consultants provided on call cover for the midwifery unit out of hours with Wynard South cover provided by the gynaecologists. Staff informed us they were able to ring any of the consultants for advice and guidance. When necessary the consultants attended the unit promptly. We were provided with one example when a woman became unwell during the night and received care and treatment from consultants from five medical specialities.
- Wynard South used an early warning system of assessing and escalating the deteriorating patient. This was a different system to the one used by the rest of the hospital. This had previously caused confusion for staff and the escalation of a deteriorating patient had not taken place in a timely manner. This was reflected on the local risk register and actions had been taken to reduce the issue happening again. Additional training and guidance had been provided to staff and was information was available on the ward for agency and bank staff. As a result staff on Wynard South were trained to use the system correctly and this had been monitored by senior staff.
- Emergency call bells were available by each bed space. While on Wynard South the emergency call bell was used and staff were immediate in their response to find out where the emergency situation was and attend the area to provide support.
- The medical emergency team (MET) were a hospital wide team who responded to early warning scores that caused concern to staff regarding the health of the patient. The team included a critical care register and often a critical care consultant. The MET attended Wynard South for an emergency during our inspection and responded very promptly to the ward staff when one patient became unwell.
- Midwives were positive in their comments regarding the support received from consultants from other specialities when women became unwell during antenatal, postnatal care or labour. Examples were given regarding the support women had received from cardiology, renal and respiratory specialist teams.
- A total of 921 of women had attended the Exeter Birth Centre between April 2014 and March 2015 in labour. Due to additional complications 31% of the women (a total of 287) transferred and delivered their baby on the labour ward.
- The staff worked towards safety procedures detailed in the Safe Surgery and Interventional Procedures Policy Monitoring. This included information for staff on the national guidance – five steps to safer surgery. Audits showed theatre staff complied with the five steps to safer surgery and if necessary any actions were recorded and monitored where necessary. We reviewed four sets of notes for patients who had recently had surgery and saw the WHO checklist had been completed in full for each patient.
- The trust was not compliant with national guidelines on patient identification bands for babies. This was because identification labels for babies were handwritten and not printed as the trust did not have the technology in place to print patient labels. This had been on the risk register since 2009. Senior managers told us it was hoped this would be addressed in the near future as a system had been introduced to enable adult identification bands to be printed. The system was able to be adapted to print baby identification bands. However, some staff were not confident this would happen as it had been awaited for six years. Since the inspection the trust informed us the necessary adaptations to the IT system would take place in February 2016.

Midwifery and gynaecology staffing

- The trust informed us that in accordance with National Institute for Clinical Excellence (NICE) guidelines, staffing levels were reviewed every 6 months and reported to the Trust Board. Staff we spoke with during the inspection told us the staffing levels and skill mix within the maternity and gynaecology services were established as part of a staffing review which had taken place approximately 18 months before our inspection. As part of this staffing review the acuity (measurement of nursing care required by patients) of patients using the maternity services had been assessed using a nationally recognised maternity assessment tool known

as Birth rate Plus. This is a complex, midwifery specific national assessment tool that informs decision making around the numbers, skill mix and deployment of midwifery staff. NICE guidelines recommend that the tool be used together with a 'red flag' system which included a checklist to review the care and treatment needs of women and babies on the wards. The red flag would indicate additional needs or delays in treatment. We were told by senior midwives that a red flag system was in the process of being developed but not in full use at the time of our inspection.

- There were 133.5 whole team equivalent (WTE) midwives who were led by the head of midwifery and two clinical midwifery managers. The number of births within the trust each year was approximately 4,200 which provided a midwife to birth ratio of 1:31, although data provided by the trust informed us that the average ration was 1:32. The maternity dashboard for the month of September 2015 this had increased to 1:34. The Royal College of Obstetricians and Gynaecologists (RCOG 2007) Safer Childbirth Minimum Standards for the Organisation and Delivery of Care in Labour states there should be an average midwife to birth ration of 1:28 which the trust was not meeting.
- There were no vacancies for midwives at the time of our inspection. Five newly qualified midwives had recently been appointed and were due to commence duties at the hospital. When these staff were in post this would bring the midwife to birth ration down to 1:30 across the year.
- The maternity services were part of the South west Strategic Clinical Network (SWSCN) whose membership included users, providers and commissioners of the health service with the purpose of making improvements in the outcomes for patients. SWSCN had adapted the Birthrate Plus acuity tool to support its use on a regular basis. The maternity services used this each month to provide assurances regarding the deployment of staff within the unit.
- The maternity services had a staffing policy and escalation plan in place. This informed staff of the optimum staffing levels together with a contingency plan for when there were times of increased workload or staff absence. There was no data collected to evidence how frequently this escalation plan was put into operation.
- The senior managers on call made the decision to move staff or bring extra staff in. The senior managers were authorised to access the bank for additional staff and authorise permanent staff to work extra hours. If no additional staff could be found the managers themselves or supervisors of midwives came in to provide clinical support.
- We spoke with staff who were part of the integrated team which meant they provided care to women at home in the city of Exeter and in the co-located birthing unit which was attached to the labour ward. We were told that when the labour ward was busy they were required to support staff within the hospital. Staff on the ante and postnatal ward and the co-located birth centre told us that often they were moved to work within the labour ward. This reorganisation of staff was to ensure women received 1:1 care during labour. Staff were confident that all women received 1:1 care during active labour and the maternity dashboard identified that between April to September 2015 100% of women in established labour received 1:1 care. The national Women's Experience of Maternity Care 2015 found that 64% of women who responded said they (and/or their partner or a companion were not left alone by midwives or doctors during labour or birth at a time when it worried them. This put the trust within the bottom 20% of trusts who participated in the survey. However, 89% said that if attention was needed during labour and birth, they were always or sometimes able to get a member of staff to help within a reasonable time. During our inspection we spent time on the labour ward. We saw that all women who were in labour were allocated a named midwife who had responsibility for their care.
- Staff on the labour ward told us they endeavoured to provide women with 1:1 care for three hours following their delivery. They added this did not always happen due to the demands on the staffing, there were no records which identified how frequently they provided this 1:1 care postnatally.
- Concerns were raised by staff to us that the movement of staff to the labour ward often left the antenatal and postnatal ward short staffed. We were told that at times this could mean one midwife and one midwife support worker were left to care for up to 34 women. The maternity service had access to bank staff who were booked when the unit was busy. In addition substantive midwives and midwife support workers worked additional hours when necessary. Two members of staff told us they did not always complete incident forms

when working under their planned staffing establishment. They told us this was because as there were no additional staff available, there was no point in raising their concerns.

- During our inspection, we noted that the antenatal and postnatal ward was working with one midwife less than the establishment. Staff told us that on this day the ward was not busy so they were able to manage safely.
- Specialist midwives were employed including the specialist midwife for complex needs (including mental health, substance misuse and vulnerable women),
- The antenatal assessment clinic was well staff during the week but this reduced at the weekend to one midwife and one midwife support worker. Often three women were assessed and induced in the clinic at the weekend. If the staffing did not enable inductions to be started safely the women were induced on the antenatal ward if there was sufficient space for them to be admitted to the ward. The induction could be delayed until the women were able to be admitted to the induction unit or labour ward.
- Wynard South (gynaecology) had no staff vacancies. There were two members of staff on long term sick leave. The ward had recently been divided providing medical care on Wynard North and gynaecology care on Wynard South. We saw that during our inspection Wynard North had been short of staff so one member of staff had moved from Wynard South to assist. This had meant one newly qualified nurse who was meant to be supernumerary completing their induction and a student nurse took the place of the nursing auxiliary.
- The gynaecology surgical day unit had provision for 10 patients and was staffed by one trained nurse and one nursing auxiliary between the hours 07.30am to 8pm. On occasions when this service had gaps in the duty rota the ward staff provided cover.

Medical staffing

- The trust had a higher percentage of consultants and senior doctors and a similar percentage of junior doctors when compared with the England average.
- Labour ward consultants were on site from 08:00 to 18:00 Monday to Friday. On Saturdays, Sundays & Public Holidays consultants were on site from 08:00 to 13:00. Outside of these hours an on call rota was in operation for the consultants. All staff we spoke with made positive comments about the advice and guidance from consultants out of hours. This equated to consultant cover for 60 hours each week which complied with The Royal College of Obstetricians and Gynaecologists (RCOG) good practice guidelines 2010. The RCOG state the recommended consultant cover for a maternity unit which delivers between 2500 and 4000 consultant led births a year should be 60 hours a week.
- Specialist registrars were on site for the full 24 hours and worked 12 hour shifts from 08:00 to 20:30 or 20:00 seven days a week covering obstetrics and gynaecology. A Specialist Registrar or SpR is a doctor who is receiving advanced training in a specialist field of medicine in order to eventually become a consultant.
- Foundation doctors in their second year (known as F2 or FY2 or senior house officer) were on site for the full 24 hour period. Consultants and senior nursing staff expressed concerns regarding the provision of junior medical staff and the difficulties in appointing them.
- An anaesthetics consultant worked on the Labour ward from 08:00 to 18:00 Monday to Fridays and was then available on call. Anaesthetic reviews were conducted daily for post-operative patients and the anaesthetist was contactable by telephone when needed. Middle grade anaesthetic cover was available to the labour ward for the whole 24 hour period but could be called to assist on the Intensive Care Unit or within major trauma. However, their priority would be for obstetrics and we were not aware of any occasions when staff had experienced a delay.
- Women on the ante/postnatal ward were seen daily by their named consultant on Mondays to Friday if they were available and not on leave. However, all antenatal women were seen by the team specialist registrar and/or the FY2 each day. One team of doctors were allocated to conduct a daily check to ensure all women had received attention from medical staff. For example if the women's own team had an emergency or sickness.
- Medical handovers took place throughout the day at 8am, 1pm, and 8pm. This was to provide information to medical staff coming on duty and to ensure a full update was provided to the medical and nursing staff once a day.
- At weekends there was a board round of all patients with the on call consultant and specialist registrar. A board round is the term used for the multidisciplinary discussion of the care and treatment of each patient on the ward. The neonatal team were available on call as and when needed.

Other staffing

- The Foetal and Maternity Assessment Unit (FMAU) was staffed during the week with between 1 and 4 midwives between the hours of 7.30am and 8pm. There were between 1 and 3 nursing auxiliaries to support them. The staffing levels fluctuated to meet the demands at different times of the day. At the weekends the unit was only staffed by one midwife and one midwife support worker. Two members of staff we spoke with told us that due to busy clinics at the weekends there were at times delays in providing the care and treatment for all women attending. We were provided with one example of when eight women attended the clinic and there were only two members of staff on duty. Staff said they followed the staffing escalation plan in these circumstances.
- Maternity Support Workers were employed throughout the maternity services. For example on the postnatal ward and in the theatre recovery where they provided support to mothers with their babies and breastfeeding.
- Ultra-sonographers worked in the antenatal clinic and provided an anomaly scanning service for women attending the service. An anomaly scan takes a close look at a baby and the uterus. The person carrying out the scan (sonographer) will check that the baby is developing normally, and evidence where the placenta is lying in the uterus.
- Patients were able to access a counselling service provided by two members of staff from a counselling suite located in the Centre for Women's Health. The two members of staff equated to one whole time equivalent position. The counsellors operated an appointments system and staff told us that sometimes women could not see a counsellor promptly due to the limited hours the counsellors were available.
- There were dedicated recovery staff for emergency obstetrics and gynaecology surgery during the week and at weekends between 09.00-18.00 on Saturdays and 10.00-18.00 on Sundays. However out of hours at night, there was no provision for dedicated staff. The cover for these times was from the trust wide surgical team but due to staffing pressures we were told this had not always been available. At these times, the recovery care for women following surgery was provided by the midwife and/or anaesthetist. This meant a longer period of time that the midwife was away from the maternity unit and this was reflected on the trust's risk register. Staff told us they would make an incident report on these occasions.
- Ward clerks worked on all of the wards and supported nurses and midwives with the documentation relating to patients' discharges, ordering of equipment and greeted patients and visitors to the ward.

Major incident awareness and training

- There was a trust wide contingency and major incident awareness plan. Staff on the maternity unit were supported by senior midwives and managers to access this when necessary. We were provided with an example of when the electricity had failed and the contingency plan had been put into action. Not all areas had access to emergency backup electricity so a plan had been made to follow at such times to ensure women were cared for in an area that did have access to electricity.
- The emergency plan for each unit was held in an easily identifiable red folder which the head of midwifery stated was available in each area. The plan was checked annually by the named lead for each department.

Are maternity and gynaecology services effective?

Good

We have judged that patients experienced good outcomes because they received effective care and treatment. Care and treatment was delivered by trained and competent staff.

Policies, procedures and practices were in line with national standards and guidance and were readily available to staff.

Women who used the service had access to effective pain relief at a time when they required this.

Consent processes were undertaken appropriately and patients were supported to be involved in decision making regarding their care and treatment.

Evidence-based care and treatment

- The audit team regularly reviewed the trust guidelines and policies and procedures provided to staff. This was to ensure they were in line with national guidance, particularly following changes at national level and also following any incidents or problems that arise.
- Trust procedures regarding the VTE prophylaxis treatment were being updated at the time of our inspection to comply with new Royal College of Obstetricians and Gynaecologists (RCOG) guidelines. Work was ongoing to establish whether funding the anticoagulant (a medicine which helps prevent blood clots) came from the trust or the GP.
- The National Institute for Clinical Excellence (NICE) had updated their guidelines on Intrapartum Care in December 2014. The trust had benchmarked their current procedures against these revised guidelines. We were told they complied with the NICE guidelines and ratification of the amended document was due from the governance committee.
- The recommended method for induction of women within the trust was based on RCOG and NICE guidelinesThe trust was not compliant with national guidelines on patient identification bands for babies. This was because identification labels for babies were handwritten and not printed as the trust did not have the technology in place to print patient labels. This had been on the risk register since 2009. Senior managers told us it was hoped this would be addressed in the near future as a system had been introduced to enable adult identification bands to be printed. This system was able to be adapted to print baby identification bands. However, some staff were not confident this would happen as it had been awaited for six years.
- The maternity and gynaecology services were part of an ongoing audit programme. There were 14 audits relating to gynaecology and midwifery that were in progress at the time of our inspection. These included national and local audits.
- An audit took place every two months to ensure the theatre staff had consistently and appropriately completed the World Health Organisation (WHO) Safe Surgery Checklist for patients undergoing surgery. Evidence of the audits was provided to us and showed that the standard of completing the checklist was good
- Audit meetings had been held monthly. We were told these had been temporarily cancelled until January 2016 to relieve financial pressure within the trust.

Pain relief

- Information was provided to patients regarding the various types of pain relief available to them during their labour. This information could be accessed on the maternity services Facebook page, on the trust website and was provided verbally during antenatal clinics and on admission to the maternity unit.
- A range of pain relief was available on the labour unit. Women had access to a birthing pool to help relieve pain during labour on the labour ward, co-located birthing unit and stand alone unit. Electronic delivery beds were provided for women which supported the women into different positions to reduce pain in labour and during the birth. Nitrous oxide gas (Entonox) was available in each delivery room, analgesia by injection and epidural were also available.
- The maternity services had no audit or data relating to the administration of pain relief for women in labour but staff told us they would expect women to receive injections promptly and an epidural within 30 minutes if clinically appropriate. We were told there may be a short delay if the anaesthetist was in the theatre suite with another patient. We were not provided with data which showed the trust monitored the promptness of pain relief to women in labour.
- The maternity services local risk register identified that women in labour may not have been able to receive their chosen method of analgesia due to a lack of equipment. The maternity services local risk register identified that since 2010 women in labour were not able to be offered a full range of choice due to the lack of specific epidural pumps to enable women to self-administer their epidural infusion boluses. We asked for data to demonstrate how often this affected women in labour. There was no written evidence to support the scale of the problem but staff we spoke with said it had not happened often but was potentially likely to be an issue in the future.
- Women we spoke with on the antenatal and postnatal ward raised no concerns regarding analgesia and the timeliness of the administration of it.
- Women who were on Wynard South had analgesia prescribed regularly and when needed. We saw that patients were asked by the staff if they had any pain both during the medicine administration round and also in between times.

- Medicine charts were completed in full and identified the dosage and time of when pain relief was administered. This ensured staff coming on duty were aware of when the patient could safely have further medicines.
- Patients on Wynard South (gynaecology) told us they had adequate pain relief. Comments included "they [the nurses] offer me pain killers regularly", "I am able to ask for analgesia and if I can have it the nurse gets it quickly"

Nutrition and hydration

- We spoke with the housekeeper on the ante and postnatal ward. Meals were obtained from the main hospital kitchen and brought to the ward on a heated trolley. Patients were able to choose what they wanted to eat from a selection of dishes available. Patients were able to eat next to their bed or in the dining room.
- Additional snacks were available in a refrigerator in the dining room for patients to help themselves to in between meal times. Staff said this was particularly useful for patients in labour or had been recently admitted.
- Hot and cold drinks were available from the dining room for patients at all times in addition to the drinks trolley that was taken around the ward three times a day.
- Midwives on the labour ward were observant when patients were delayed waiting to go to theatre. We observed information was requested from the anaesthetist regarding whether a patient could have a full drink, sips of water or mouth care whilst waiting for theatre. This meant women were not kept without fluids for longer than was necessary.
- The maternity services had full accreditation with the UNICEF Baby Friendly Initiative. The Baby Friendly Initiative works with health professionals to ensure that mothers and babies receive high-quality support to enable successful breastfeeding. The accreditation had been awarded after a three-stage external assessment by UNICEF identified best practice standards were in place.
- The Women's Experience of Maternity Care 2015 which had been carried out by an external organisation, found the trust came within the top 20% of trusts when considering the active encouragement and support midwives provided to women regarding breast feeding. However, some women commented they did not get consistent advice about the feeding.
- The trust provided us with data which showed 76% of women initially breastfed their baby post-delivery but that this dropped to 74% when discharged from the hospital. The trust had appointed breast feeding coordinators to assist women in the feeding of their babies and midwife support workers were allocated to the post-natal ward to provide practical support to new mothers. Women we spoke with were positive about the support they had received. Data was not available to show the percentage of women breastfeeding on discharge from maternity care.
- On Wynard South (gynaecology) staff completed a nutritional assessment within 24 hours of a patient being admitted. The assessment used was the Malnutrition Universal Screening Tool (MUST) which is recognised nationally. The assessment was completed electronically and if the patient required support with their diet or drinks, a care plan was generated and to inform staff's practices and was available at their bedside.
- The patient's information board on Wynard South provided a quick reference to indicate whether a patient required additional assistance or a special diet.
- We saw menu cards for patients listed the meals available for them to choose for the next day. There were 5 choices of meal at lunch time and supper time. The menu card identified if the meal was suitable for vegetarians and other specialised diets.
- Each patient we saw on Wynard South and the maternity wards had access to a jug of water unless they were nil by mouth awaiting surgery or other test.
- On Wynard South we saw milkshakes and build up drinks were available for patients who required additional supplements to their meals or instead of solid food.
- Patients we spoke with were complementary about the food and said "it's tasty", "there is a good choice", "the food comes in big portions" and ""I always get what I order". One patient who had been in hospital for one week told us that whilst there was a choice, it was repetitive.
- The Patient Led Assessments of the Care Environment (PLACE) 2014 scored the trust at 93% for food compared to the national average of 88%.

Patient outcomes

- The trust gathered information relating to outcomes for women which was made available to us in the maternity

services performance dashboard. For example, the number of women experiencing a post-partum haemorrhage, significant tears to the perineum, retained placenta and shoulder dystocia. This data was monitored monthly with defined upper and lower targets which were reviewed and compared to previous years to show evidence of good practice and where improvements may be required.

- The trust's internal reporting system showed a total of 4,102 births between April 2014 and March 2015. Based on national statistics (Hospital Episode Statistics) this was approximately a third of the average number of births per trust in England. The trust position for still births in 2013 was higher than the average for the comparative group with a total of 15 reported and analysed by the maternal newborn infant and clinical outcome review (MBRRACE-UK Perinatal Mortality Surveillance Supplement 2015). In the year April 2014/ March 2015 there were 5 still births.
- Data demonstrating the number of births in the trust run maternity units for 2014/15 was as follows: Exeter midwifery led birth centre 630 babies, Honiton birthing centre 51, Tiverton 74 and at Okehampton birthing centre 51 were born during this time period. 102 women had been assisted to give birth at home. The remaining 3194 births had been in the obstetric led unit. The numbers of multiple and single births were comparable to the England average.
- Between April 2013 to March 2014 data showed there were 500 unexpected admissions to the Neonatal Intensive Care Unit (NICU). This figure was similar between April 2014 and March 2015, which is in line with the national average of approximately 1 out of 8 babies (National Neonatal Audit programme). A further 186 babies who were born full term were admitted to NICU between April 2013 to March 2014 and 209 babies between April 2014 and March 2015. The head of midwifery and senior midwives reviewed the reasons for these admissions to identify any themes or trends and ensure appropriate reporting took place if necessary. For example through the trust's own reporting system or to the national Strategic Information Executive Information System (STEIS). This ensured action would be taken if the care and treatment could have been improved.
- The National Neonatal Audit Programme (NNAP) 2015, which includes data for 2014 (published November 2015), showed that 79% of mothers who delivered babies between 24+0 and 34+6 weeks gestation were given doses of antenatal steroids. This is below the NNAP standard of 85% of all mothers who delivered babies between 24+0 and 34+6 weeks gestation being given doses of antenatal steroids.
- The National Neonatal Audit Programme (NNAP) 2015, which includes data for 2014 (published November 2015), showed that in 68% of the cases there was a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission. The NNAP standard is for 100% of parents to be consulted.
- Based on national statistics provided by Hospital Episode Statistics (HES), the data regarding maternal and neonatal readmissions did not identify any risk when compared to the England average. There were no maternal deaths for the period August 2014 to July 2015 and the number of women who were admitted to the intensive care unit following delivery of the year 2014 to 2015 was five which had reduced by one patient from the previous year. Individual reviews took place for all patients admitted to the intensive care unit to ensure the care and treatment could not have been improved upon.
- Data provided by the trust through HES showed that the modes of delivery were similar to those across England. We noted that the number of elective caesarean section was slightly higher than the England average at 13% in 2013/14 and 12% in 2014/15 and emergency caesarean sections slightly lower at 12% for 2013/14 and 11% in 2014/15, but this did not evidence a risk to women. Assisted vaginal deliveries, for example forceps and ventouse (vacuum), were similar in number to the national England average.
- The gynaecology outpatient clinic had a referral to treatment time of approximately two weeks. Patients who required emergency admissions and appointments were seen promptly and admitted to either the labour ward or Wynard South for care and treatment.
- The trust participated in the National Audit of Heavy Menstrual Bleeding which identified the results to be generally good with no specific actions recommended. Findings from the audit were shared within the trust through presentations at meetings and groups. For example at the gynaecology governance meeting.

- A Baseline Assessment Tool (BAT) had been completed to review the trusts performance against the NICE Quality Standard – Ectopic Pregnancy and Miscarriage The completed BAT was reviewed at the gynaecology governance meeting. It found there was not full compliance with the standard regarding women who were seen in the early pregnancy assessment services within 24 hours of referral. However, to increase the compliance it would be necessary to expand the service which the trust considered was not an option at this current time. The standard that women with a suspected miscarriage who have had an initial transvaginal ultrasound scan should be offered a second assessment to confirm the diagnosis was complied with.
- Since the most recent reconfiguration of the gynaecology ward, patients had been able to be admitted to the Wynard South for their planned surgery and not to other surgical wards. Staff were positive in their comments regarding this and were proud this had been achieved. Close monitoring took place to demonstrate that women with gynaecology emergencies were found a bed on Wynard South, either on admission or as soon as possible when a bed became available.

Competent staff

- A consultation exercise was taking place at the time of our inspection which considered changing the working practices of midwives to rotate through the service. For example between the community and consultant led unit. This was aimed at keeping each midwives skills and competencies up to date.
- The regulation of midwives included an additional layer of investigative and supervisory responsibilities provided by a supervisor of midwives (SOM). A SOM is a midwife who has been qualified as a midwife for a minimum of three years, and has completed additional training in midwifery supervision in line with the Nursing and Midwifery Council rule 8, 2013. By law midwives must have a named SOM who they meet with annually to discuss and review their practice.
- The recommended ratio of SOM to midwives is 1:15 as detailed in the Midwifery Rules and Standards (rule 12 Nursing and Midwifery Council 2014). The ration at the trust was 1:18. To improve this, two midwives had recently completed their SOM training and were yet to be allocated midwives to supervise and another was in the process of undertaking the training.
- The Local Supervising Authorities (LSAs) monitored the quality of the midwifery practice at the trust through the supervision of midwives and included an inspection of the maternity unit at the trust. The latest report of the LSA inspection was published in 2015. There were areas of good practice identified within the report. For example, the information provided to midwives to update and guide them in the trust's supervisory newsletter and the information provided to staff on the communication notice boards on each ward.
- Newly qualified midwives who were employed by the trust were provided with a preceptorship programme for the first year. The aim of preceptorship was to enhance the competence and confidence of newly registered practitioners as autonomous professionals.
- Student midwives from Plymouth University had placements on the maternity unit and within the community. Positive comments were made by five students we spoke with regarding mentorship and preceptorship for newly qualitied midwives. Students found that the consultants and qualified midwives were very willing to teach and pass on skills.
- A number of midwives had completed additional training to enable them to carry out examinations of the new born prior to their discharge. The new born examination is part of the national Newborn and Infant Physical Examination (NIPE) screening programme and takes place within 72 hours of the baby being born. Training provided to midwives was updated annually and their Supervisor of Midwives checked this had been completed during their annual supervision.
- Staff said they were able to request and were supported to attend additional training regarding midwifery skills. For example, one midwife told us they had completed training regarding the assessment of tongue tie in the new born. This enhanced their skills as a new born screening midwife. Tongue tie can affect some babies when a tight piece of skin between their tongue and mouth affected their feeding.
- Auditing took place of the number of repeat blood screening tests that were required to take place due to poor technique. The previous audit had shown 3% of

tests needed to be repeated and the most recent audit was 7.6%. Action had been taken to address the issue with individual midwives and additional training provided.

- Annual appraisals were completed for nursing staff on Wynard South. These were 83% compliant. This meant that some staff had not been given an opportunity to discuss areas for improvement or further development in their role. An action plan was in place to ensure all appraisals were completed within the time frame.
- The Nursing and Midwifery Council has introduced a new revalidation system which is due to take effect from April 2016. This is a process which will require nurses and midwives to demonstrate that they practice safely and effectively. The trust had provided staff with a study day and eLearning training to prepare them for this process.
- Staff were kept up to date with changing practices, procedures, national guidance and reminders were provided regarding policies and procedures already in place within the staff newsletters. For example, the 'Maternity Matters' (produced by the maternity governance forum), Supervision newsletter and the 'Gynae Gazetteer and Fertility Writes'.
- Foundation doctors were provided with formal teaching sessions from the consultants on a weekly basis. Teaching had previously taken place for all medical staff at the regular audit meetings but we were told these had been cancelled for the foreseeable future due to finances and increasing surgery. Concerns were raised by one consultant regarding the balance between working clinically and time for education/learning. It was felt that at times the pressures of work reduced the time available for teaching and learning for junior medical staff. Regional teaching was provided to doctors at least every month.
- Junior and middle grade doctors commented that the consultants were all approachable and provided good training and learning experiences.

Multidisciplinary working

- Student midwives reported observations of excellent team work with all staff communicating well and respecting and valuing each other. Medical staff reported very good working relationships between junior and middle grade doctors and the midwives. We observed during our inspection all staff treated others with respect and communicated well regarding the care and treatment needs of patients.
- The theatre staff made positive comments regarding the team working between themselves and the labour ward. Theatre staff attended the ward medical handover at 8am to help them be aware of any patients who were likely to require theatre services.
- The consultant on call phoned all wards at 10pm to ensure they had up to date information for their night on call.
- Staff made timely referrals and followed pathways for other specialities when necessary following antenatal screening. For example for patients who tested positively with HIV or hepatitis
- Positive comments were made to us regarding the support from the renal specialist medical team who came to the maternity wards every day to review and care for one patient.
- Specialist nurses were valued, respected and praised by staff regarding the care and support they provided. For example, the cystic fibrosis special nurse visited or telephoned maternity ward each day to provide care, treatment and /or support.
- There was a transitional care bay which had space to provide care and treatment to four women and their babies. The care and treatment of the baby and mother was shared between the neonatal unit and the midwifery team. Patients reported this worked well and they were kept informed of the care and treatment plans. One patient said that at times there was a delay in answering questions they had about their babies' treatment. They felt this was because the transitional care was located on the postnatal ward and separate to the neonatal unit.
- Postnatal care was managed effectively. Systems were in place to ensure community midwives had sufficient information when women were discharged and were aware of when they were required to visit.

Seven-day services

- The trust provided us with information about the medical cover on the consultant led maternity unit. We were told that on the labour ward consultants and middle grade and junior grade doctors were present each day for seven days a week.

- An anaesthetics consultant worked on the Labour ward from Monday to Fridays. Middle grade anaesthetic cover was available to the labour ward for the whole 24 hour period over seven days.
- The Foetal and Maternal Assessment Unit was open seven days a week, although the opening hours were reduced hours at the weekend. This unit provided a monitoring service, including ultrasound scans, for pregnancy and diagnosed potential complications.
- Women had access to emergency gynaecology services seven days a week. This included access to early pregnancy assessment. An early pregnancy assessment clinic was available Mondays to Fridays with patients with urgent early pregnancy concerns seen at the weekend through the emergency gynaecology services.
- Pharmacy support was available seven days a week, although there was reduced opening hours at weekends. Emergency pharmacy support was available out of hours through an on call pharmacist rota.

Access to information

- Women carried their own pregnancy records, which were used by all clinicians they had contact with during their pregnancy. These were used to inform all professionals within the multidisciplinary team of the patients care and treatment. For example, community midwives, GPs and health visitors.
- We saw women attending the hospital with their pregnancy records. One woman arrived at the hospital and had forgotten to bring their records with them in the rush to get to the ward. Staff reassured her and took details from her and her relative. Contact was made with the woman's community midwife to establish and specific medical history. We were told that this process would take place for a woman attending who was not known to the service.
- We saw patients who attended the maternity and gynaecology clinics had records which were prepared or obtained ready for their appointment so that health professionals had access to the appropriate information.
- On discharge from the labour or postnatal ward, women took their records for themselves and baby, to inform the community midwife who would provide their ongoing care.
- The ward clerks ensured discharge summary information was sent by fax or post to the patients GP, midwife or health visitor.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patient records reviewed showed discussions were carried out with women and verbal consent was obtained to procedures and treatment. For example, prior to any examinations and the management of the third stage of labour. Patients we spoke with said they were consulted about their care and treatment and felt involved in the decisions made.
- Written consent was recorded for patients prior to certain treatments and procedures being carried out. On Wynard South the consent form was carbonated so that a copy was kept in the patient notes and also a copy handed to the patient. The forms provided guidance to health professionals on consent and the law. Consent forms were in place for patient's agreement to investigation or treatment (adults), surgical treatment of miscarriage/evacuation of the uterus, diagnostic laparoscopy and medical termination of pregnancy.
- Staff we spoke with had an understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Standards. One member of staff gave us an example of when a best interest meeting had been carried out on behalf of one patient who could not consent to care and treatment. We were told their relative had been included in the discussions as well as health professionals.
- Patients' records showed whether the patient had given their permission to share their personal and confidential information and with whom. Two patients we spoke with on the gynaecology ward confirmed that staff had asked them and recorded which relatives they wished the staff to converse with. They said they were asked if they wished a relative/friend to be present when they received results or information regarding their treatment.

Are maternity and gynaecology services caring?

Good

We have judged caring in the maternity and gynaecology services to be good. Patients who used the service were consistently respected by the staff and encouraged and

enabled to be involved in the planning and decision making regarding their care and treatment. Staff provided patients and their partners/representatives with information and supported them to make decisions. Their individual preferences and choices were consistently reflected in how the care was delivered. We observed staff demonstrating a strong positive patient centred culture throughout our inspection. Staff were passionate about the high care provided and involvement of women attending for maternity services. Feedback from women and their representatives was consistently positive and in many cases exceeded their expectations.

Compassionate care

- The NHSFriends and Family Test (FFT) was created to help service providers understand whether their patients were happy with the service provided, or where improvements were needed. Information from the FFT feedback was collated by NHS England and showed the maternity feedback was similar to the England average. During the period of July 2014 to July 2015 the feedback regularly exceeded the England average for positive feedback. On occasions the feedback was slightly lower than the England average. Scores for the postnatal community service dipped during the winter of 2014-2015. However, between March 2015 and July 2015 100% of patients consistently recommended this service. The antenatal and postnatal community figures are from typically less than 20 respondents which may explain variation in responses. The birth and postnatal responses were around 60 per month.
- The CQC survey of women's experiences of maternity services 2013 found the trust had received consistently good outcomes from the survey performing about the same as other trusts or better than other trusts for all areas.
- The national Women's Experience of Maternity Care 2015 found that the trust was within the top 20% of all trusts with 95% of women stating they had been treated with dignity and respected during labour and birth.
- The Patient Led Assessments of the Care Environment (PLACE) 2014 scored the trust at 90% for privacy, dignity and wellbeing compared to the national average of 86%.
- Patients were able to provide feedback on the national NHS Choices website. We saw that during 2014 and 2015 positive feedback had been left regarding the maternity services. One person had commented that the "staff went above and beyond….amazing and a tribute to the NHS providing a personal and excellent level of care".
- The maternity services had a social media internet page to provide women with information regarding their pregnancy and birth. We saw a high number of comments had been made regarding the friendliness and kindness of the security member of staff who sat at the front desk welcoming people to the unit.
- During our inspection we spent time on the maternity unit and Wynard South and saw that staff consistently treated women with kindness and compassion. We observed staff showed empathy and understanding to their patients. One patient told us that staff had sat with her and held her hand at a time when this was needed.
- Patients we spoke with on the Wynard South and the maternity wards were effusive in their praise of the staff. Comments included "they are all, everyone of them, absolutely marvellous" and "the nurses cannot do enough for you, there is nothing they won't do". "everyone was just amazing when I was admitted in labour it was a really positive experience and I felt safe".
- Women attending the gynaecology clinic were treated with respect and their dignity promoted. We saw a medical student was observing one clinic during our inspection. Each woman was asked if they wished the student to stay during their consultation. We observed the women were asked before they entered the consulting room and in a way that enabled women to be able to ask that the student leave.

Understanding and involvement of patients and those close to them

- The CQCs Survey of Women's Experiences of Maternity Services 2013 found that the trust compared the same as other trusts when providing advice and support to women at the start of their labour and involved partners in their care and provided appropriate information and explanations to women during their stay in hospital.
- The national Women's Experience of Maternity Care 2015 found that 87% of women who responded had been given information to make a choice about where they gave birth. 4% said they had not been given information and 13% said they did not need this information. This placed the trust within the top 20% of all trusts who were part of the survey. 84% of women said they were always involved in decisions about their

care, 15% of women said they were sometimes involved with 1% commenting they had not been involved. 93% of women stated they were given enough time to ask questions or discuss their pregnancy.

- Patients we spoke with on the maternity wards were positive regarding the information provided to them and the support from staff to help them understand. One woman and their husband told us that staff had discussed their care and treatment options with them. As a result they had felt involved, able to ask questions and express their choices and opinions at what was a very worrying time for them. They told us they were "kept well informed at all times of potential complications [and] felt involved in decision making"
- We heard staff provide detailed information to patients on Wynard South regarding their care and treatment. One patient's first language was not English although they spoke English quite well. The staff ensured they had no questions and fully understood all aspects of their treatment and medicines prior to going home.
- One patient expected to be a day case but were told in recovery they were not well enough to go home. The patient said full information had been provided to them why they should remain in hospital and they had been able to ask questions regarding the ongoing treatment and care they would require.
- Comments made by patients on Wynard South included; "I know who is looking after me as their name is on the board and they introduce themselves to me at each shift. I can ask them anything and they explain exactly what is happening"
- Patients who attended the maternity and gynaecology clinics were enabled to bring a relative/representative with them. One patient we spoke with was glad of this support and said "they [the staff] welcome my husband to come and explain things to both of us. This has helped me to understand exactly what is happening and they never mind if we both ask questions." Another patient who had attended the clinic for several weeks for antenatal scans commented they had miscarried their baby but the staff were "exceptional in their gentle manner and attitude….. [they] treated me with the upmost respect at a difficult time" . The patient required further treatment and found the staff provided full information on this care episode.
- Patients attending the gynaecology clinic were advised of when the clinic ran late. During our inspection staff came to tell patients there was a half hour delay and the information was also written on the noticeboard in the waiting room. One patient we spoke with was pleased of this information and said it helped to know the timescales for delays. Another patient commented they had attended the clinic before and had not experienced delays.

Emotional support

- The national Women's Experience of Maternity Care 2015 found that the trust was within the top 20% of trusts surveyed when 81% of women said their midwives asked them how they felt emotionally. We saw midwives and nurses assessed the emotional and mental health needs of patients on admission. Records evidenced discussions had taken place with women regarding this aspect of their care. If further support was required referrals were made promptly to ensure patients received the correct care and treatment from specialist mental health services.
- Counsellors worked within the Centre for Women's Health and provided emotional support to patients. For example, for parents whose babies were admitted to the neonatal unit following birth, women who attended for gynaecology care and treatment and bereaved or traumatised mothers. Staff and patients we spoke with made positive comments about the counsellors and the support they provided.
- The local population was predominantly Christian by recorded religion but had a wide range of minorities from other belief groups. The trust funded a chaplaincy service which had increased its multi-faith membership. This service was available twenty four hours a day seven days a week to provide spiritual support. Staff we spoke with were aware of this service and provided examples of when they had used the service and requested support for individual patients.
- The Maternity Services Liaison Committee (MSLC) arranged for peer supporters to be available on the maternity wards for patients to talk with. Information was available on their contact details. The MSLC is a team of local mothers and/or/ fathers, midwives and commissioners who work within or have experience of the local maternity services.
- Patients who attended the maternity unit to undergo induction of labour were provided with verbal information and support by staff regarding what the treatment and process involved. A midwife support

worker was available to meet the patient in the maternity assessment unit and took them to and show them around the ward. This enabled 1:1 care to ensure any anxieties were able to be shared.
- Women who required a medical termination initially attended the clinic and then transferred to the labour ward to deliver their baby. Two matrons were available who had a specialist interest and additional training in supporting women following the loss of their baby.
- Breastfeeding support staff provided both physical and emotional support to women who experienced difficulties with breast feeding their babies. Patients made positive comments about this care including; "very supportive with breastfeeding – I didn't breastfeed my first and found the maternity support workers brilliant" and "I had good support with breastfeeding which was difficult and also someone took my baby for a few hours at night so I could sleep"

Are maternity and gynaecology services responsive?

Good

We have judged responsiveness in the maternity and gynaecology services as good.

The trust had an integrated maternity service and staffing was flexed to provide care and services to women in their local areas. This also provided women with a choice of where they gave birth whenever possible, based on their risk assessment.

There was good understanding of the individual needs of patients for example, patients with learning disabilities or living with dementia. Translation and interpretation services were available and in use during our inspection.

People were informed on how to complain and the trust took complaints seriously and investigated any complaints received.

However, no second theatre for obstetric emergencies, and Wynard South was not dementia friendly and didn't appear to be doing anything to address the PLACE findings

Service planning and delivery to meet the needs of local people

- The Maternity Service Liaison Committees (MSLCs) are a forum for maternity service users, providers and commissioners of maternity services to come together to design services that meet the needs of local women, parents and families. Three MSLC groups met across Devon meet every two months. Minutes from the meetings were provided to us and demonstrated the meetings were well attended by patients and staff. Discussions about the local services were recorded for example, the birth centres availability and proposed new housing developments which may impact on services in the future.
- The trust provided maternity services to women in their local areas in three stand-alone midwife led Birth Centres which were based at Honiton, Tiverton and Okehampton. Midwives employed by the trust provided antenatal and postnatal clinics and parent craft clinics at the birth centres for women from the local areas. One patient we spoke with had attended the maternity clinic to discuss induction of their labour. They had been provided with information on when to attend the hospital and when they were likely to be able to go to Honiton birth centre.
- Partners were able to stay with the patients when they were in active labour. Whenever possible partners were able to stay on the ward at other times. We spoke with one patient and their husband who told us they had been provided with a side room so that they could both stay together as they lived a long distance from the hospital. They had been admitted to the hospital due to the need for a neonatal bed following the birth of their baby. Both the patient and their husband were grateful for this at such a worrying time for them.
- The gynaecology ward had experienced a reduction in beds due to the need to increase the number of beds for medical patients. Initially the beds had been reduced in number to 10 from 33. Records kept by staff since this reduction evidenced that there were insufficient gynaecology beds available to meet the needs of patients. For example, two patients following gynaecology surgery had been placed onto a general surgical ward, two patients with hyperemesis had been admitted to the antenatal ward and one patient who had a medical termination of pregnancy had not been nursed in a side room which was the preferred option. This concern had been escalated to senior management

and the gynaecology beds were increased to 14. Staff confirmed that since the increase in beds, patients who required treatment on Wynard South had access to an appropriate bed.

- Women who attended the service for a surgical termination of pregnancy were offered contraception in the form of an intrauterine device (coil) or implant at the time of their surgery. Records showed that 70% of women consented to this.
- Gynaecology outpatient clinics were held in an area near to where women lived. For example, one woman we spoke with had an appointment in Barnstaple and had tests carried out there. They then attended the hospital for their treatment.
- A café was located in the Centre for Women's Health for relatives and representatives to access and was open from 08.00 to 5.30pm. We saw one woman and their relative sitting in the café to give them a change from the antenatal ward where they were staying. There were two other restaurants open for longer hours until 7.30 and 7.45pm in the main hospital building if visitors required additional services.

Access and flow

- Patients who required gynaecology care and treatment were admitted via the emergency gynaecology clinic and the surgical assessment unit. Very rarely a patient with a gynaecology need may be admitted through the emergency department. We saw from records that one patient had been woken at 05.45 hours and moved from the surgical assessment unit to Wynard South. They had expressed unhappiness at this disruption to their sleep. Staff commented that where possible ward moves took place during the day time to minimise disruption to the wards. The staff recorded when patients were moved at night and the records showed this had happened infrequently over the previous three weeks (since the increase of gynaecology beds from 10 to 14).
- The gynaecology service implemented a programme of enhanced recovery in 2014. This enabled women to access services in a timely way and spend less time in hospital which had increased the flow of patients through the ward. This was achieved by carrying out more tests and procedures in the clinic setting, providing surgery in ways in which the day surgery unit could be utilised more often and preparing women prior to surgery to effectively understand the planned outcomes of their treatment. For example, mobilising promptly after their operation with a view to being discharged sooner. Auditing had evidenced a reduction in the patient length of stay. Senior clinical staff told us this programme had enabled the number of beds allocated to gynaecology surgery to be reduced. However, close monitoring took place to ensure that women did not experience delays waiting for gynaecology surgery.
- Information provided to us identified the bed occupancy for maternity and gynaecology services was between 47-59% during the period from July 2013 to March 2015. This was lower than the England average when comparing similar trusts nationally.
- Patients were transferred between wards as required to meet their care and treatment needs. For example from the antenatal ward to the labour ward and in some cases returning to the postnatal ward or a community birth centre.
- Midwives had been trained as sonographers to increase the patient flow through clinics.
- The trust informed us that the main consultant led obstetric unit had not been closed between January 2014 and July 2015. However, at times the midwife led birthing units had not been able to remain open due to staffing shortages, for example during times of sickness. On such occasions, women were offered the opportunity to deliver their baby at the main consultant led unit or one of the other midwife led units.
- A number of midwives had completed additional training in order to be able to carry out Newborn screening checks. This enabled women and babies to be discharged home promptly. If the women wanted to go home prior to this check being carried out, appointments were available to return to the ward later in the day or the next day for the screening. Some community midwives had also completed training in order to provide this screening service following discharge.
- Gynaecology and maternity clinic appointments were made by a central booking system and were available each weekday at varying times. The booking system sent out automated appointment reminders for all gynaecology patients. Monitoring took place to record the number of patients who did not attend and a report produced on a monthly basis. We were told this was in

the region of approximately ten per month for the gynaecology clinics and five for the maternity. Staff commented that the clinics were getting busier and seeing more patients than previously.

- The maternity and gynaecology services had their own theatre suite which consisted of three theatres and three anaesthetic rooms. One theatre was allocated to obstetrics, one to gynaecology and one to day surgery. The Royal College of Obstetricians and Gynaecologists (RCOG) recommend that where a service delivers over 4000 births annually a second obstetric theatre should be available. The trust delivered 4102 babies between April 2014 and March 2015. The need for a second obstetrics theatre was identified on the risk register and we were told that at times there had been the need to use an anaesthetic room for an emergency caesarean section as it was not always possible to use one of the other theatres as they were in use. This meant there was a risk of delay in accessing treatment in the event of a second emergency situation occurring simultaneously requiring theatre. We requested data from the trust regarding the monitoring of how frequently this occurred but were not provided with this information. Since the inspection the trust told us this would be reported as an incident through both the trusts and the theatre specific electronic reporting systems. It remained unclear whether the information had been monitored to quantify the risk this posed.

Meeting people's individual needs

- Staff had access to translation and interpretation services for patients whose first language was not English. The three largest ethnic minority groups within the local population were Polish, Lithuanian and Russian. The trust informed us prior to our inspection that each ward had access to language identification cards, a multilingual phrasebook and communication book. We saw the multilingual phrasebook on the nurse's station on Wynard South and staff confirmed this was useful.
- Information on how to access British Sign Language interpreters and the Royal national Institute for the Blind for translation into Braille was available for staff, although those we spoke with had not been required to use these services.
- Records we reviewed on Wynard South demonstrated that staff paid attention to the translation and interpretation requirements for patients and their representatives. We saw an example of when an interpreter had been provided for a patient whose only language was Turkish.
- The staff on Wynard South were aware of the dementia liaison support team employed within the trust. However, the staff members we spoke with had not previously needed to use this service to meet the needs of patients on the ward. There was access to resources for staff to use with patients living with dementia. For example, the ward had a box of equipment such as appropriate games, activities and 'fiddle mitts'. These were material/knitted tubes that patients could put their hands in and had attachments, such as buttons, to occupy restless fingers.
- The Patient Led Assessments of the Care Environments (PLACE) audit for Wynard South had identified a number of areas which were not dementia friendly. For example, the shiny flooring looked as though it was wet, signage for toilets were not visible from all areas and signs were not attached to doors but adjacent walls. This could cause confusion for patients as they attempted to navigate around the ward. Our observations found these issues had not been addressed. We were not provided with an action plan of how this was planned to be addressed.
- The learning disability support team provided assistance to patients living with a learning disability who were admitted to hospital. The team consisted of two whole time equivalent Registered Learning Disability Nurses who were employed by an external provider and had honorary contracts with the trust. For planned admissions the Learning Disability liaison nurses contacted the patient or their relatives/ representatives to help decide what reasonable adjustments were required if any. We were provided with examples of such reasonable adjustments that had been provided to previous patients including easy read information, being first on the theatre list to reduce waiting, provision of a quiet environment and open visiting. For emergency admissions any reasonable adjustments required would be documented in the patient's Learning Disability care plan and discussed and agreed with the ward team.

Maternity and gynaecology

- We heard how a patient admitted for a termination of pregnancy was supported through the process and treatment by one of the learning disability specialist nurses. Staff on the ward were positive about this service and how it helped patients.
- Not all patient bed spaces had access to the radio or television on Wynard South. There was a dining area with a small comfortable seating area with a television on the ward. However, two patients told us that they had not felt well enough to sit in this area and would have preferred access at the bedside to help pass the time.
- Patients admitted to the maternity services for induction of labour were provided with a detailed information leaflet that described the process of treatment. A noticeboard was on display outside of the four bedded induction bay which provided further information for patients. This was as a result of feedback as patients had not been able to remember all the information provided.
- Staff told us that at times due to reduced staffing levels women who had attended the clinic or antenatal ward for induction of labour experienced a delay Staff also commented that since the provision of a four bedded bay had been implemented for the use of women requiring induction, delays had been reduced. We asked for data regarding the number of women who experienced such a delay but this information was not maintained by the service. Therefore we were unable to clarify how many women this affected and how long the delays were.
- The midwifery services were able to refer ante and postnatal women to the mental health clinic which ran on alternative weeks. The trust had a dedicated perinatal mental health team which was available during office hours. Additional support was obtained if women were acutely mentally unwell through a neighbouring trust which provided mental health care and treatment. Midwives acknowledged a concern that it was difficult to admit women to mother and baby units as availability of beds within the mental health trusts were often at a premium.
- Supervisors of Midwives supported midwives to develop personalised care plans for women who had requests for birth plans outside of guidelines. This helped ensure the individualised care needs and wishes of women were met.
- It had been deemed necessary to close the co-located unit six times in the last 12 months for a period of two to three hours and on one occasion overnight due to increased activity and staff sickness. This may have had an impact on women's choices if they had wished to deliver their baby in this unit.
- A stop smoking specialist midwives was in post. Information regarding stopping smoking before or during pregnancy was provided for patients on the trust's Facebook page. Data collected by the trust showed that the number of women smoking at the point of delivery had decreased from 7.9% to 6.8% this year when compared to information from the previous year. Other specialist roles included a midwife for complex needs such as substance misuse, domestic violence and vulnerable adults, screening co-ordinators and infant feeding coordinators. One midwife had a specialist interest in teenage pregnancy took referrals of teenage others from other midwives. A young parent group had been set up in two children's centres. Parents who were up to the age of 23 if they were vulnerable or had experienced a previous teenage pregnancy
- The CQC Survey of Women's Experiences of Maternity Services in 2015 found that the trust was better than other trusts in enabling women to move around and choose a comfortable position during their labour. The results from the survey also found that when women used their call bell to summon assistance this was responded to better than the England average.
- Appointment times for the maternity and gynaecology clinics were confirmed in a letter to the patient. Patients told us they also received information either within the letter or in an accompanying leaflet regarding the expected care and treatment and what that would entailOne patient we spoke with had been referred to the maternity clinic for an urgent scan. They expressed to us that they were frightened of the possible outcomes. They told us they had been waiting 45 minutes for their scan.
- Women were provided with information regarding baby cafes that met in the local areas and provided breast feeding support to mothers.
- The gynaecology clinic was responsive to individual patient's needs. We spoke with one patient who had been advised by their GP to request that their appointment be brought forward. They rang the clinic and were given an appointment the next day.

Maternity and gynaecology

- The co-located birthing centre had been decorated and furnished to look less clinical and more homely.
- Women who experienced a loss of pregnancy or baby were supported and cared for in the Heartsease bereavement room. This room had been refurbished to provide the women with a homely and calm environment where they and their relative/ representative were able to spend time alone or with staff.
- Clinic waiting rooms had toys and magazines available for patients and their children when visiting the department.

Learning from complaints and concerns

- Information about how to make a complaint was displayed on the wards. We also saw a folder was placed in each room and bed space for patients to refer to regarding their stay in hospital. This identified the complaints procedure.
- The numbers of complaints was identified as significantly increased during April 2014 and April 2015 from patients of the maternity service. A total of 30 complaints had been received. This had been investigated and identified that communication emerged as a theme. Action was taken and staff training was provided to raise awareness. Data collected from April 2015 to September 2015 showed a significant reduction of complaints as 9 complaints had been received.
- Senior midwifery staff or the head of midwifery liaised with complainants and discussed issues personally with them.
- Staff were aware of the outcomes from complaint investigations and learning from complaints and patient feedback was discussed at staff and divisional performance meetings.

Are maternity and gynaecology services well-led?

Good

We judged the leadership of the maternity and gynaecology services as good.

Staff were positive about the management of their services and the accessibility to their line and senior managers.

The service welcomed public engagement through the NHS Friends and Family Test. Staff were encouraged to share their views on the service and how improvements could be made. Staff award ceremonies took place with credit given to teams and individuals who had been nominated for awards.

Vision and strategy for this service

- Staff we spoke with were aware of the vision and values of the trust. The trusts annual report identified their charter and values had been launched together with staff. The trust's long term vision was to provide "safe, high quality, seamless services delivered with courtesy and respect." The trust values were honesty, openness and integrity, fairness, inclusion and collaboration, respect and dignity.
- The head of midwives and the clinical lead for gynaecology and obstetrics stated they were waiting for the NHS England major review of maternity services which was announced in March 2015. This was included in the NHS five year forward view and planned to assess current maternity care provision and consider how services should be developed to meet the changing needs of women and babies. The clinical lead and Head of Midwifery advised us the services would be developed in response to this report where needed.

Governance, risk management and quality measurement

- The gynaecology and maternity services had local service risk registers which linked to the trust wide risk register. Staff were knowledgeable about how to raise concerns and risk and the senior staff we spoke with were aware of the risks that were identified to their service and whether there was any action that was being taken to reduce the risk. Some risks had been on the risk register for long periods of time for example the handwritten identification arm bands. The actions recorded on the risk register since 2010 and reviewed annually were that the trust was reviewing other organisations systems to negate this risk. However, no action had been taken to address the situation.
- The local risk register was reviewed at the maternity governance meeting which took place on a monthly basis. This meeting was attended by the head of

midwives, matrons, the governance manager, consultants and the cluster manager. The cluster manager was a senior manager linked to the maternity and gynaecology service.
- Every two weeks an incident review group held a meeting which was attended by staff from different divisions. All incidents rated as moderate risk were reviewed and discussed at this meeting. Decisions were made at this meeting to escalate incidents to the trust governance meeting.
- A recent incident reviewed at this meeting was regarding a baby who required admission to the neonatal unit following a shoulder dystocia during the birth. (Shoulder dystocia is an emergency situation which occurs when a baby's head has been born but one of their shoulders is stuck behind the mother's pelvic bone). A detailed investigation into the circumstances and responses of the midwives and doctors was carried out by an external midwife. The obstetric clinical lead for governance reviewed the investigation and escalated to the trust governance meeting.
- The Head of Midwifery, risk manager and community senior midwife visited one of the three birthing units on a monthly basis to hold a governance meeting to which all community midwives were encouraged to attend. ……
- Not all risks on the risk register were linked with audit and activity. For example, the maternity service were not able to provide evidence to demonstrate women received pain relief in labour within appropriate timeframes as this was not subject to audit or incident reporting in the event of delays. This was a concern as the local risk register identified that since 2010 women in labour were not able to be offered a full range of choice due to the lack of specific epidural pumps to enable women to self-administer their epidural infusion boluses.

Leadership of service

- Information provided to us by the trust prior to the inspection referred to senior managers spending time on wards and departments, meeting with staff and patients. Staff we spoke with on the maternity and gynaecology wards were not aware of this happening.
- The gynaecology ward had gone through a considerable change period. The ward had originally provided 33 gynaecology beds, which had been reduced to 14 at the time of our visit. Staff told us they had felt supported by the ward sisters and matrons during this period of change. The trust informed us that during this period of change the Assistant Director of Nursing, Divisional Director of Medicine, and other senior managers invited all of the Wynard staff to open meetings between every 7-10 days where they could share their concerns.
- Staff told us and the off duty showed Wynard South staff were always supported by one matron and/or one ward sister on each day shift.
- The maternity unit was managed by the Head of Midwifery and two senior midwives. Staff reported they were visible in the department and were approachable and helpful. Day to day management of the wards and departments was the responsibility of the matrons and again staff comments were positive regarding the support, approachability and leadership provided.
- The site management team was on call at night and staff reported if needed this team responded promptly and were helpful.

Culture within the service

- Staff were overwhelmingly positive about their comments regarding working at the trust. Midwives were exceptionally proud to work on the maternity unit.
- Student nurses and midwives told us they had requested to be placed at the trust as it was viewed as a good placement for learning and students were supported and nurtured in their learning.
- It was clearly evident throughout our inspection that team work between nursing/ midwifery and medical staff in their own departments and between other departments was good.
- Staff told us many times during our inspection that patient safety and care was the priority of the trust.

Public engagement

- Women were consulted and their views heard by the Maternity Services Liaison Committee (MSLC) who met every two months to share information regarding the services provided.
- Access to a social media Facebook page was in operation to share information. This was monitored on a daily basis. We saw guidance regarding the maternity services and important information regarding pregnancy and health and wellbeing was available on this site.

- The Local Supervising Authority (LSA) carried out assessments of the maternity service in Exeter. Adverts for new members to carry out the assessment were placed on the trusts Facebook page.
- Representatives from the maternity services attended the The South West Strategic Clinical Network which consisted of people who used, provided and commissioned health services to make improvements in outcomes for complex patient pathways using an integrated, whole system approach.
- The supervisors of midwives met two to three mothers who were on the ward each month to gather feedback on the services they had received.

Staff engagement

- Each ward displayed information for staff on a board known as the 'comm cell'. Com cell meetings took place on Wynard South (gynaecology) twice a week. This meeting included providing staff with information on any changes within the trust or ward, suggestions for improvements and training availability or requirements. Staff on Wynard South stated the meetings were well attended and useful to them.
- Staff meetings took place in wards and departments and enabled staff to discuss issues and update on changes and new information.
- Various newsletters were sent to staff including the Supervisors of midwives newsletter, maternity newsletter and gynaecology and fertility newsletters. These were sent monthly by email and were informative and contained relevant news and information for staff.
- Maternity and gynaecology services were part of the specialist services division. The divisional management team produced a newsletter between two and three times a year and provided an email version to all staff with a hard copy displayed on wards. Contributions were requested from each cluster and included professional and personal news. We saw this newsletter displayed in the centre for women's health.

Innovation, improvement and sustainability

- The gynaecology service had implemented a programme of enhanced recovery in 2014. This enabled women to access services in a timely way and, spend less time in hospital which in turn increased the flow of patients through the ward. Senior clinical staff told us this programme had enabled the number of beds allocated to gynaecology surgery to be reduced. However, close monitoring took place to ensure that women did not experience delays waiting for gynaecology surgery.
- A telephone follow up service for women following specific gynaecology surgery had been implemented. This had reduced the need for women to make additional journeys to hospital.
- The Heartsease room had been refurbished and provided a calm, homely environment for women to use when they had experienced the loss of a pregnancy or baby. Staff had worked with an external bereavement organisation to provide women with memory boxes which could be filled with mementos of their baby. Staff worked with women to choose relevant and appropriate items. For example, a teddy, the babies hand or foot cast, or a blanket or item of clothing.
- The maternity services had developed access to social media using Facebook to provide women with information regarding pregnancy and birth. This was also used to enable women to provide feedback on their stay. Staff monitored the page each day and replied to comments made as necessary.
- Patients had provided feedback to the trust regarding their wish to have their partners stay with them during their time in the hospital. Previously partners had been able to stay with women during active labour and then attend during visiting hours. Facilities for partners to stay overnight with women undergoing induction of labour or in early labour on the antenatal ward had been expanded to meet this request. Also there were facilities available for a limited number of partners to stay with their partner on the postnatal ward.

Services for children and young people

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

Information about the service

Services for children and young people at Royal Devon and Exeter NHS Foundation Trust are located at Wonford Hospital and comprise the paediatric unit, the paediatric assessment unit (PAU), paediatric outpatients and the neonatal unit.

The paediatric unit is situated on Bramble ward which has four high dependency spaces (one side room and three beds); 33 inpatient beds (16 side rooms, three six bedded bays and a five bedded bay); and day care beds for urology, spinal and general surgery. The unit is divided into several different teams:

- The Yellow Team has eleven beds, six side rooms (two dedicated to paediatric oncology) and a six bedded adolescent unit for teenagers. The team cares for children over the age of two with a wide variety of medical conditions and also treats oncology patients.
- The Blue Team has six elective beds and two side rooms (mainly for day care). The team cares for children pre and post operatively following emergency and elective surgery for ENT, maxilla facial orthopaedic, urology, spinal and surgery.
- The Green Team has eight side rooms and cares for babies under the age of two years.
- The high dependency unit is a four bedded unit (one side room and three beds) and cares for children and young people of all ages who require close observation and monitoring.

There are two day case areas, one for general paediatric attenders with five spaces and one for oncology day attenders with four spaces.

There are two playrooms and play specialists who also provide activities at the bedside. A school run by Devon County Council is available in the morning and afternoon during term time for all children in hospital for three days or more.

The paediatric assessment unit (PAU) is situated adjacent to the emergency department. There are six paediatric trolleys situated within the unit. Children and young people are triaged in the emergency department and are assessed in paediatric assessment unit between the hours of 10am and 10pm unless otherwise directed by infection control or the need for resuscitation in the emergency department. The emergency clinician will refer to either the paediatric team or a specialist team, for example orthopaedics, plastics and the Child and Adolescent Mental Health Services (CAMHS) according to their diagnosis. Unwell children and young people are treated in the emergency department resuscitation bay which has a space set up for stabilisation of children prior to admission. Children and young people can also be cared for in the main intensive care unit where there is one paediatric side room.

The paediatric service also supported other hospital services which children accessed and used, for example outpatients and surgery.

Services for children and young people

The department provides a specialist referral service for children with suspected child abuse and contributes to the work of a multi-agency team which supports the victims of child abuse and those caring for them. The unit has specialist status for oncology and cystic fibrosis.

The neonatal unit is located on the first floor of the centre for Women's Health and is part of a network called the South West Neonatal Network. There are 26 cots providing intensive care, high dependency care, special care and transitional care. The majority of admissions to the unit are via the labour suite although some are transferred back from the Bristol Children's Hospital or elsewhere in the South West Neonatal Network.

During our inspection we spoke with 19 parents and eight children and young people. We also spoke with over 35 members of staff, including nurses, consultants, doctors, administration staff, support staff and housekeeping staff. We visited all the areas within the paediatric unit and the neonatal unit. We observed how babies, children and young people were being cared for, handover meetings and looked at care and treatment records and also other documents provided by the trust.

Summary of findings

Services for children and young people were found to be good. We found that services were safe, effective, caring, responsive and well-led.

Risk was managed and incidents were reported and acted upon with feedback and learning provided to most staff. Staff adhered to infection prevention and control policies and protocols. The units were clean and well organised and suitable for children and young people.

Treatment and care were effective and delivered in accordance with best practice and recognised national guidelines. There was excellent multidisciplinary team working within the service and with other agencies.

Children and young people were at the centre of the service and the priority for staff. Innovation, high performance and the highest quality of care were encouraged and acknowledged.

Care and treatment of children and support for their families was delivered in a compassionate, responsive and caring manner. Parents spoke highly of the approach and commitment of the staff who provided a service to their families. Children, young people and their families were respected and valued as individuals. Feedback from those who used the service was consistently positive. Children received excellent care from dedicated, caring and well trained staff who were skilled in working and communicating with children, young people and their families.

Staff understood the individual needs of children, young people and their families and designed and delivered services to meet them.

There were clear lines of local management in place and structures for managing governance and measuring quality. The leadership and culture of the service drove improvement and the delivery of high-quality individual care.

All staff were committed to children, young people and their families and to their colleagues. There were high levels of staff satisfaction with staff saying they were proud of the units as a place to work. They spoke highly of the culture and levels of engagement.

Services for children and young people

There was a good track record of lessons learnt and improvements when things went wrong. This was supported by staff working in an open and honest culture with a desire to get things right.

Are services for children and young people safe?

Good

Overall we have judged the safety of children and young people's services as good. There were systems in place for recording and learning lessons from incidents and staff told us they were encouraged to report incidents.

Nursing and medical records had been completed appropriately and in line with each individual child's needs. However, there were inconsistencies with some records by way of incomplete documentation particularly with regard to some medicine charts.

Staff we spoke with were knowledgeable about the trust safeguarding process and were clear about their responsibilities. Mandatory training was monitored each month and most staff were compliant with their training.

The units were clean and well organised. Staff adhered to infection prevention and control policies and protocols.

Systems were in place for the safe storage and administration of medicines and appropriate audit trails were in place for controlled drugs.

Incidents

- Staff were open, transparent and honest about reporting incidents. Systems were in place to make sure that incidents were reported and investigated appropriately. All staff told us that they would have no hesitation in reporting incidents and were clear on how they would report them. All staff received training on incident reporting at induction and through periodic updates. Staff leading investigations received training in root cause analysis.
- Once reported incidents were reviewed by the appropriate clinical manager and where necessary investigated. Staff told us they were able to get feedback on incidents they reported. However, feedback was variable with some staff reporting that it was not always forthcoming.
- Incident reporting activity was reviewed and discussed at management and governance meetings. We saw evidence that learning was discussed through division communication cells, email and group managers

cascading information through departmental, speciality and unit governance meetings. For example, we heard about a change in practice for nappy care following input from the tissue viability team where the use of water and cotton wool balls had stopped and been replaced by gauze and aqueous cream.

- For the children's services there were no serious incidents reported under the Strategic Executive Information System (STEIS) or never events (serious, largely preventable patient safety incidents that should not occur if the available preventative measures had been implemented) reported for the period August 2014 to July 2015.
- The children services held paediatric mortality and morbidity meetings and minutes showed cases were discussed and learning points and actions taken were documented. Concerns were expressed about the governance of the perinatal mortality and morbidity meetings as they were standalone and did not feed into the divisional governance processes. Revised terms of reference for the meeting had been circulated to address the governance issues.
- Any exception in the trust mortality and morbidity would be reported to the governance committee via the safety & risk report. From August 2015 a revised process was introduced where all deaths were reviewed by a multi-professional team using a standardised trust proforma. . All information was collated in a central database for analysis (including triangulation) and dissemination of learning.

Duty of candour

- Staff demonstrated an understanding of duty of candour responsibilities. This new regulation was introduced in November 2014. It required staff to be open, transparent and candid with patients and relatives when things went wrong. We saw evidence of an incident involving a documentation and medicine error where the duty of candour process had been deployed within the service. We saw that parents had been contacted to discuss the incident. A follow up letter had been sent offering apologies, confirming an investigation was underway and explaining they would be offered an opportunity to discuss the findings. We saw the investigation screening tool and subsequent review and the letters that were being prepared to send to the parents following discussions about the incident. We spoke to the mother who was happy with the way the incident had been dealt with and informed us she had received an apology.
- The trust did not have a formal training programme for duty of candour, however, we were told that communication, openness, honesty and transparency were central themes running through many training programmes. The proposal outlining the changes in relation to duty of candour had been widely publicised at the time and went through the divisional and speciality governance groups.
- The electronic reporting system had a forcing function for duty of candour for any incident of moderate harm and above which had to be completed. A set staff circulation list was also triggered within the relevant division and the governance manager would follow the process to ensure that duty of candour had been undertaken.
- Duty of candour compliance was monitored through the fortnightly incident review group. A quarterly report on closed incidents and compliance with the duty of candour requirements was presented to the group. This compliance was also reported to the safety & risk committee and was included in the monthly Integrated performance report to the board. All duty of candour requirements were monitored through to their conclusion.

Safety thermometer

- The service participated in the national safety thermometer performance and achieved consistently positive results. From July 2014 to July 2015 harm free care was consistently maintained across the service with safety thermometer results showing no falls with harm, no catheter associated urinary tract infections or category 2-4 pressure ulcers.

Cleanliness, infection control and hygiene

- At the time of our inspection the units and clinical areas were seen to be visibly clean, well-organised and tidy.
- Bed and cot spaces were visibly clean in both the easy and hard to reach areas. Bed linen was in good condition, visibly clean and free from stains or damage to the material. Notices and posters were housed in acrylic containers or laminated and stuck to walls or noticeboards with pins or reusable adhesive. We saw completed cleaning schedules and audits. We saw

cleaning schedules with information logged daily in work books and cleaning standards information was available for parents and visitors in a folder on Bramble ward and the neonatal unit. Environmental audit scores showed an average of 99% for the period September 2014 to August 2015. Both units also had a dedicated team of housekeepers who ensured the areas were clean and tidy. These teams were fully integrated with the clinical teams and one member of staff told us there was "a real family feel" and "I take pride in my work."

- Disposable items of equipment were disposed of appropriately, either in clinical waste bins or sharp instrument containers. Nursing staff said these were emptied regularly and none of the bins or containers we saw were unacceptably full.
- We observed doctors and nursing staff washing their hands and using anti-bacterial gel in line with infection prevention and control guidelines. Children and their parents were asked to use alcohol gel when arriving on the unit and this was freely available and clearly visible. Most staff were bare below the elbow although some staff were seen to be wearing wrist watches.
- Bramble unit was well equipped with hand wash basins with good access to liquid soap and paper towels for staff to use. There was a wash hand basin at the entrance to the neonatal unit and we were asked to wash our hands before entering the unit. Alcohol hand gel was located in all of the nurseries and all parents and visitors were asked to apply the gel to their hands on entering and leaving the nurseries, remove rings (except a wedding band) bracelets and watches and to roll up long sleeves and to wash as far as the elbow. Parents feeling unwell were asked to enquire from the nursing team if it was safe for them to visit. No other visitors were allowed on the unit if they felt unwell.
- There were no unit-acquired Methicillin resistant staphylococcus aureus MRSA infections during the past four years.

Environment and equipment

- Areas were suitable for children and young people. The units were bright, welcoming and suitable for children and young people. Photographs of staff working on the units were positioned around the unit to inform parents who was on duty. and play areas with a range of toys and activities were available.
- Access to Bramble ward and the neonatal unit was secure to maintain the safety of babies, children and young people. Robust intercom / buzzer systems were in place for staff and visitors to access the units. Entry and exit was as secure as reasonably possible.
- Staff told us they had access to the equipment they needed for the care and treatment of babies, children and young people and were trained in its use where necessary. There was equipment competency training with specialist trainers providing instruction on the use of equipment. Every member of staff on the neonatal unit had adopted a piece of equipment and was responsible for training. Equipment was well maintained in line with manufacturer's instructions. Faulty equipment was labelled and left in designated areas and the fault reported electronically. There was resuscitation equipment available in all areas appropriate for babies, children and young people. The trolleys had been checked each day and this was documented. However, there were gaps during the last six months where checks had not been recorded on Bramble ward. Incubators in all areas were checked weekly and details recorded. Filters for humidifiers were changed every three months and breast pump kits were sent to a medical fast clean as required and returned to be made up into kits for future use. Freezers were defrosted every month.
- Play areas were available in the neonatal unit and paediatric outpatients with prominent signage reminding parents of their responsibilities and alerting parents and carers that children should not be left alone in the children's waiting and play areas. Television screens with a slide reminding parents not to leave children unattended were also available.
- Parents were encouraged to stay with their child on Bramble ward and there were no restrictions to visiting.
- There was open visiting on the neonatal unit, however, parents were asked to observe ward rounds and quiet times when the lights were lowered and babies left undisturbed to allow them to sleep to promote growth and development.

Medicines

- Staff had access to the trust medicines management policy which defined the policies and procedures to be followed for the management of medicines and included obtaining, recording, handling, using, safe

keeping, dispensing, safe administration and disposal of medicines. Staff were knowledgeable about the policies and told us how medicines were ordered, recorded and stored.

- We looked at medicines audits, incidents and complaints, storage security, medicines records and supply and waste processes. Medicines, including those requiring cool storage, were stored appropriately. During our inspection we found that most medicines were stored securely and were only accessible by staff. There were medicine preparation areas and all cupboards were locked and the areas well organised. However, one refrigerator on the high dependency unit on Bramble ward was found to be unlocked and as it was on the floor was easily accessible to children and the public. The refrigerator contained medicines, syringes and needles. We alerted staff and on subsequent visits the refrigerator was locked.
- Controlled drugs were stored in separate locked cupboards and were checked daily by two registered children's nurses. Where medicine needed to be stored in a refrigerator, the refrigerator temperatures had been checked consistently.
- Nursing and medical staff had access to three named pharmacists with a poster displaying contact details. We spoke to pharmacists on the neonatal unit and Bramble ward who told us there was a good strong senior pharmacy team who were supportive.
- Medicine incidents were reported via the trust electronic reporting system. All medicine incident investigations had pharmacy input and were reviewed by the trust Medication Safety Committee. We saw there had been an increase in medicinen errors on Bramble ward in the yellow team followed by an in depth trend analysis undertaken by the ward matron and an action plan implemented.
- All pharmacy services were available Monday to Friday during working hours with dispensary services available over weekends and bank holidays.
- Within the high dependency unit the lighting had been modified to maximise the light in the areas where medicines were prepared.
- We saw from records on the neonatal unit that prescriptions were signed and dated and antibiotics were prescribed in line with National Institute for Health and Care Excellence (NICE) guidelines. Writing was legible and the weight of the baby was recorded, however, there was no section to record the age of the baby on the prescription chart.
- We saw from records on Bramble ward that children's weight and allergies were recorded on medicines charts. However, of the ten records checked on Bramble ward we found inconsistencies in eight records, particularly on the medicine charts. For example, some records had missing documentation or incomplete documentation, some medical entries were illegible, there were medicine chart inconsistencies with entries of regular prescriptions where no doses were recorded and no explanation given, dates and times were missing and signature sheets did not include all signatures.

Records

- Records were stored safely at nurse stations to ensure confidentiality and security.
- We reviewed 16 sets of notes on Bramble ward and the neonatal unit. We checked a range of information including the diagnosis and management plan, observations, input from the multidisciplinary team, discussions with the family, consent, allergies, and the signature and date with the name and grade of the doctor or nurse reviewing the patient.
- On the neonatal unit information was clear and concise with details of what was happening now, the long term goals, how they would be achieved and clear review dates. Care plans were reviewed and updated regularly in conjunction with the baby's family. This made sure they were tailored to meet the needs of each baby.
- Consent forms for sharing information and consent for procedures or operations were completed and most paediatric early warning scores were completed but not consistently scored. An early warning score was not used on the neonatal unit.

Safeguarding

- Staff we spoke with were knowledgeable about the trust safeguarding children's policy and processes and were clear about their responsibilities. They were able to explain their role in the recognition and prevention of child abuse and what actions they would take should they have safeguarding concerns about a child or young person. Staff were trained to the appropriate level set out in the intercollegiate document 'Safeguarding children and young people: Roles and Competencies for

Health Care Staff' and were familiar with government guidance 'Working Together to Safeguard Children'. Staff were trained to recognise and respond in order to safeguard children and young people. Records indicated that safeguarding training to at least level 3 was up to date for all staff. Staff were knowledgeable about female genital mutilation (FGM) and aware of their responsibility to report FGM in girls up to 18 to the police. FGM was included in all safeguarding children training.

- A yellow divider was used in notes to identify a baby with safeguarding concerns. Safeguarding information was recorded in notes and the actions taken to keep children safe were recorded in medical records.
- The trust used the Peninsula Section 11 Standards self-evaluation for 2014 to monitor and challenge the effectiveness of local arrangements for the purpose of safeguarding and promoting the welfare of children. All safeguarding committee meetings were confidentially archived on a shared drive with records of minutes and actions stored and updated regularly. A safeguarding children flowchart set out guidelines and paperwork used to ensure effective reporting and information sharing when any safeguarding children or vulnerability were identified. Staff were familiar with forms to complete for the Multi Agency Safeguarding Hub (MASH) enquiries. Referrals set out the practitioners' assessment of risk of harm to the child or young person and what response was expected to best inform children's social care decision making. We saw evidence of MASH forms filed with notes to highlight any relevant issues or concern which indicated that a child or their family would benefit from early help or advice from a health visitor or school nurse. A threshold tool was used to assess need and included concerns about diet or hygiene, frequent attendance at hospital, behaviour problems, family or parents under stress or not coping, or attendance by a child subject to a child protection plan or in care.
- The Medical Director was the executive lead for safeguarding and there was a safeguarding lead nurse for the trust who supported a programme for safeguarding supervision and peer review. Staff were aware of and able to access supervision and review. There was a named doctor for child protection and there was always a senior officer on duty or an on call consultant paediatrician contactable 24 hours a day who had received additional child protection training. We saw child protection multidisciplinary team minutes filed in notes.
- We observed a 'New baby in the family' meeting held weekly and attended by a Women's Health counsellor, a consultant, specialist safeguarding nurse, a matron and junior medical staff to discuss the baby's care and family circumstances and the parents' relationship. The team would alert the safeguarding team about any concerns, for example if they had concerns about violence and domestic abuse. Vulnerable baby meetings were held monthly and attended by the perinatal mental health lead, specialist midwife and substance misuse specialist.
- Staff were offered opportunities for debriefing and learning following difficult safeguarding events. Paediatric doctors attended monthly peer review sessions and staff were encouraged to use reflection to record their learning. Safeguarding supervision was offered routinely to staff who worked with children and their families. For all other staff supervision was available on request and was offered either individually or as a team around a particular case.
- Children and young people with a learning disability were electronically flagged on the hospital patient administration system as part of their care pathway. This was identified when an 'identification of specific requirement agreement form' was completed when they were pre-assessed and / or admitted to the hospital. This was then recorded and filed in their medical records.
- There was a newly expanded Learning Disability (LD) Liaison Team consisting of two part-time and one full-time nurses who were all registered learning disability nurses. The nurses were employed by Devon Partnership Trust and had honorary contracts with the trust. The team were part of, and resided with, the trust Integrated Safeguarding team, and were managed by the Named Nurse for Safeguarding. There were robust security systems in place to ensure the safety of babies on the neonatal unit. To gain access parents and visitors needed to identify themselves at the reception desk using an intercom / buzzer system. Only staff with a valid ID badge could enter the unit without using the intercom. The reception desk was manned by a security guard 24 hours a day who gave access to the unit through another secure door. To gain exit from the unit

parents were required to press a bell and the security guard would release the door to exit the unit and move through to the reception area. Parents were then required to exit through a second secure door. This meant that exit from the unit was as secure as reasonably possible.

- The doors to Bramble ward were closed and locked 24 hours a day. Entry was gained by using the intercom system. If a parent was concerned about leaving their child a member of staff would sit with their child until they returned. Staff continuously engaged with children through play to find out how safe they felt on the unit and also with parents to find out about their concerns and ideas to improve safety.
- If a child or young person went missing from Bramble ward guidelines set out in the trust Missing Patient Procedure were followed and the security team and the police were notified.

Mandatory training

- The trust provided a programme of mandatory training for staff which included infection control, information governance, safeguarding children, moving and handling, fire training, hand hygiene and equipment training.
- Electronic staff training records were monitored to review attendance and expiry dates, thereby ensuring compliance with mandatory training. Most staff told us they were up-to-date with their mandatory training or had dates booked to attend training in the near future. Data provided by the trust showed a 91.3% compliance rate. Compliance data was displayed on unit communications cell with staff out of date identifiable by a RAG (red, amber and green) rating. This meant that staff remained up-to-date with their skills and knowledge to enable them to care for children and young people appropriately.
- Staff told us that training was delivered to meet their needs and that they were able to access training as they needed it. Training was provided through a mixture of e-learning and face-to-face modules.

Assessing and responding to patient risk

- Risk assessments were completed and evaluated. There were clear processes in place to deal with deteriorating children. Paediatric early warning scores (PEWS) were in place on Bramble ward. Each chart recorded the necessary observations such as pulse, temperature and respirations. Staff were able to articulate and were knowledgeable in responding to any changes in the observations which necessitated the need to escalate the child to be seen by medical staff. Details of the escalation required, depending on the scores, were in place on each PEWS chart. An early warning system was not in place on the neonatal unit. Deteriorating babies were identified by clinical judgement and escalated to medical staff. Plans to incorporate temperature monitoring, saturation and observation were going through governance.
- All nursing staff within the unit had been trained in paediatric life support and consultants had also been trained in advanced paediatric life support.
- Surgical services for children were provided in various theatres across the trust. Children and young people were admitted and discharged through Bramble ward in line with theatre schedules. In addition, there were theatre lists when required for scoliosis surgery and pectus carinatum procedures where a bed on the high dependency unit was required on return to the ward. Staff from Bramble ward delivered children and young people to the theatre and collected them from the recovery area and returned to the ward.
- Safety checking procedures were in place in theatres to ensure the right child was present and we saw a consent form signed by the parent. The anaesthetist told us one parent or carer was allowed to stay with the child in the anaesthetic room and on this occasion one parent was present. In theatre the surgeon checked they had the right child and were carrying out the right operation. On completion of the operation staff started to bring the child round in the theatre and the anaesthetist took the head end of the trolley and pushed the child into the recovery room. The recovery area had two bays and paediatric resuscitation equipment was available.
- There had been a total of 253 admissions of children with mental health / CAMHS-related issues to Bramble from 1 July 2014 to 31 July 2015. The number and complexity of CAMHS admissions to the unit was a high risk for the trust and was on the risk register, particularly regarding the risk to the other children, their families, and staff on the unit. Children and young people were at risk of absconding and / or risk taking behaviours which would impact upon them and other children on Bramble ward awaiting assessment. There had been an increase in children and young people displaying

anti-social behaviour resulting in security and police presence on the ward. The length of stay of more complex CAMHS patients was increasing due to the lack of Tier 4 beds locally and across the UK.
- Staff on Bramble ward had a missing patient algorithm to follow if the whereabouts of a child or young person were unknown. Where teenagers were seen to be leaving the unit following gentle persuasion to stay, staff were instructed not to intervene and to call the security team and the police.

Nursing staffing

- We were told that there was adequate nursing staff to safely meet the needs of children and young people. Nurse to baby or child ratios were in line with the Royal College of Nursing (RCN) guidelines. At the time of the inspection levels of nursing staff and other clinical staff levels were close to the establishment as follows:
  - The neonatal unit had 39.43 whole time equivalent (WTE) nurses in post against an establishment of 40.14 WTE and 12.13 WTE other clinical staff against an establishment of 12.94 WTE.
  - On Bramble ward there were 53.85 WTE nurses in post against an establishment of 53.89 WTE and 12.54 WTE other clinical staff against an establishment of 12.64 WTE. The shortfall did not adversely impact on the care of children and young people.
- Data for planned registered nursing cover from April to July 2015 showed variation from month to month on Bramble ward with cover generally fulfilled for both day and night. However, actual levels for unregistered staff showed a slight deficit from the planned levels from between 90.6% to 95.4%. On the neonatal unit data showed planned staffing levels were almost met with a slight deficit of between 97.9% and 99.0% for nurses, and for care staff between 94.8% and 98.6%. A senior nurse was always present in the unit which meant senior nursing advice was always available. We looked at rotas on Bramble ward and the neonatal unit for the month prior to our inspection and saw that most shifts were covered with bank or agency filling any gaps. Senior nurses were shown as supernumerary.
- During the period from May 2014 to March 2015 the median bank or agency usage of appropriately trained staff was 7.8% (ranging from 2.7& to 15.6%) on Bramble ward and 1.8% (0 to 3.35%) on the neonatal unit.
- The Keith Hurst acuity tool had been used and reviewed, however, professional judgement and the RCN guidelines had been found to be more useful. The case, age, specialty mix and ward lay out meant it was difficult to find one tool that met the requirement to produce a robust skill mix.
- In addition to this there were other considerations that would increase staffing requirements. These included whether there were resident parents staying especially with babies and young children, if a child had special and / or complex needs, children with eating disorders, complex CAMHS patients who required one-to-one supervision and paediatric oncology patients. There were also occasions where children with tracheostomies received one-to-one care whilst they waited for a home care package.
- The neonatal unit adhered to the British Association of Perinatal Medicine (BAPM) standards. Acuity was measured using a national database. Staffing levels were adjusted accordingly and monitored via a staffing dashboard on the database. The unit aimed to meet the staffing standards from the Department of Health's 'Toolkit for High-Quality neonatal services' (2009).
- There was a low staff turnover on both units evidenced by the presence of a number of the team who had been working on the units for some years.
- We saw there was time built into shift changes to allow for handover. We were not able to observe a handover but saw comprehensive notes of the handover. Staff told us the handovers were well structured and worked well with opportunities for learning.

Medical staffing

- Staffing levels and skill mix were complaint with the Royal College of Paediatrics and Child Health (RCPCH) and the British Association of Perinatal Medicine (BAPM) standards. The medical staffing skill mix showed 38% consultants, 8% middle grade doctors having at least three years at senior house officer (SHO) level or higher grade within their chosen specialty, 48% specialty registrar 1-6 and 6% at foundation year 1-2 trainee level.
- There were 14 consultant paediatricians on Bramble ward providing a service from 9am on Monday to 5pm on Thursday, or from 9am on Friday to 9am on Monday. During weekdays consultants were on the ward seeing all new and complex inpatients, any day cases or acute referrals requiring attention. At weekends consultants were present from 9am to 6pm.

- From 5pm to 10pm during weekdays consultants or staff grade covered the emergency department and the adjacent paediatric assessment unit referrals with additional support from the on-call consultant if required. On Fridays the PAU consultant doubled up as on-call consultant.
- Staff grades worked on the paediatric assessment unit, normally providing one shift per week as the frontline decision making doctor. Seven to eight middle grade doctors worked on a full shift rota together with seven to eight specialist registrars. This was supplemented by academic foundation year trainees. Out of hours two SHOs worked on week days between 5pm and 10pm and at weekends between 9am and 1pm. For the remainder of the time a single SHO was on duty.
- Each consultant had a special interest and took the lead responsibility on one or more aspects of the service. For example neonatology, childhood disability, oncology, child abuse, endocrinology, respiratory disease, gastroenterology, cardiology, nephrology, cystic fibrosis, diabetes and juvenile arthritis.
- There were seven neonatal consultants providing 24 hour cover seven days a week. They were rostered from 9am to 6pm on week days and from 9am to 3pm at weekends, then on call at other times with two consultants covering the neonatal unit and Bramble ward. Weekend registrars also covered both units.
- Foundation year trainees were rostered to cover on a full shift pattern basis with dedicated cover for the neonatal unit from a registrar from 9am to 5pm on weekdays.
- An electronic method of requesting and co-ordinating out of hour's doctors' tasks was carried out using an electronic doctors' whiteboard. Bleeps were used only to notify doctors of urgent tasks. Each junior doctor carried a mobile tablet device which contained their patient lists and real time list of their tasks requested for completion. Tasks were requested by the ward nurses and were assigned to the relevant doctor or site practitioner. The site practitioners had visibility of the totality of the doctors' ward workload and were able to monitor and reallocate tasks to other doctors or to themselves to ensure timely patient care.
- We observed consultant led ward rounds. They were well attended, thorough and comprehensive and included social care aspects and acknowledged parent's wishes. Discharge plans and pain management were also identified and discussed. There were training opportunities for junior doctors.

Major incident awareness and training

- There was a trust Business Continuity Strategic Response and Recovery Plan which outlined the decisions and actions to be taken to respond to and recover from a range of consequences caused by a significant disruptive event. The staff we spoke to were aware of the trust major incident plan and how to access this. There was also guidance for severe weather, the management of seasonal influenza and an influenza pandemic contingency plan.
- Local escalation plans were also in place for Bramble ward and the neonatal unit to support the units with capacity and staffing issues, and limited equipment. Appropriate actions were outlined depending on the status of green, amber or red.
- The plan had recently been deployed on the neonatal unit following the smell of gas.

Are services for children and young people effective?

Good

Overall we judged the service as good. Treatment by all staff was delivered in accordance with best practice and recognised national guidelines. Children and young people were at the centre of the service and the priority for staff. High quality performance and care were encouraged and acknowledged and all staff were engaged in monitoring and improving outcomes for children and young people. There were robust governance arrangements in place.

Staff skills and competence were examined and staff were supported to obtain new skills and share best practice. All staff were treated with respect and their views and opinions heard and valued.

Children, young people and their parents understood what was happening to them and were involved in decisions about treatment and care.

Evidence-based care and treatment

- Policies and guidelines had been developed in line with national policy. These included the National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Paediatrics and Child Health. Policies were available to all staff via the trust intranet system

and staff demonstrated they knew how to access them. NICE quality standards and guidance were discussed at monthly business and governance meetings and we saw minutes of the meetings where guidelines and policies were presented for ratification. Examples included prescribing for acute pain in children, a paediatric scoliosis pathway and a psychological screening tool for diabetes.

- Clinical pathways were in place for the most common reasons where children presented to hospital including head injury, abdominal pain and fever. These gave clear and consistent guidance about how to treat these conditions.
- We saw a number of guidelines in operation. For example, guidelines for neonatal skin integrity were adopted on the neonatal unit. The principles were applied in order to maintain optimum skin integrity and prevent potential damage, minimise water and heat loss, protect against absorption of toxic materials and medicines, treat damaged skin and ensure optimum healing of wounds. Staff assessed and maintained optimum skin integrity and potential damage and involved and educated parents in managing the healthy skin of their baby.
- Another example was the risk assessment pathway followed in conjunction with the Child and Adolescent Mental Health Services (CAMHS) when a young person up to the age of 18 presented with self-harm. There was also a pathway to follow for a patient requiring one-to-one support while awaiting a risk assessment by CAMHS
- Staff told us about the community based eating disorder service that had been devised and established with CAMHS. The service provided consultation and physical and psychological treatment for children and young people who were experiencing a range of severe and complex emotional and mental health problems. The team consisted of psychiatry, psychology, family therapy, dietetics and nursing. If required there was a three week pathway for feeding admission where the first week involved bed rest and a feeding plan, a second week of consolidation and a final week where control was returned to the parents at home. There were two beds available on Bramble in the yellow team. There was a strict care plan where the child or young person was not allowed out of bed, they were taken to the bathroom in a wheelchair and meals were supervised. There had been around 30 admissions in the last year and data for Exeter and mid Devon showed a reduction in the need for inpatient admissions or transfers to the Tier 4 units in Plymouth, Taunton, Birmingham and London. These are highly specialised services with a primary purpose of assessing and treating severe and complex mental health disorders in children.

Pain relief

- There was guidance in care plans about pain management for children where it was appropriate for example after surgery and where necessary children's pain was assessed using a variety of methods suitable for children and young people.
- The Astrid Lindgren and Lund Children's Hospital Scale (ALPS-Neo) was used to assess pain in preterm and sick new-born infants. Pain and stress were monitored and registered simultaneously with other physiological parameters making it possible to continuously evaluate pain and the need for analgesics or comfort measures. ALPS-Neo consisted of five items scale and included scores for facial expression, breathing pattern, tone of extremities, hand / foot activity and level of activity. Every infant was assessed on admission to the neonatal unit and before and after potentially painful interventions, and at regular intervals depending on the dependency of the baby.
- We were informed that babies who were ventilated were given morphine and pain scores were documented on observation charts. A new pain assessment tool was being formulated for trust governance approval as staff felt this would be easier and more effective to use.

Nutrition and hydration

- Snacks, sandwiches and drinks were available for children in addition to the regular breakfast, lunch and tea. There were plans to provide a stand on Bramble ward where children, young people and their parents, and staff could buy food rather than going to the canteen. This would be trialled for a couple of months.
- The service had achieved stage 3 of the UNICEF Baby Friendly Awards which championed evidenced based practice to promote and support breastfeeding. This meant that staff were able to support mothers to recognise the importance of breastfeeding, make informed choices and to enable them to continue breastfeeding for as long as they wished.

- Breast feeding support was provided by the nutrition team and gave advice on milk supply, initiating lactation, pumping, transition to responsive feeding and any other feeding issues. A room for breast feeding was available on the neonatal unit. We saw care plans for feeding on the unit where parents would sign when consenting to formula or donor breast milk. Milk kitchens and milk refrigerators were available in all areas. Breast milk was stored for 24 hours in the refrigerators and for 3 months in the freezers and temperatures were checked daily and recorded. Breast milk was checked by two nurses and signed for. Special feeds were made up by nurses.
- Multidisciplinary team nutrition meetings were held weekly with input from speech and language therapists, infant feeding coordinators, consultants, the nurse in charge and a paediatric dietician. A speech and language therapy referral was made for any baby with a low birth weight or extreme prematurity.
- Paediatric dieticians provided nutritional support, advice and education to children and parents about diet and enteral feeding.

Patient outcomes

- A number of regular audits were carried out on the unit to monitor performance and maintain standards and were monitored by the monthly business and governance meetings.
- Examples of audits ranged from constipation in children and young people, the National Audit of Epilepsy 12 (Childhood Epilepsy), the National Neonatal Audit Programme, paediatric asthma and neonatal therapeutic hypothermia. We saw details of a National Diabetes Paediatric Audit 2013 - 2014 to look at patient characteristics, demographics, care processes and glycaemic outcomes. Data showed glycaemic outcome data had improved year on year and were near national average levels with data for 2014 – 2015 showing better than average UK outcomes. Data also showed low admission rates for diabetic patients, improvement in service delivery, education, transition and dietetic provision. The clinical audit and guidance group identified a clinical guidelines assurance report for the neonatal unit with details of the number of guidelines that existed, number in date and fit for purpose and those out of date and details of actions in place and time frames to ensure the service moved to a positive assurance statement. The action plan was regularly reviewed.
- The neonatal unit gained a silver score in an audit of documentation, observations, patient and staff. 11 questions were asked and included communication, elimination, food and nutrition, infection control, mental health, pain management, respect and dignity, self-care, safe environment record keeping and pressure ulcers.
- Indicator reports were submitted quarterly to commissioners demonstrating their progress against the measures of the quality schedule and the Commissioning for Quality and Innovation (CQUIN) for paediatric sepsis. To raise the profile of sepsis and to provide swift, appropriate treatment, this became a CQUIN for the Trust in 2014 - 2015. Throughout this process the profile of parent /carer education had also been raised regarding concerning signs to look out for and when to seek further advice.
- Readmission rates for asthma and epilepsy for ages 1 – 17 years was slightly higher than the England average. The multiple admission rate for epilepsy in 1 – 17 years was 36.4% compared to the England average of 27.9% (33 having at least one admission and 12 with two or more admissions). For children under the age of one, percentages were below the England average.
- Multiple admission rates for asthma were 20.2% compared to the England average of 17% with 124 having at least one admission and 25 having two or more admissions.
- For asthma there was less than 6% compared to the England average of 15.5%; for diabetes there were no admissions compared to the average of 34.8% and for epilepsy there was under 6% compared to the average of 33.4%.
- Outcome data and patient feedback had helped to guide treatment and develop their practice. The service had developed an online reporting system for outcome data. The team were trying to replicate the model of joint working with CAMHS in other areas of care with mental health difficulties such as self-harm.

Competent staff

- All staff had specialist knowledge and skills to treat children with their presenting conditions.

Services for children and young people

- All nursing staff within the unit had been trained in paediatric life support and consultants had also been trained in advanced paediatric life support.
- There was a commitment to training and education within the service. Staff told us they were encouraged and supported with training and that there was good teamwork. Staff were encouraged to keep up-to-date with their continuing professional development and there were opportunities to attend external training and development in paediatric specific areas.
- There was a trust wide electronic staff record where all training attended was documented. Managers were informed of training completed and alerted to those staff requiring updates.
- Most staff we spoke with were positive about the quality and the frequency of clinical supervision they received. Attendance was monitored by managers with follow up for non-attendance.
- All the staff we spoke with told us they had received an appraisal during the last year. The figures provided by the trust showed a compliance rate of 100% for the children and young people's services. Staff learning needs were identified through the appraisal process and through supervision meetings.
- There was a competency training framework for staff treating children with complex care and discharge needs. The framework was shared with community staff who alongside ward staff worked with a child with a long term condition. An honorary contract with the trust enabled them to come into the trust to work in partnership with ward staff. No one was working unsupervised unless they had enhanced checks under the Disclosure and Barring Service (DBC).
- Respiratory nurses who supported consultants with clinics for asthma and allergies supported mandatory training for registrars and SHOs on basic asthma education, self-management and inhaler techniques.
- Paediatric nurses on Bramble ward were complimented by health care assistants and play specialists. On the neonatal unit nurses were supported by health care assistants and nursery nurses who were specifically trained to care for this group of babies.
- Surgeons and anaesthetists had appropriate training and competence to handle emergency surgical care of children and nurses were required to maintain paediatric competency.

Multidisciplinary working

- We saw evidence that staff worked professionally and cooperatively across different disciplines and organisations to ensure care was co-ordinated to meet the needs of children and young people. Staff reported good multidisciplinary team working with meetings to discuss children and young people's care and treatment. Staff told us they were most proud of the integrated work across all disciplines.
- There was daily access to paediatric physiotherapy and speech and language therapy (SALT) on Bramble ward, with occupational therapy provided on request. Physiotherapy was provided weekly on the neonatal unit and SALT was available for any baby with a low birth weight or extreme prematurity.
- Paediatric dieticians provided nutritional support, advice and education to children and parents about diet and enteral feeding.
- Nursery nurses on the neonatal unit were supported by health care assistants who were all specifically trained to care for the group of babies. Assistants were responsible for cleaning equipment and documenting cleaning schedules and ensured the nurseries were well stocked for consultants and nurses.
- Babies who needed to be moved to or from another hospital for intensive care / emergency surgery were accompanied by a nurse from the peninsula transport team based in Derriford Hospital in Plymouth who were experienced in working the equipment needed to look after babies on the move. Babies were transferred in a transport incubator which was specifically designed to give the baby the care needed to ensure a safe and comfortable transfer
- Play specialists helped children to understand their condition and medical treatment. They provided preparation and support for potentially stressful experiences such as medical or surgical procedures. Play in hospital week included magic shows, pottery, painting and balloon modelling. The outside play area was closed during our inspection for refurbishment to improve facilities and safety. There was also a sensory room. The play team visited all ward areas to assess need and to set up play areas with toys and materials. They also provided support to siblings. The play team were responsible to the ward matron to whom they turned for advice and support. Funds were available through trust funds and voluntary supporters.
- The Devon Hospitals Short Stay School was an education provision for those children and young

people in hospital who might miss a significant period of schooling. Medical staff identified children and young people who might need education input. Each pupil was allocated a designated lead teacher, who coordinated schoolwork, liaised with school if appropriate and attended any specific meetings. Pupils were taught in the classroom, in their side room or on the ward. School operated in the morning and afternoon during term-time. Arrangements could be made for pupils to take exams in hospital if necessary.

- Other areas with play facilities included paediatric outpatients, the paediatric assessment unit, the neonatal unit for siblings, orthopaedic clinics and imaging where support was available during procedures such as an MRI scan. Play workers also provided support to children whose parents were patients on the intensive care unit.
- There was a "read alone" scheme where the library trolley was available to loan books. A story teller visited a couple of times a term, a drama student performed a couple of times, a volunteer supported play, a dog for patting visits and a reindeer and donkey visited in the outside space last Christmas.
- Other professionals were called upon to care for babies, children and young people including ophthalmologists and geneticists. Pharmacists attended some ward rounds and had regular input when required and the Women's Health counsellor provided support for parents on the neonatal unit.
- The clinical teams on Bramble ward and the neonatal unit were assisted by a dedicated team of administrators ranging from medical secretaries to ward clerks who provided comprehensive support to consultants, doctors and nurses with a host of administrative tasks from preparing and despatching letters, preparing discharge reports, answering telephone calls to arranging appointments.

Transition

- A transition of children to adult services policy had been ratified by the clinical effectiveness committee on 17 September 2015. The policy addressed the medical, psychological and educational or vocational needs of the young person and the needs of their parents or carers.
- Most young people transferring to adult services were following a 'Ready Steady Go' transition pathway where young people and their family were initially introduced to the concept of transition; moving to developing an understanding of their condition and finally feeling confident about leaving the paediatric system with the young person having a considerable degree of autonomy over their own care.
- Young people and their family were introduced to the pathway through a 'Transition moving into adult care' information leaflet followed by a series of questionnaires at each stage of the pathway and key documents in the form of a transition plan.
- The process commenced at approximately 13 years of age and a young person was introduced to the adult team at least a year prior to transfer. The timing of transfer was tailored to individual need depending on emotional maturity and cognitive and physical development. All young people with a learning disability were referred to the adult Learning Disability Team.
- Transition worked well for the sub-specialties such as diabetes, respiratory and oncology. However, the standard varied and for some young people with long-term conditions or complex needs the transition was less effective and confusing. The trust had been very involved in the formation of the NHS England Transition Network (South West) to improve young people's and their families' experiences when transferring to adult services. In addition, one of the trusts Commissioning for Quality and Innovation (CQUINS) for 2015/16 centred on transition.
- The trust had identified a training programme for staff leading on transition that was accessible via e-learning. A nurse had recently been appointed to lead on the transition work on a one year fixed term contract. The trust had developed a database to identify young people requiring transition, their progress and outcome. As a result of the age of the trust IT systems it had been difficult to identify the young people requiring transition and to track their progress and outcome. To achieve this a 'K' code had been developed to identify all young people who required transition and to enable an audit of those who had passed through transition to understand their experiences, and to learn from them to develop processes.

Seven-day services

- The trust had completed the NHS Improving Quality 7 Day Services Baseline Self-Assessment and each

division had undertaken a more detailed self-assessment against the relevant 7 Day Services Clinical Standards. The paediatric and neonatal services were compliant with the standards.
- There was 24 hour medical cover seven days a week on the units with access to radiology support at weekends and an on-call pharmacy outside of normal working hours

Access to information

- An audit of the number of notes prepped for clinics showed consistently above 99% notes available. Notes were placed at the reception desk prior to delivery to the nurses in clinics and there was a risk of exposure when the desk was left unattended when the receptionist delivered notes to the nurses.

Consent

- Staff told us they obtained consent from children, young people and their parents / carers prior to commencing care or treatment. Staff told us about how they dealt with consent issues for young people who did not want to tell their parents. They always tried to sensitively manage the situation while ensuring that the young person received the help they needed and always gave children and young people choices when they accessed their service.
- Throughout the inspection we saw staff explaining the assessment and consent process and the need to share information with other professionals such as GPs, nursery or school before obtaining written consent. We saw consent forms signed by parents.
- We observed staff discussing the treatment and care options available to children, young people and their parents.

Are services for children and young people caring?

Good

We have judged the care given to children, young people and their families as good. Parents, carers, children and young people were treated with compassion and respect. Feedback from children, young people and parents had been positive and they were happy with the care provided by the staff.

Staff were skilled to be able to communicate well with children and young people to reduce their anxieties and keep them informed of what was happening and involved in their care. Parents were encouraged to be involved in the care of their children as much as they wanted to be, whilst young people were encouraged to be as independent as possible.

All parents we spoke with felt they had enough information about their child's condition and treatment plan. They praised the way the staff really understood the needs of their children, and involved the whole family in their care.

Compassionate care

- During our inspection we observed children, young people and their parents being treated with dignity and respect at all times.
- We observed staff taking time to talk to children in an age appropriate manner and involved and encouraged both children and parents as partners in their own care. Parents were aware of the named nurse caring for their baby, child or young person.
- The trust used the NHS Friends and Family Test to find out if children, young people and their parents would recommend their services to friends and family if they needed similar treatment or care. Data from January to June 2015 showed that 94.5% said they would be either likely or extremely likely to recommend the service to them. Comment cards were also available for children and young people or their parents to complete. Feedback showed that parents found the staff to be efficient and friendly and would recommend the service.
- During our inspection we observed good interactions between staff, children, young people and their families. We saw that these interactions were very caring, respectful and compassionate. The staff were skilled in talking and caring for children and young people. Parents were encouraged to provide as much care for their children as they felt able to, whilst young people were encouraged to be as independent as possible.
- Children, young people and their parents we met spoke highly of the service they received. Feedback we received from the parents we spoke to was positive about the care their children received. The comments we received included "the staff have been fantastic",

"very happy with the care given to my child", "staff kept my child at the centre of everything", "staff are amazing, kind and lovely. I can't fault them. They are very knowledgeable."

- The children and young people we spoke to told us how good the staff had been in looking after them. Comments from children and young people included "the staff help me to feel better", "the staff are nice and explain things to me."
- Care from the nursing and medical staff was delivered with kindness and patience. The atmosphere was calm and professional without losing warmth and reassurance.

Understanding and involvement of patients and those close to them

- We observed staff explaining things to parents, children and young people in a way they could understand. For example, during a complex explanation time was allowed for either the child or their parents to ask whatever questions they wanted to. Another parent commented that they had been "updated on everything in a language I understand".
- Parents were encouraged to be involved in the care of their babies and children as much as they felt able to. We observed that children and young people were also involved in their own care. Children, young people and parents that we spoke to all confirmed this was the case. One parent on the neonatal unit told us how staff had taken time to advise her about developmental care, positioning and turning of her baby and had a good understanding of the reasons for the procedure.
- Parents, children and young people told us the nurse who was looking after them always introduced themselves. The trust launched the "~hellomynameis" campaign to remind staff to make a personal connection with children and young people when caring for them.

Emotional support

- We observed staff providing emotional support to children, young people and their parents during their visit to the unit. Children's individual concerns were promptly identified and responded to in a positive and reassuring way.
- Not all parents on the neonatal unit were aware of the support groups available and some did not feel involved in care planning. One mother had seen a counsellor around the unit but was not sure if she could access the service.

Are services for children and young people responsive?

Good

The service responded well to children, young people and their families.

Services were tailored to meet the needs of individual children and young people and were delivered in a flexible way.

There were good facilities for babies, children, young people and their families.

There were no barriers for those making a complaint. Staff actively invited feedback from children and their parents, and were very open to learning and improvement. There were, however, few complaints made to the unit. Those that had been made were fully investigated and responded to with compassion.

Service planning and delivery to meet the needs of local people

- The environment on Bramble unit and the neonatal unit were designed to meet the needs of babies, children and young people and their families and staff had been involved in the design phase of the neonatal unit prior to the move to the hospital. However, other areas used by children were not child friendly particularly in the outpatient departments and theatre recovery rooms.
- The paediatric assessment unit opened in January 2013 adjacent to the emergency department. The impact of the unit was measured and results showed improved patient flow and reduced admissions from 2012 to 2013. There had been a reduction in total time spent in the emergency department for all paediatric patients and a reduction in breaches of the four hour total time in emergency department. This meant time for all paediatric patients in the emergency department fell from 2 hours 12 minutes to 1 hour 32 minutes, and for paediatric expected patients from 3 hours 28 minutes to

2 hours 8 minutes. The admission rate fell from 54% to 39% and breaches fell from 63% to 36%. The largest reduction in admissions had been for children referred by GPs as a result of the support and advice available via the unit "hot phone". GPs were able to refer children and young people to the unit during week days from 10am to 10pm.

- Staff felt that having a facility whereby patients could be observed for longer than four hours allowed the paediatric team to reduce their admission rate to inpatient areas. The model had therefore improved the patient flow in the emergency department and also in ward areas.
- The intensive critical care unit provided short term care for children prior to transfer to a specialist unit such as Bristol Hospital for Sick Children. The side room was fully equipped and a reasonable size but not child sensitive or friendly in appearance. Liaison and support was available from the paediatric intensive care unit at the Bristol Children's Hospital where protocols were shared and telephone support was available, and regular audit meetings were attended.
- Transfers to other local paediatric intensive care units such as Plymouth or Bristol were arranged by consultants and managed by the Regional Retrieval Team who supplied the appropriate staff during the transfer. Critical care group meetings would regularly discuss these arrangements and pathways and case scenarios.
- Babies at less than 27 weeks gestation were transferred to Plymouth and those requiring surgery were transferred to Bristol. Network transport services were used for the transfers.
- Parents were encouraged to stay with their child on Bramble ward and there were no restrictions to visiting. One parent per child was welcome to stay overnight and beds or reclining chairs were provided next to their child. There were also two parent's rooms available for parents staying for a longer-term or for children in the high dependency unit. There was a parent's kitchen with tea and coffee making facilities, a microwave and refrigerator. Breakfast was provided for all resident parents. A shower room was also available.
- There were five family rooms for parents to stay overnight on the neonatal unit, with access to bathrooms and a number of reclining chairs and fold away beds. There was a lack of chairs at cot side for parents; however, staff were able to borrow chairs from other areas as required. There was a kitchen, lounge and siblings' play area. A water cooler was available for parents on the unit. Whilst on the unit parents were given a car parking pass which enabled them to park without paying. Linen and baby clothes knitted by the 'unit knitters' were available for parents to use for their babies.

Access and flow

- Data showed admissions on Bramble ward during April to July 2015 totalling 1,580 of which 270 were for the age band 0 – one years; and 1,310 for those over two years of age.
- The total number of spells for January to December 2014 was 5,486 of which 13% were day cases, 5% elective and 82% emergency. National levels showed a total number of spells for the same period with the corresponding percentage division of 23%, 9%, 68%. The number of emergency admissions to the trust were considerably higher than national figures.
- The median length of stay for all children and young people from 0 -17 years was similar compared to the England average.
- Access to Child and Adolescent Mental Health Services (CAMHS) services were not managed by the trust. However, 1.0 whole time equivalent CAMHS worker was based on Bramble ward. A scheduled email was forwarded to CAMHS each morning highlighting the children and young people currently on the unit who either had mental health and / or social care conditions or issues. CAMHS services would then normally come to the unit to assess young people admitted under their service. This was provided during office hours Monday to Friday but not out of hours or at weekends. There was a phone on-call service which provided support out of hours. Staff told us this could cause issues at weekends and particularly over Bank Holidays for complex CAMHS patients who were at risk and required urgent support or required one-to-one support. Contact was always made with the duty worker to obtain their advice and authorisation about one-to-one support for a young person.
- Outpatient clinics requiring a paediatrician included dental and dermatology, diabetes, ophthalmology, ENT and orthopaedic. The paediatric outpatient clinics were situated next to Bramble ward and were based within the adult outpatient area. There was one reception area which served both adult and children appointments. It

was very busy during the time of our visit with nine clinics running that afternoon. The receptionist checked children's details for accuracy and update and recorded children who did not attend.

- There was a designated area for some clinics with a waiting area for children with a television playing cartoons. However, children waiting for an ENT, orthodontics and maxilla facial appointments waited in the main adult waiting area which was not child friendly and parents felt it was confusing and could be frightening for some children. There was a play area which was situated between the main waiting area and the designated children's area. It was equipped with toys and books.
- A television screen displayed welcome messages, information and details about informing a nurse if there was a delay of more than 30 minutes. Parents told us they were satisfied with the speed of appointments and waiting times were kept to a minimum, and they were always informed if the clinics were running late. From data for the period July 2014 to July 2015 we saw only one patient had waited longer than 18 weeks from referral to commencement of treatment.
- Surgical services for children were provided in various theatres across the trust. Children and young people were admitted and discharged through Bramble ward in line with theatre schedules. In addition, there were theatre lists when required for scoliosis surgery and pectus carinatum procedures where a bed on the high dependency unit was required on return to the ward. Staff from Bramble ward delivered children and young people to the theatre and collected them from the recovery area and returned to the ward.
- The paediatric assessment unit (PAU) is situated adjacent to the emergency department. There are six paediatric trolleys situated within the unit. Children and young people are triaged in the emergency department and are assessed in paediatric assessment unit between the hours of 10am and 10pm unless otherwise directed by infection control or the need for resuscitation in the emergency department. The emergency clinician will refer to either the paediatric team or a specialist team, for example orthopaedics, plastics and the Child and Adolescent Mental Health Services (CAMHS)
- Staff in the main theatres told us they asked parents for a mobile telephone number and they called them directly as soon as their child was in the recovery area. Staff in the main recovery areas were required to achieve and maintain a set of paediatric competencies.
- Intrathecal treatment for children was carried out in the ophthalmology theatre with one oncology nurse present on each shift. Patients were recovered by theatre staff.

Meeting people's individual needs

- Children and young people were treated as individuals with treatment and care being offered in a flexible way and tailored to meet their individual needs.
- There was a newly expanded Learning Disability (LD) Liaison Team were notified of admissions by phone, email or letter. They were also able to print off daily reports from the trust electronic whiteboard of admissions of children or young people with a learning disability. Children and young people with a learning disability and their parents or carers were encouraged to use the Hospital Passport when they came into hospital. This also alerted the staff to contact the learning disability liaison team who could then provide appropriate support. The passport gave hospital staff important information about children and young people and reasonable adjustments that might be required outlining the "Things you must know about me; Things that are important to me; my likes and dislikes".
- We visited the orthopaedic theatre and recovery area. In the recovery area there was one bay dedicated for children. The bay was positioned by a door at the opposite end to the door where patients were brought in from theatre. Staff told us this prevented parents or carers having to walk past other patients being recovered. However, in order to leave the recovery area children and their parents had to pass all other patients in recovery. Parents were concerned about the impact for their child. Although there were child appropriate stickers on the wall the area was not child friendly.
- We also followed a child through surgery from the anaesthetic room, to the ophthalmic theatre to recovery. In the anaesthetic room there were two stickers of rabbits on the wall with no other child friendly pictures on the ceiling. There were robust end of life services for children and young people in the acute hospital setting with good interaction with adult end of

life services, pain management and symptom control and the local hospice. Palliative care in the community was provided by an external provider. However, we were told that provision was variable particularly in the Torbay area. The team provided an outreach service in the community often travelling for up to an hour to some parts of the county to visit children and young people. This impacted on resources by taking staff away from the day-to-day service. Management plans involving all services from clinical, dietician, psychology, and physiotherapy were devised in partnership with parents.

- A county wide child and young people's treatment escalation plan was to be introduced to ensure consistency of care for all children and young people requiring palliative care.
- Bereavement services were available through the trust chaplaincy and the Women's Health counsellors. Consultants would always write to parents following the death of their child and arrange to meet with them. Access to bereavement services for families and siblings were limited in the community.
- Palliative care on the neonatal unit was rare as most babies requiring palliation would be cared for at a level 3 centre. Although the unit did not have an outreach team they would consider providing this service if required depending on a case by case decision.
- The areas we visited were accessible to disabled people and there were appropriate toilet facilities. In line with the trust interpretation and translation policy services were available for face to face interpretation and translation services, and a language line for phone interpretation. BSL interpreters were also available and the RNIB provided translation into braille. Language identification cards, a multilingual phrasebook and communication books were available on the units.
- The trust had formed a partnership agreement with Supporting Neonatal Users and Graduates (SNUG) to work collaboratively to enhance the development of peer support volunteering in the neonatal unit and community. The aim was to reduce social isolation and promote community inclusion and to provide a continuum of support between neonatal units and, on discharge from the neonatal unit into the community, to signpost parents to the most appropriate support service.
- A number of advice leaflets for parents were seen during our visit, for example nutrition screening, croup, safeguarding, spiritual, febrile convulsion and discharge advice. One parent told us that this information was "very reassuring" and helped them "to know what to look out for and what to do."
- Parent information boards were positioned on Bramble ward giving details of meal times, infection control, parking, shops, a map of the ward, activities, chaplaincy services, activities and education, pictorial images for those who signed, internet access and the use of mobile phones. Notice boards displaying comments from parents were also available.
- Developmental care booklets were available on the neonatal unit and posters about topics such as skin to skin care, breast feeding, positive touch, feeding resources, hand hygiene, need to rest, making a nest and low noise environment were displayed around the unit.
- Information was also available about website links to the Exeter SNUG Group (supporting neonatal users and graduates), the national childbirth trust, breast feeding support, BLISS, Multiple Births Society and the Child Bereavement Charity.
- "Handi App", a mobile phone application, was being introduced to provide advice and information for parents about the need for a referral.

Learning from complaints and concerns

- Parents knew how to make a complaint if they needed to and also felt they could raise concerns with the clinical staff they met. Most parents told us if any issues arose they would talk to the senior nurse available. Information about making complaints was available in all the areas we visited.
- Prior to the inspection the trust provided details of the complaints in the preceding 12 months. We saw details of the outcomes, actions taken and lessons learned. Complaint subjects ranged from communication, clinical treatment, appointments and integration of care.
- Staff encouraged children, young people and their parents or carers to provide feedback about their care and comment cards were available and asked parents to indicate how likely they were to recommend services to friends and family.
- Staff were aware of complaints that had been made and any learning that had resulted. The staff we spoke to were all aware of the complaints system within the trust and the service provided by the Patient Advice and

Liaison Service (PALS). They were able to explain what they would do when concerns were raised by parents. Staff told us that they would always try to resolve any concerns as soon as they were raised, but should the family remain unhappy, they would be directed to the clinical manager or the trust complaints process.

- Complaints and any themes arising from them were reviewed at the divisional governance group. Learning from complaints was discussed in communication cells and learning from patient feedback, of which complaints formed part, was seen in the minutes of the divisional performance assurance framework meetings.

Are services for children and young people well-led?

Good

We have judged the leadership of the children and young people's service as good. The leadership, governance and culture were used to drive and improve the delivery of high-quality care. The clinical managers were committed to the children and young people in their care, their staff and the unit.

Frontline staff and managers were passionate about providing a high quality service for children and young people with a continual drive to improve the delivery of care.

There was a high level of staff satisfaction with staff saying they were proud of the unit as a place to work. All the staff were complimentary about the senior nursing and medical leadership. Staff also told us they received support from the assistant director of nursing.

Most staff were positive about working for the trust. Staff took pride in their work and wanted to come to work.

Children and young people were able to give their feedback on the services they received; this was recorded and acted upon where necessary.

Vision and strategy for this service

- Staff had a good understanding of the core values of the service and were committed to providing family centred care. The teams were very proud of the unit philosophy where "a child treated was an individual; care centred around their needs and the needs of the family; appropriately trained and experienced nurses, medical and ancillary staff were available to meet those needs in a safe, child orientated environment; the importance of each child's family in the care process would be recognised and parents assisted to become confident and competent partners in participating in nursing care."
- Through the content of governance papers and talking with staff, we saw the leadership of the unit reflected the requirement to deliver safe, effective, caring and responsive and well-led services.

Governance, risk management and quality measurement

- There was a clear structure for clinical governance with regular meetings attended. We saw minutes from the monthly business and governance meetings from April to October 2015 which showed that issues affecting the service were discussed and actions taken. These included a review of incidents reported, risks identified on the risk register, an update of the specialty audit programme, NICE quality standards, clinical guidelines presented for ratification, clinical documents, new clinical techniques, new business items, Commissioning for Quality and Innovation (CQUINS) and staffing issues. The meetings fed into the monthly paediatric cluster meetings, the specialist services divisional governance meeting and ultimately the trust governance meeting. Action trackers ensured actions were reviewed and updated.
- We saw that regular auditing took place with evidence of improvement or trends. Performance data and quality management information was collated and examined to look for trends, identify areas of good practice, or question any poor results.
- There was a clear performance management reporting structure with regular meetings looking at operational performance and team analysis which fed into the executive performance reviews and a mid-year review.
- The units understood, recognised and reported their risks. A risk register was in place and we noted that this had been kept up to date. Risks were identified on the risk register with actions required and taken and a review date. Reference was made to known risks, for example, the risks posed by increasing referrals of more complex CAMHS patients to Bramble ward as a result of pressures and challenges for Tier 4 beds, where unsocial behaviour presented a risk to other children and

families on the ward. There was continual escalation to ensure relevant external organisations were aware of the risks and the trust continued to work with partner agencies to reduce the risk. The risk had been escalated to the Clinical Commissioning Group (CCG) and had also been raised with the chief nurse at the CCG and the independent chair of the Devon Safeguarding Children's Board. Risks on the register were reviewed at management and governance meetings.
- Clinical policies and guidelines were available for all staff via the trust intranet system.

Leadership of service

- The local leadership of the services had the skills, knowledge and integrity to lead the teams. The clinical managers were an experienced and strong team with a commitment to the children, young people and families who used the service, and also to their staff and each other. They were visible and available to staff and we saw and heard about good support for all members of the team.
- The senior management team communicated with staff by email and face-to-face. We received positive feedback from staff who had a high regard and respect for their managers.

Culture within the service

- The staff we spoke to during the inspection told us they were proud to work on the units and were passionate about the care they provided. Managers we spoke with told us they were proud of the staff they supervised and that there was a high level of commitment to providing quality services to the children and young people. One member of staff told us "I feel supported by my colleagues and a valued member of the team … we are like a family and do the best we can."
- Staff were positive about working for the trust, although at times they told us they felt stretched and under pressure because of the volume of their work.
- The culture encouraged candour, openness and honesty. Staff said they were encouraged to raise concerns. All staff felt comfortable about raising any concerns with their line manager.
- The teams told us that they were always keen to learn and develop the service. Innovation and improvement was encouraged with a positive approach to achieving best practice.
- It was apparent during our inspection that all the staff had the child, young person and their families at the centre of everything they did.

Public engagement

- We saw there were systems in place to engage with the public to ensure regular feedback on service provision for analysis, action and learning. In addition to the Friends and Family Test and comment cards, parents and young people were encouraged to make comments via comment boxes and notice boards. Details of comments, including the date they were raised, were displayed together with the response and the date. Most comments were positive. One parent commented that "Everything's been brilliant, all staff very friendly". However, there was one comment where a parent said they were "nervous about leaving my child when I use the bathroom and would have been reassured if security tags were in use."
- Children, young people and their parents and carers were encouraged to contribute to service development. Various specialist services within paediatrics had support groups where children and young people were involved in contributing to service delivery. Examples included the teenage and young adults' cancer work plan and cystic fibrosis and paediatric diabetes.
- The trust participated in the Care Quality Commission's National children's inpatient and day case survey 2014. The survey focussed on young patients who were admitted to hospital as inpatients or for treatment as day case patients and covered every aspect of a child's stay in hospital from interactions with staff, pain management and facilities for parents and carers. 137 acute and specialist NHS trusts across England participated and feedback was received from nearly 19,000 young patients. The report showed how a trust scored for each evaluative question in the survey, compared with other trusts. Statistical analysis was used to determine if the trust performed about the same, better, or worse compared to other trusts. Results were presented for two main groups: children and young people, and their parents or carers.
- Children and young people were asked to answer questions about different aspects of their care and treatment. Based on their responses a score out of ten

for each question was allocated and showed most results about the same as other trusts. Questions were divided into issues relating to safety, effectiveness, caring, responsiveness and well led.

- The trust performed better than most other trusts in staff communication with children, young people and their families. Information about treatment and procedures was given in a way they could understand and they were encouraged to be involved in decisions about their child's care and treatment. They also felt listened to and staff told them what to do or who to talk to if they were worried about anything.
- Other areas where the trust performed better than most other trusts included confidence and trust in the staff treating their child particularly in doing everything they could to ease the child's pain; and access to hot drinks on the units.
- In 2014 a survey was carried out of parents' experiences of neonatal care involved in 72 NHS trusts and 88 neonatal units in England. The survey was carried out by 13 neonatal networks in England and was supported by Bliss, the special care baby charity and NHS England. A sample of 100 parents whose babies were consecutively discharged alive were sent a questionnaire to complete at home. Parents were asked a range of questions ranging from the admission process, interactions with staff, the environment and facilities, the information and support available, their involvement in their baby's care and the process for leaving the unit. Compared with average results the trust consistently fell within the intermediate 60% of trusts nationally and in some areas fell within the best performing 20% of units with the highest scores.

Staff engagement

- Systems were also in place to engage with staff. All staff said they felt valued and part of the team and were able to express their opinions and raise concerns through unit and trust-wide forums. Staff reported the trust intranet was a good forum for communication and links between groups. Good intranet-based guidance information was distributed to staff by global email
- Teams were encouraged to use communication cells as part of a new way of working called "Connecting Care". This focussed on continuous improvement through connecting individuals and engaging in creative problem solving techniques. "Connecting Care" had also delivered improved team communication, more robust monitoring of performance and increased staff engagement. Regular meetings and emails provided opportunities to have feedback about governance issues such as incidents, complaints and risk assessments. Performance and continuous improvement was also assessed through discussions about essential training, clinical skills and competencies.
- Managers worked clinically and were available to engage with staff at ward and unit level and to address issues. Staff confirmed they were visible and approachable. An award system was in place where staff were nominated for particular projects and selected by managers to receive recognition for their achievements.
- Staff were aware of the trust whistleblowing policy and the arrangements for reporting poor practice without fear of reprisal and felt confident about using this process if required.

Innovation, improvement and sustainability

- Staff were clear that their focus was on improving the quality of care for children, young people and their families. They felt there was scope and a willingness amongst the team to develop services.

End of life care

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

Information about the service

Staff of Wonford Hospital at Royal Devon and Exeter NHS Foundation Trust provide end of life care as part of their day-to-day work. Those providing end of life care include nurses and doctors, staff from the chaplaincy department, mortuary staff, ward housekeepers, porters, administrative staff and others.

End of life care is also provided by a specialist palliative care team for patients needing complex symptom management. This team also provide support when there is need of a complex hospital discharge or to provide specialist advice and education to the trust. The end of life specialist palliative care team works with the specialist services division of cancer services and is based at the hospital. There is a service level agreement that uses honorary contracts for hospice employees who are part of the hospital specialist palliative care team to provide end of life care, education and training to the hospital staff.

The hospital (including chaplaincy and spiritual support and mortuary services) and hospice teams work together according to trust policies and practices to provide specialist end of life care and advice and education to patients, relatives and staff involved in end of life care.

End of Life care is clinically lead by a Consultant Clinical Oncologist and a lead Nurse in close collaboration with members of the Specialist palliative care team and other members of the end of life steering group. There are also two lead nurses. One nurse leads in oncology services and is the trust's end of life lead nurse. The other is the specialist palliative care team lead nurse who leads the palliative discharge team and works closely with community services. The consultant oncologist and trust end of life lead nurse work mainly on the trust hospital site. The consultant in palliative care and the palliative care nurse lead work mainly in the hospice.

From April 2012 - October 2015 the specialist palliative care discharge team saw 1095 patients. From 1 May to 31 July 2015 the specialist palliative care team saw 75% of referrals on the same day and 96% of referrals within 24 hours. The specialist palliative care team visit patients or carers in the hospital following a request from ward staff and is provided Monday to Friday 8.30am to 4.30pm. Outside those times, there is a 24-hour on-call telephone advice service from the hospice. There is consultant medical cover 24 hours, seven days a week.

During the inspection we visited the following wards and departments: Clyst, Creedy, Kenn, Torridge, Yeo, Ashburn, Yealm and Bolham wards, the acute medical unit and the emergency department. We also visited the chaplaincy, the mortuary, and Patient Advice and Liaison (PALS). We spoke with 50 staff, including ward clerks, housekeeping staff, nurses, and the medical director. We spoke with five patients who were receiving end of life care and two relatives. We also reviewed 29 sets of patient records, which included five advance care plans and 24 treatment escalation plans (TEPs) which described what should be done when health worsens or what a patient would like to happen if they needed resuscitation.

Before and during the inspection, we also reviewed data relating to end of life care at the hospital from the trust and from other sources such as Healthwatch, some of which is included in this report.

End of life care

Summary of findings

We rated end of life care as good overall. The service had enough staff with the appropriate skills to provide care. Although the trust had identified vacancies across nursing and medical staff posts this had not affected end of life care. Trust staff and the end of life team staff followed systems, processes and practices to keep patients safe. Staff kept adequate patient records, which were audited, and we found evidence of continuous improvement in record-keeping.

The service learned lessons from incidents and complaints, and made improvements when things went wrong and had followed duty of candour process.

We rated effectiveness to be good. Patients' care, treatment and support achieved good outcomes, promoted a good quality of end of life and was based on the best available evidence. Staff assessed patients' needs and provided care and treatment in line with legislation, standards and evidence-based guidance including well managed pain and nutrition and hydration. The service monitored patients' care and treatment outcomes through audit, which compared well with other similar services. Specialist staff had the skills, knowledge and experience to provide effective end of life care. Training rates in relation to end of life could be improved across the trust. End of life care documentation (for instance, treatment escalation plans) and recording in patients' notes had improved but use of some forms and sharing of information needed improvement which had been noted in audit outcomes.

We rated caring to be good. Staff treated patients and those close to them with kindness, dignity, respect and compassion. Hospital staff demonstrated an understanding of patients personal, cultural, social and religious and spiritual needs. Patients and bereaved relatives were involved as partners in their care contributing to patient records and engaging in bereavement groups set up by the trust. Support was available to enable patients and those close to them to have the support they needed to cope emotionally with their care, treatment or condition with the provision of support from volunteers and chaplaincy services.

We rated responsive to be good. Services were planned and provided to meet the needs of patients and those close to them, taking account of the needs of patients including those with learning disabilities and those with dementia,. Patients could access care and treatment in a timely way with a few exceptions such as occasional delays in discharge.

There were excellent links between specialist palliative care team and the palliative discharge team and community nursing staff and others. Patients and those close to them who raised concerns and complaints were listened and responded to, and staff used the experience and information shared to improve the quality of care.

We rated well-led to be good. The leadership of end of life care was evident from all staff. The service had a clear vision and strategy to provide good quality end of life care, and leaders recognised that progress was still needed. The governance framework ensured that responsibilities were clear and lead roles within the trust and specialist palliative care team had a detailed service level agreement.

The trust encouraged openness and transparency and promoted good quality care. Patients and others who used the service, the public and staff were engaged and involved in the delivery and development of it.

End of life care

Are end of life care services safe?

Good

We judged safety to be good for end of life care.

The service learned lessons from incidents and complaints, and made improvements when things went wrong and had followed duty of candour process.

When an incident that related to end of life care was raised though the electronic system the the clinical leads (Oncologist and lead nurse) reviewed them. This enabled them to investigate and to monitor trends. Equipment was properly maintained.

The specialist palliative care team (SPCT) was able to provide enough staff with the appropriate skills to provide safe care. Patients were protected from abuse and avoidable harm through staff knowledge of safeguarding. Trust and SPCT staff followed systems, processes and practices to keep patients safe. This included assessing risks to patients and taking appropriate action to monitor and maintain their safety for example with medicines. We saw patients who were prescribed just in case medicines for when symptoms such as breathlessness needed easing. Staff kept adequate patient records, which were audited, and we found evidence of continuous improvement in record-keeping.

Incidents

- Staff understood their responsibility to raise concerns, to record safety incidents and near misses, and to report them. We looked at 27 incidents reported from September 2014 to July 2015 relating to end of life care. These were reported through the electronic system. There had been six incidents where the lead nurse for end of life care had investigated issues raised by ward staff regarding pain relief. One where a patient had had a syringe driver set up and pain was not being relieved. This was remedied quickly by the ward doctor who adjusted the dose and pain relief was achieved with the patient dying pain free. Another incident where no harm had occurred had led to a change in syringe driver training. Other incidents had led to the end of life education facilitator working with ward end of life care link nurses to improve the timing and type of pain relief being prescribed to enable a more comfortable death for patients. Incidents not related to clinical practice were about, lack of availability of care at home and funding delays.
- An incident had been reported where a patient was moved to another ward before a relative was told. We saw evidence the ward and specialist palliative care team acted on relative's feedback. The information was shared in matrons meetings to change practice. There was evidence of flexible accountable decision making outside of policy guidelines to meet a patient's needs. An incident report described a patient admitted to a side room which wouldn't generally be used for inpatients as there was a lack of toilet facilities. This was deemed suitable for use at the time as the patient was unable to transfer from a bed and ensured the patient at end of life had a room to themselves. Investigation of the incident reinforced this practice. Another example was reissuing guidance to medical staff to update treatment escalation plans before transfer from the acute medical unit this ensured medical staff and patients were supported. Other examples included what staff should do when a patient receiving end of life care refused treatment.
- When an incident that related to end of life care was raised through the electronic system the ward lead nurse and lead end of life nurse based in the hospital received a notification. This enabled them to investigate and to monitor trends. One trend identified was delays in discharge due to a range of issues outside of the teams or trust control.
- Most incidents that had occurred on a ward had led to improvements across all wards. The wards and other members of the end of life team had responded to patient and staff feedback and contributed to education sessions for specific wards. Learning included contributions from chaplaincy and mortuary services. Sessions included contributions from the tissue donation officer. One particular incident led to improved contact details being available for the specialist palliative care team for all wards.
- Mortuary staff reported incidents appropriately. There were nine incidents reported relating to mortuary services which included, a false fire alarm triggered by refrigerator alarm maintenance engineers and one forensic refrigerator breakdown.

Duty of Candour

End of life care

- Staff we spoke with had a good understanding of duty of candour and that it was a legal duty to be open and honest with patients when things went wrong. For example when patients receive overdoses of medicines or treatment. They were aware of how to find the policy.
- The trust followed 'duty of candour' processes. We saw evidence that patients and relatives who used the end of life service were told when they were affected by something that had gone wrong, were given an apology and informed of any actions taken by the trust.

Cleanliness, infection control and hygiene

- All mortuary staff including the bereavement officers followed trust infection control policy and were bare below the elbow, had access to personal protective equipment and sinks were situated appropriately.
- We saw staff washing hands appropriately and wearing personal protective equipment for instance gloves and aprons in all wards we visited.

Environment and equipment

- We visited the mortuary and saw it was clean and tidy. We also spoke with mortuary cleaning staff and saw evidence that monthly cleaning took place which included equipment, bins and surfaces. This was in addition to routine cleaning of equipment after each procedure. If refrigerator temperatures were out of range they signalled an alarm to the on call mortuary officer, this had occurred once in the last year for an empty refrigerator.
- During an unannounced health and safety audit undertaken on the 26 February 2015 by the trust the mortuary achieved 97.6%, the same as 2014. There were five risks and associated action plans to be completed. For example the risk assessment for personal protective equipment was incomplete which was updated and completed by the mortuary manager 18 March 2015 as were three other risks. The final risk and action was completed 21 April 2015 this was to ensure that refrigerator racking be added to the monthly cleaning rota. Risks and actions identified had all been completed at the time of our inspection.
- Syringe drivers used to deliver pain relief were available and maintained for safe use.

Medicines

- We saw evidence that arrangements for managing medicines in end of life care kept patients safe. Information about prescribing at end of life produced by the end of life steering group was available on all wards. Guidance and advice from the consultant lead for end of life care and the palliative care consultant was available for complex situations. The specialist palliative care discharge team and other members of the end of life team also supported wards with managing and reviewing medicines prescribed on the ward and for home use.
- Anticipatory medicines were in place when needed. We observed one patient being advised about 'just in case' medicines to help manage symptoms such as distress or anxiety when at home. We saw other patients being involved in discussion about 'just in case' medicines that helped manage feelings of sickness, anxiety and secretions that made breathing difficult.
- One member of the specialist palliative care team was undergoing a nurse prescribing course and there were plans for other nurses in the team to do so to support prescribing at end of life on wards. This would improve response times for prescribing of end of life medicines and to support their role in reviewing end of life medicines.

Records

- People's individual care records were written in a way that kept people safe. Patient's records were accurate, complete with few exceptions, legible, up to date and stored securely. We reviewed 29 individual care records including advance care plans and treatment escalation care plans which included the resuscitation decision record. The records that included the form for decisions about resuscitation sometimes referred to as do not attempt cardio pulmonary resuscitation or DNACPR. This form was included in the treatment escalation plan or TEP. We saw records that included medical care plans for doctors when the patient was at end of life. It was clear that a senior clinician was leading the care.
- Following the outcome of a CQC inspection in 2012 where documentation was found not to follow resuscitation guidelines, bi-monthly audits of treatment escalation plans (TEPs) were started by the resuscitation officers. In October 2015 the bi-monthly TEP audit was carried out. The audit reviewed completion of the forms and whether it was appropriate for a patient to have one in place. Not all records should have one and it depended on patients condition. The audit showed TEPs had been signed by an appropriate clinician in

100% of cases. Do not attempt cardio pulmonary resuscitation decisions or DNACPR decisions included in the treatment escalation plan record were made and recorded appropriately in line with national guidance in almost all cases. In addition matrons on wards carried out TEP audits monthly to support improvement and maintain standards. We looked at 29 care records. Of the 15 records that should have TEPs or DNACPR information, 11 of the records had do not attempt resuscitation decisions completed within the treatment escalation plan. This was similar to audit outcomes carried out by the trust. We saw action plans to address improvement. One action was that the specialist palliative care team supported the audit and fed back to wards via the comm cell board communication system. The end of life steering group, the practice facilitators and link nurses and specialist palliative care team were also ensuring the planning ahead leaflet was used across the trust so that more conversations were started about this subject..

- The audits noted improvement in record keeping and that recognition of dying was identified and recorded. It also recorded that improvement and education needed to continue.
- Sometimes information in records was not known by the team caring for patients. We saw one example when a patient in the acute medical unit had made clear instructions not to receive resuscitation and this was recorded on their treatment escalation plan (TEP). We observed that this information was not discussed at the morning ward handover despite the instructions being recorded on the TEP and in the patient record. We spoke with the nurses caring for the patient, the resuscitation status was not known by them. When we alerted the senior nurse on duty they immediately spoke with the senior doctor on the ward and the nurses caring for the patient so that the patient's resuscitation wishes were known. We also discussed the incident with a senior medical nurse who explained that this level of detail may not always be discussed at the main handover in the morning. This risk of this information not being consistently passed from staff to staff would be that the patients choices and preferences for treatment may not be observed.
- We saw records of when difficult discussions had taken place. There was discussion recorded where a patient had wanted a relatively high level of intervention at end of life, given their physical condition. The medical staff felt that the level was inappropriate and would not have enabled a dignified death or changed the outcome for the patient. The medical team and patient had agreed to a plan of care which supported the patient's choice and medical best interest.
- An individualised planning of care audit took place in November 2014. The end of Life steering group introduced guidance and paperwork for individualised planning of care in the last few days of life. Following the introduction of the personalised care planning guidance the clinical lead oncologist and lead nurse had hoped to audit against the 13 standards of care of a dying patient but this could not take place. In the interim period an audit of "five sets of case notes" had been implemented. The outcome informed ongoing education of ward staff and included clearer explanations to relatives. The results demonstrated that practice varied from ward to ward and we saw this to be the case. Clear improvements had been seen in the audit since November 2014.
- We noted that there were still some shortfalls in record keeping which suggested that more and regular training was needed for all ward staff providing care. We reviewed notes on wards that included Kenn, Culm, Torridge, Bolham and Yealm we observed a similar trend. For example on Bolham and on Yealm ward we reviewed a total of eight treatment escalation plans. Six out of the eight had capacity assessed, seven of eight had a summary of resuscitation not in best interests, six of eight had recorded communication with patients, and four of eight had conversations with relatives recorded. However, on Torridge ward we reviewed five sets of records and they were 100% completed

Safeguarding

- Staff were aware of the safeguarding policy for the trust. Staff we spoke with shared examples of practice and what they would do if they suspected abuse. Staff we spoke with understood their responsibilities and adhered to safeguarding policies and procedures and were aware of how to raise safeguarding alerts. The specialist palliative care team were aware of what constituted abuse and told us they would use the trust policy and procedures if they had concerns.
- All staff including volunteers had the required safety checks completed when undertaking work at the trust. This was done to ensure safety of all patients.

- We saw training records of medical and nurse staff relevant to safeguarding. Safeguarding training for trust overall in October 2015 was 75.4%. The trust compliance threshold was 75%

Mandatory training

- Staff who supported end of life care on the wards and elsewhere at the hospital received mandatory training. The trust target for mandatory training was 75% and overall staff had achieved 86%. Records showed 97% had achieved equality and diversity training, 83% were compliant with fire safety training and 83% had achieved moving and handling training.
- End of life training was planned to be implemented in mandatory training.
- We saw evidence that the specialist palliative care team staff were compliant with trust mandatory training requirements.

Assessing and responding to patient risk

- Risks to patients who used the end of life care services were assessed, and their safety was monitored and maintained by staff providing care. Advice and support was available from all members of the end of life team for staff caring for patients whose condition was deteriorating. The advice was available by telephone and pager. Hospital staff were complimentary about the speed of response of the specialist palliative care team when requesting advice.
- We saw evidence of risk being assessed and comprehensive risk assessments carried out for patients. Hospital staff worked to identify those needing palliative or end of life care, whether that was through the resuscitation team, auditing use of TEPs, the use of flags on the handover boards, and work of link nurses.
- Staff identified and responded appropriately to changing risks to patients who were at end of life. We saw one example of a patient admitted to the emergency department who was assessed, diagnosed and treated appropriately with consultant input and transferred to a ward setting within a few hours. Decisions had to be made whether to support the patient's wishes of preferred place of care which involved patient being exposed to elements of risk. Treatment plans and options were risk assessed and planned with the patient. Risks assessment by staff also enabled some patients to achieve their preferred place of care with carers who were cognitively impaired themselves. This supported patients and carers to be clear about the risks they were exposed to when decision making.
- The trust also monitored acutely ill patients through an early warning scoring system to establish if a condition was deteriorating. The system scored observations of patients breathing and other signs. The trust had audited the use of the early warning system and found that 136 out of 150 were correct. When the score was raised the staff recorded it in the patient's records and on the electronic white board system to monitor any change in condition. We reviewed patients records and saw the early warning score was completed and actions recorded when scores identified increased risk.

Nursing staffing

- Staffing levels and skill mix in the specialist palliative care team were planned and reviewed so that patients received safe care and treatment. The Palliative discharge team had recently received funding to support recruitment and several staff were in the process of employment checks. Response time to referrals was good.
- In the end of life team there were 8 nurses. These included a Band 8 end of life lead nurse who held a trust wide role who also managed the team of cancer nurse specialists in the trust. There was a band 8 palliative discharge team lead nurse. The palliative discharge team provided end of life care in the trust through a service level agreement. The lead nurse managed the palliative discharge team (4 nurses and 1 administrator) and the end of life education facilitator.The Band 8 specialist palliative care nurse managed the two band 7 specialist palliative care nurses and the cover from the bank for absence.
- Arrangements for using bank staff for occasional cover in the specialist palliative care team kept patients safe at all times. Bank staff were trained and familiar with end of life care. There were two bank nurses for end of life care.
- The specialist palliative care team met at the hospice each Thursday to discuss the support needed for patients and staff, discharge planning needs and ensured that links with the community teams were in place. They then moved to the hospital based 'comms cell' board to complete the in hospital information

sharing for patients there. Comms cell was a system used through the hospital to focus discussion on people (staff), performance (quality, cost) and continuing improvement (risk and ideas, what went well, what if…).
- There were also link nurses on each ward who supported end of life care strategy and information for ward staff. They did this by ensuring information was shared at team meetings and were considered information resources for end of life care. Some wards had recruited end of life link nurses from the night shift cover for example the acute medical unit had two link nurse in the day and one for nights.

Medical staffing

- Medical consultant cover was provided seven days a week, 52 weeks a year for the hospital. End of life care was provided by a mix of trust employees and hospice staff with honorary trust contracts. The Trust contributes 6.5 planned activity sessions to the 8 planned activity job plan of the lead specialist palliative care physician. A second consultant Palliative care physician holds a Trust contract which is funded by the Hospice. All doctors in Specialist palliative care hold honorary contracts with the Trust and contribute to the out of hours cover
- All wards had information on how and why to contact the hospice doctor including telephone and pager numbers. All staff we spoke with described the system as working and were very positive about the support available from the on call medical cover.
- Part of the medical specialist palliative care team was based at the hospice. The specialist palliative care team met with the Trust palliative Discharge team at the hospice each Thursday. Handover of information between medical staff occurred information was then shared within the hospital

Major incident awareness and training

- Arrangements were in place to respond to emergencies and major incidents. Winter planning arrangements were in place for winter 2015 and staff could refer to the emergency preparedness, resilience and response policy if experiencing unexpected pressures.
- Potential risks to the mortuary service had been anticipated and planned for. Temporary mortuary facilities that would be used in a major incident had been used recently. The mortuary manager described that equipment had been supplied to them through the emergency planning officer at the local authority.

Are end of life care services effective?

Good

We judged Effective as Good.

Care, treatment and support achieved good outcomes for patients. The Gold Standards Framework (GSF) was used on three wards to co-ordinate and communicate care needs of patients who are within their last year of life.

Staff provided care and treatment in line with legislation, standards and evidence-based guidance including well managed pain, nutrition and hydration. The service monitored patients' care and treatment outcomes through audit, which compared well with other similar services.

Specialist staff had the skills, knowledge and experience to provide effective end of life care and treatment and hospital staff knew who to ask if they needed additional advice on end of life care. Training rates in relation to end of life could be improved across the trust.

We saw completion of end of life care documentation for, treatment escalation plans had improved which improved outcomes for patients. Use of some forms for advance care planning and some sharing of information needed improvement.

Staff, teams and services involved with delivering end of life care worked together effectively and used information systems well so enabling community staff such as general practitioners and community nurse to have relevant information.

Evidence-based care and treatment

- Patients' needs were assessed and care and treatment delivered in line with legislation, standards and evidence-based guidance. The trust and specialist palliative care team had responded to the 2013 review of the Liverpool Care Pathway by phasing it out, putting temporary guidelines in place to ensure appropriate care was maintained. We saw minutes of board meetings where the decision was discussed and action

plans detailing what would be done. When the pathway was withdrawn the trust then introduced an end of life care plan that was individual to the patient. The end of life care plan at the hospital included Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying Patients 2014. We saw evidence in patient records and observed care that recognised the five priorities. The five priorities were that staff recognised that someone was in last year of life, patients were communicated with, patients and those close to them were involved in their care; those close to them were listened to and where possible their needs were met and appropriate care plans put in place. The trust continued to respond to the national care of the dying audit 2014 and they had a comprehensive action plan in place in response.

- We reviewed the trust end of life care (adults) policy. The policy referenced eight other trust polices including the draft spiritual care policy, Mental Capacity Act 2005 policy and the resuscitation policy. The end of life policy was the trust document to support and embed the principles into practice in the hospital with a focus on one chance to get it right. It incorporated the draft National Institute for Health and Care Excellence document Care of the Dying Adult Clinical guideline methods, evidence and recommendations July 2015. The consultant for end of life care at the trust was part of the draft working group.
- Junior doctor projects led by the consultant in end of life and training programmes provided by the trust such as 'opening the spiritual gate' was used to review, monitor and improve end of life care. There were over nine audits conducted in the last year by the end of life team.
- A national care of the dying audit was completed in 2013 when almost 100 case notes were included. The results published in 2014 had been presented widely within the trust and learning from the audit formed part of the current induction presentation for new staff. The trust performed better than England average for 8 out of 10 of the clinical patient care indicators. At the time of audit they did not score highly enough in 'access to specialist support in last days of life' (the team had since increased this), care of the dying continuing education (which had improved since by the inclusion of 105 minutes of time during induction) and trust board representation (board representation since achieved October 2015). Overall they achieved good results in reviewing care and communication with family. We reviewed an action plan created in response to the 2014 audit. Some actions had dates to be achieved some were ongoing.
- The death rate was monitored in the trusts Integrated Performance Report on a monthly basis and information was presented at every Patient Safety Group and included in its regular report to the Trusts Safety & Risk Committee, a sub-group of the Governance Committee. Any exception in the Trusts Mortality would be reported to the Governance Committee via the Safety & Risk Report to the Governance Committee. The Trust had reviewed the way that Mortality reviews were undertaken and from August 2015 a revised Mortality review process was in place. All deaths were to be reviewed with a standardised trust form with any unexpected death having a multi-professional review. All information was planned to be collated in a central database for analysis and sharing of learning.
- We saw evidence of end of life projects carried out by junior doctors under direction of the end of life steering group which included; the effect of opiate or pain relief prescribing patterns on inpatients at end of life - examining documentation and clinical reasoning behind the choice or change of opiate. The intention was to understand reasoning around changes in medicines and to improve information being fed back to General Practitioners in order to improve bereavement support of families. The projects were not complete.
- The Opening the Spiritual Gate project was in place. The 'spiritual gate' project included audit of notes of patients who had died. In addition to measuring patient experience the project focusses on documentation of spiritual and religious needs. It also examined the impact of the end of life paperwork and evidence of involvement of palliative care including palliative discharge team. The first review conducted in Dec 2014 showed initial low recognition in patient records of spiritual and religious needs but with significant improvement by May 2015.

Pain relief

- Management of pain was good. We saw evidence of 'just in case' medicines being prescribed and records of this in patients notes. We reviewed incidents where timely response had occurred when patients needed increased pain relief. Anticipatory or 'just in case' medicines are

prescribed for patients at end of life if symptoms such as shortness of breath or increase in pain or anxiety are anticipated. There were guidelines on every ward we visited for anticipatory medicinesprescribing for patients identified as requiring end of life care. The information was in a silver resource box for end of life care that most wards had been issued with. Some wards that had less than five deaths a year did not have any silver boxes issued but were encouraged to refer to the specialist palliative care team so that guidance could be given, tailored to the patient. This enabled wards with a low death rate to build and reinforce end of life care skills such as anticipating symptoms.

- We saw that medicine regimes for patients including receiving pain relief were discussed at multidisciplinary meetings. One of these discussions involved a complex decision to prescribe pain and anxiety relieving medicines to the patient whose carer also had complex needs. The carer was advised on how to manage assisting pain and anxiety relief for their relative. Further support to manage pain and anxiety was discussed with the patient and a referral was made to the community team. We saw another patient's pain was assessed and managed by the ward staff with regular review and support from the specialist palliative care team which included the specialist palliative discharge team nurses. The medicines reviewed was primarily for pain relief but included medicines to reduce inflammation which assisted pain relief. Staff on wards used pain charts to measure patient's pain. Staff told us that ways to measure pain included observation of body language or their facial expressions for those patients who were not able to speak or make their pain known.
- We observed one patient who was admitted urgently to the hospital receiving adequate pain relief and then being transferred to a ward with a syringe pump and medicines prescribed as required.

Nutrition and hydration

- We saw evidence that patients' nutrition and hydration needs were assessed and met through standard nursing and medical assessment supported by the use of individualised care plans.
- We saw nationally recognised malnutrition universal screening tools (MUST) used and spoke with staff who supported patients to eat and drink such as hospitality/ housekeeping staff. Staff were very knowledgeable about end of life care and the importance of eating and drinking as well as ensuring patients were supported when required to achieve adequate nutrition and hydration.
- Hospital staff were aware that patients must be supported to eat and drink for as long as they wished and are able to do so. Patients unable to take oral fluids and food must have a multidisciplinary decision regarding artificial hydration and nutrition and that the patient and those close to them to be made aware of reason why this was so. We saw examples of the new individualised care plan for end of life which included a fluids and foods care plan with advice to staff on how to support patients who were unsafe taking food by mouth. The forms prompted staff to do risk assessments and to enable patients to make an informed decision.
- We saw examples of information given to relatives including information about why a patient might not be eating or drinking and the use of artificial hydration or the use of intravenous drips

Patient outcomes

- The Hospital received Gold Standards Framework accreditation for end of life care for Yeo and for Yarty wards in 26 February 2015, Creedy ward was accredited 27 August 2015 and a fourth ward was undergoing resubmission. The hospital was one of only two acute hospitals in the UK to have wards recognised to meet the standard of the Gold Standards Framework for the care they provide to patients who are nearing the end of their lives. The Gold Standards Framework (GSF) was used to co-ordinate and communicate care needs of patients who are within their last year of life. It has been used within the community and care home setting for many years but is a new initiative for acute hospital trusts.

- Members of the end of life team were made aware of newly admitted patients with end of life care needs that were complex or were in need of advice and support for discharge planning. We saw evidence of this during an admission of a patient to the emergency department and when the patient was transferred to a ward. Staff followed well established referral criteria available on all wards. The specialist palliative care team were also able to view ward electronic information to identify patients who had been diagnosed as 'end of life'.

End of life care

- Patients' care and treatment outcomes were monitored in several ways. Information about the outcomes of patients' care and treatment was routinely collected by the end of life team and monitored via several audits. Audits included patients preferred place of care. Of 327 patients who died between 1st October 2014 and 30th September 2015 45% had their preferred priorities of care met this includes places to receive care and to die.
- The palliative care consultant had led projects to understand what did and didn't work for junior doctors when starting conversations about advanced care planning with patients. The project was funded by the Small Research Grants Scheme at the Royal Devon and Exeter Hospital Foundation Trust. The outcome was not known during inspection.
- Information from audits and Gold Standards Framework (GSF) accreditation was used to improve services for patients and carers. For example treatment escalation plan audits were improving discussion about resuscitation with patients and those close to them. The GSF was improving the standard of care for end of life on several wards and influencing improvements elsewhere.
- Patient's immediate outcomes were met by being seen regularly by either medical or nursing staff, we saw episodes of care for patients at end of life who were assessed regularly.

Competent staff

- Staff in the end of life team had the skills, knowledge and experience to deliver effective care and treatment. We saw that there were arrangements for adequately supporting the specialist palliative care team staff. This included one-to-one meetings, appraisals, coaching and mentoring. The specialist palliative care team provided evidence that all staff in the team were up to date with professional development reviews or appraisal and one to one supervision.
- We saw that they had attended courses such as advance course in pain and symptom management, Diplomas and masters level in palliative care and other end of life related training. Other hospital staff were supported by teaching from the end of life team including, mortuary services and the chaplaincy. For example of the 2234 medical and nursing staff 380 had attended end of life training in 2015 this was in addition to mandatory training. Syringe driver training had been completed. Correct syringe driver pumps where being used and it was a requirement for all registered nurses to be competent in this area. All nurses we spoke with were up to date and competent in the management of syringe driver pumps
- We spoke with the nurse educator who worked three days a week as an end of life educator within the trust. We saw a range of evidence that the specialist palliative care team provided support and training to other professionals and staff in the hospital. This included learning on induction, developing future competencies for mandatory training for nurses and sharing learning with other wards from the gold standards accreditation. Further end of life training was planned for all staff including housekeeping staff for 2016 (a day which included, syringe driver, communication, nutrition and hydration supported by the national care of the dying audit).
- The mortuary team provided support with training for nurses with managing tissue donation requests and conversations with bereaved. The mortuary team informed a significant amount of training to the hospital porter supervisors who cascaded the training to the porter's team in areas such as infection prevention and control, refrigerator management, sensitive management of deceased patients and security of mortuary.
- We saw evidence staff were encouraged and given opportunities to develop through carrying out audit, teaching and other professional development. Band three link workers were an integral part of end of life care learning on the wards reinforcing end of life care principles and providing a link between wards and specialist teams
- We saw evidence in the specialist palliative care team of when variable staff performance had been identified and how it was managed. Staff were supported to improve with a clear action plan from the senior nurse in the specialist palliative care team.
- Hospital wide staff accessed some training through 'eLearning' online and some in house trust developed training. Overseas staff had additional support in induction. The training was a good base to develop quality end of life care.

Multidisciplinary working

- Care was delivered in a coordinated way. The specialist palliative care team was involved with some patients'

end of life care but ward staff also managed end of life care also without their support. When patients were involved with the specialist palliative care team the consultant lead for end of life or the palliative care consultant were responsible. Team members were aware of who had overall responsibility for each individual's care and they were reviewed at weekly multidisciplinary meetings. Specialist palliative care team members and cancer nurse specialists attended the meetings. The lead nurse for end of life was also the manager of the oncology nurse team. This enabled good communication of issues in both teams. Trust consultants' attendance at weekly multi-disciplinary meetings varied between 83% and 0%. Attendance at lung multidisciplinary meeting was 75% and for gastro intestinal conditions 83%. The medical director and consultant lead for end of life care had plans to increase consultant attendance as a part of the gold standards framework initiative and other end of life guidance.

- The service used electronic systems to ensure that relevant information for end of life care was available to ward staff, to hospice staff and community staff. Some electronic systems did not communicate with each other directly. We observed weekly end of life care multi-disciplinary meetings at the hospice with trust staff. Then further end of life care meetings occurring immediately after in the hospital.
- We saw evidence that treatment escalation plans for community patients were backed up with paper copies in the emergency department just in case electronic systems were unavailable. These were updated monthly by email from general practitioners to the emergency department. They were monitored by one person in administration.
- We saw evidence of staff working together to assess and plan ongoing care and treatment in a timely way when a patient had been admitted to the emergency department. The patient received care through effective communication between hospital staff from different departments. The patient was assessed and a care and treatment plan outlined by nursing and consultant staff followed up with additional support from the specialist palliative care team. The patient was rapidly moved to a ward while discussions about preferred priorities of care took place. This included where the patient wanted to be cared for at end of life and who was important to be involved.
- When patients were due to move between teams or services we saw no evidence that patients were routinely discharged from a trust service at inappropriate times of day. There were occasions when discharge to a patients preferred place had been delayed where paid carers were not available in the area the patient wanted to return to. Some delay was caused when patients had not had funding agreed from other agencies, or placements were unavailable. Occasionally delay was caused when placements were felt to be inappropriate by patients and relatives and.
- The palliative care discharge team was the route through which community services were accessed and the lead nurse for the palliative care discharge team had direct access to resources to enable discharge. The end of life specialist palliative care team works with the specialist services division of cancer services and is based at the hospital. The end of life team had noticed trends regarding delays in discharge including not enough carers in the community. These trends were being used to inform different uses of resources to ensure future discharges were delayed as little as possible. We also saw evidence of the trends being shared with the clinical commissioning group to attempt to identify longer term more sustainable solutions.
- We observed the palliative discharge team nurse respond to a patient who ward staff had identified as wanting to die at home. The interaction between ward staff and patient and carers was excellent and the multi-disciplinary work to begin planning discharge included occupational therapy and other non-cancer specialist nurse input. The palliative care discharge team had rapid access to occupational therapist who could assist with enabling patients to retain as much function as possible to support their autonomy. The process for organising ambulance transport for palliative care was efficient. Patients discharged to the community were asked consent to be entered onto the electronic patient record which enabled other community professionals to see relevant end of life information.

Seven-day services

- The specialist palliative care service for patients in hospital was available Monday to Friday 8.30 to 4.30. Outside of those times there was a 24 hour a day on call telephone advice service from the hospice inpatient unit

or one of the two Hospicecare doctors on call. They were funded to cover 3 whole days on call cover a week. Patients could be seen by the on-call hospice doctors if there was a clinical need and the advice service was available to nurses and doctors.

Access to information

- Staff had access to information they needed to deliver effective care and treatment to patients who were using the hospital services. They had access to prescribing guidance in an end of life resource box (silver box) which was maintained by the end of life education facilitator and ward link nurses. Staff spoke highly of this resource because all end of life information was available immediately. For example anticipatory medicines prescribing guidance, information leaflets, at least five copies of individualised care plans for use at end of life.
- Information was available in electronic format with patient details from community and in hospital. Patients were asked consent before being recorded on electronic systems that other professionals could use when out in the community.
- The hospital based electronic information system did not communicate with the community based system. So, the specialist palliative care team would photocopy hospital information to use at their base to ensure there were no gaps in information availability. Confidentiality was ensured by the team disposing of the copies on the trust site when not needed.
- Information to identify end of life patients in ward areas included magnetic labels in the shape of a butterfly on patient information boards and a hand icon on electronic whiteboards. Electronic systems were accessible by community staff for example general practitioners and where some information was not available staff used paper based records. Information was also available from the specialist palliative care team and other staff at the onsite hospice. The paper information included 'blue forms' a set of documents that were the individual care plan for a patient. The documents were specifically for those in the last few days of life and included symptom control plans, patient and family nursing assessment, psychological, social and spiritual care planning, mouth care, communication and comfort rounding plan. We saw examples of these in use. While not all parts needed to be completed some staff told us the new forms were cumbersome and with too much information in them.
- General practitioners were informed by letter when patients were discharged and information as available in the electronic system that the specialist palliative care team updated.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff on wards and within the hospital we spoke with understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- We saw patients being supported to make complex decisions about their care. At times anxiety could have led to a lack of capacity to make decisions and staff took this into account giving time for decision making.
- Treatment escalation plans (TEPs) included a mental capacity assessment tool. We reviewed evidence of the most recent treatment escalation plan audit which included 'do not attempt to resuscitate' decision making and recording. Following a CQC inspection in November 2012 the trust was found to not always follow resuscitation guidelines. Following the outcome of the 2012 inspection, action was taken by the resuscitation lead who wrote to all trust consultants in November 2012 about following resuscitation guidelines. There then followed quarterly treatment escalation plan audits. In the October 2015 audit of treatment escalation plans (TEP) 131 patients records were reviewed with the following findings:
  - Of the 131, 48 had a treatment escalation plan and 83 did not.
  - Of the 83 that did not have a TEP four were judged they should have had a TEP in place. One of the four had the information required located elsewhere in the patient record.
  - 93% of patients had had their mental capacity to make decisions documented and 94% had been involved in a discussion regarding resuscitation.
  - For patients who were assessed as lacking capacity, 100% had received a mental capacity assessment and this was documented correctly on the TEP.
- While significant good practice was noted the audit highlighted that more discussions should be held with family and these conversations documented for patients who do not have capacity
- When we spoke with the bereavement officers they told us of the practice of informing the coroner should a

patient die while being under formal 'deprivation of liberty safeguards' in the hospital. They explained to us that this was technically a death in custody and needed to involve the coroner.

Are end of life care services caring?

Good

We rated Caring as Good.

Staff treated patients and those close to them with kindness, dignity, respect and compassion.

Hospital staff demonstrated an understanding of patients personal, cultural, social and religious and spiritual needs. Patients and relatives were involved as partners in care contributing to patient records and engaging in bereavement groups set up by the trust.

Support was available to enable patients and those close to them to have the support they needed to cope emotionally with their care, treatment or condition with the provision of support from volunteers and chaplaincy services.

Compassionate care

- Patients were treated with kindness, dignity, respect and compassion while they received care and treatment. Staff understood and respected patients' personal, cultural, social and religious needs, and took these into account. We saw this in interviews with staff, in paper records reviewed and when we observed care. When we visited wards we saw that staff made sure that patients' privacy and dignity was respected and used curtains where necessary. Staff respected confidentiality at all times with appropriate volume of conversation. We saw hospital and specialist palliative care team staff work with patients who were experiencing physical pain, discomfort and emotional distress. They cared for patients in a compassionate, timely and appropriate way.
- The local population was predominantly Christian, but had a wide range of minorities from other belief groups. The Trust funded a four hour seven day week chaplaincy service. We saw evidence that it extended spiritual support to those of little or no religious faith; it had a humanist chaplain and had completed a successful trial of a secular befriending service for lonely patients.
- Mortuary staff said they would report issues if the care of the deceased policy had not been followed to enable ward staff to learn the importance of dignity and safety for patients.
- We saw porters using concealment trollies to move patients at the end of their lives and they were appropriately covered. This ensured the dignity and respect to patients being transported around the hospital.
- We were told there was space and time on wards for some religious practices (care after death) if patients had died before their relatives or others had arrived at the hospital. Relatives were able to use part of the mortuary space under supervision to wash patients who had died. Relatives would be required to wear appropriate protective clothing and adhere to mortuary health and safety practices. The mortuary was fitted with red lights above doorways to alert mortuary staff to the presence of bereaved friends and relatives either in the relatives' room or elsewhere in the mortuary. This meant that relatives and were given privacy and respect while spending time with their loved one
- We were told that mortuary staff offered family and carers the opportunity to participate in processes around bereavement and supported them to do so. Mortuary staff were involved in how to support patient's wishes for organ and tissue donation as well as how to have these conversations with relatives.
- One relative we spoke with described the experience of their relative's care as excellent, all the staff were kind and compassionate and staff went beyond the call of duty, staff cared for the whole family not just the patient.

Understanding and involvement of patients and those close to them

- Patients who used services and those close to them were involved as partners in care. We saw and heard hospital staff communicating with people so that they understood their care and treatment and condition. Staff were able to tell us how they recognise when people who use services and those close to them need

additional support to help them understand and be involved in their care and treatment. They would enable this by using translation services or contacting local advocacy services if needed.

- Staff made sure that people who used the hospital and end of life care services and those close to them were able to find further information or ask questions about their care and treatment. We saw evidence of this during a patient being admitted. Staff used information available in every ward with a 'silver box'. In the box was all the immediate information needed for questions to either be answered or for people to be directed to the correct place to ask their questions or receive answers. Information included advance care planning for patients, guides for relatives and friend after death.
- Relatives and those close to patients approaching the end of life were able to take breaks and eat at a discount in the hospital café. They also were given opportunity to use fold up beds, side rooms and flats were available at a charge through a local provider so that they could stay near to the wards. .
- We saw examples of care taking place for patients in the last days and hours of life, the dying person and those identified as important to them were involved in decisions about treatment and care to the extent that the dying person wanted.
- Patients were enabled to have contact with those close to them. Relatives and friends of dying patients were allowed to stay and visit freely. Staff offered comfort packs for relatives and friends staying with dying patients (containing flannel, soap and other comfort items).

Emotional support

- Counselling services were available for patients and staff through a local charity, the hospice based team and through the chaplaincy. A bereaved relatives group had recently been set up and the aim was to improve the experience at end of life for bereaved relatives and patients. We saw minutes of the bereaved relatives group run by the trust where emotional support and information was provided to those close to patients who had used services. It was in its early stages and the second meeting had yet to happen. Membership of the group was for up to a year after bereavement. Staff we spoke with had a good understanding of the impact that a person's care, treatment or condition might have on their wellbeing and on those close to them.
- Patients who were receiving end of life care who did not have family, friends or carers to support them were supported spiritually and emotionally by the large chaplaincy volunteer support service. These were staff who had been checked via the disclosure and barring service and went onto wards to offer support. We met a volunteer chaplain who carried out this role in addition to more formal chaplaincy tasks such as carrying out religious service.
- There was training called opening the spiritual gate and Schwartz rounds which included managing spiritual and emotional pain for staff provided by the trust. There was also support from external agencies such as local charities who provided counselling for patients and those close to them.
- We spoke with one of the bereavement officers about recent changes they had instigated in the issuing of death certificates. The mortuary and bereavement services were now receiving notes and records with the deceased rather than having to request several different people process the request. The process was quicker. The bereavement officers would also use a dedicated relative's room at the front of the hospital entrance rather than a relative have to return to the mortuary to pick up the certificate. This reduced anxiety for some and was more efficient and caring process.

Are end of life care services responsive?

Good

We rated Responsive as Good.

Services were planned and provided to meet the needs of patients and those close to them, taking account of the needs of patients with learning disabilities and those suffering from dementia.

Patients could access care and treatment in a timely way with a few exceptions such as occasional delays in discharge.

There were excellent communication links between specialist palliative care team members, palliative discharge team and community nursing staff.

End of life care

Patients and those close to them who raised concerns and complaints were listened and responded to, and staff used the experience and information shared to improve the quality of care.

Service planning and delivery to meet the needs of local people

- Facilities and premises were appropriate for the services that were planned and being delivered. There were two rooms available for relatives and representatives to meet with hospital staff; one was at the mortuary when viewing recently deceased patients. One was at the front of the hospital which ensured that people didn't have to return to the mortuary to collect death certificates. We saw evidence of plans to create a quiet space similar to the garden that was used by patients with dementia for fresh air and quiet space.
- There were no designated ward or area for patients receiving palliative care. End of life care was embedded within the practice of caring throughout the hospital. Requests for side rooms for patients approaching the end of life had caused some problems in the past and there were plans to expand some wards' provision of side rooms. The main issue was when a side room being used by a patient at end of life was needed for a patient who posed an infection risk to others. This was solved usually by finding another room in the hospital if available, or an empty bay which minimised transfer of patients with infection. Sometimes it wasn't possible to ensure someone had a room to themselves as infection control measures took priority. We were told this was a rare occurrence.
- Where people's needs were not being met the learning was being used to inform how services were planned and developed. The trust was dealing with a complaint about side room use and the transfer of someone at end of life to another location. Staff on the acute medical unit spoke about discussions with the local mental health provider to expand a little used small room as a side room. We saw action plans for a list of quiet spaces for relatives planned for December 2015.

Meeting people's individual needs

- Services took account of the needs of different people, including those in vulnerable circumstances through a full comprehensive assessment of individual's needs. When ward staff were unable to deal with patients with complex needs they would refer to the specialist palliative care team. We saw evidence of this in records audits by the trust and during inspection.
- Patients who were approaching the end of life identified by specialist palliative care team were offered and given the opportunity to create an advanced care plan. This included end of life care wishes and any advanced directives. The specialist palliative care team showed us the trust document planning for future care advance care planning.
- Reasonable adjustments were made so that disabled people could access and use services on an equal basis to others. The trust employed a dementia lead nurse and worked with a local authority learning disability (LD) nurse to identify increased needs. The LD nurse supported staff to care for people with a learning disability if they were admitted to the hospital. They had personalised care plans which related to any specific needs. The hospital system flagged up people recorded with a learning disability when they were admitted to hospital to ensure the earliest possible contact with the support nurse. The LD nurse said that people with a learning disability were treated the same as everyone at end of life but higher priority for a side room was considered.
- Chaplaincy at the hospital provided a full range of support for patients' spiritual, religious, psychological and social needs. Chaplaincy volunteers were aware of patients who might need someone to talk with and might not have relatives of friends nearby. The chaplaincy worked with ward staff in developing spiritual care plans. Spiritual care was understood to be a responsibility of all staff. A significant training programme 'opening the spiritual gate' had been invested in and had been rolled out to medical, nursing and allied health professional staff to offer spiritual care, especially around the end of life. The Trust was finalising a spiritual care policy to support good practice for all patients and ensure that the 2015 hospital chaplaincy guidelines 'Promoting Excellence in Pastoral, Spiritual & Religious Care' were followed.
- The religious space in the hospital was a large area with room for approximately 100 people standing. The chaplain emphasised it was also a quiet space for all. We saw evidence of this. There was a dedicated washing facility for people to wash before prayers. There were movable screens to increase or decrease a particular

space for prayer depending on numbers of attendance and if males and females wished to pray separately. Holy books including a bible, Quran and Bgahavad gita - a key Hindu text were available. There were removable symbols (e.g. cross) and a Hindu deity that had been carved specifically for the chapel space.

- The three largest ethnic minority groups within the trust's population area were Polish, Lithuanian and Russian. The trust had an interpretation and translation policy for staff available on the trust intranet site. They used external providers for face to face interpretation and translation. For hearing impaired patients and relatives they used British sign language interpreters and Language Line for phone interpretation. The RNIB was accessed for translation into Braille. There were language identification cards and multilingual phrasebooks available on all wards.

Access and flow

- Patients who needed support for end of life care accessed care and treatment in a timely way. The specialist palliative care team by their very nature prioritised care and treatment for patients with the most urgent needs. The hospital staff provided the day to day end of life care and we observed rapid referral by hospital staff and timely response by the specialist palliative care team.

From April 2012 - October 2015 the palliative discharge team saw 1095 patients of which 549 achieved the preferred place of care. From 1 May to 31 July 2015 the specialist palliative care team saw 75% of referrals on the same day and 96% of referrals within 24 hours.

- There were 14 patients who were in hospital and supported at end of life by the specialist palliative care team during the inspection. The specialist palliative care team received 512 referrals from 1 April 2014 to 31 March 2015. Of the 512, 428 where cancer related and 84 were non-cancer related for example patients with chronic obstructive airways disease or motor neurone disease needing specialist support from the team. The number of referrals was down slightly compared to the previous year when there were 532 referrals. Figures suggest that the importance of non-cancer referrals was being recognised across the trust with an increase of 16% in referrals for these patients.
- From April 2012 to October 2015 50% of patients were discharged or transferred to their preferred place of care.

Learning from complaints and concerns

- The concerns and complaints of patients and those close to patients were listened and responded to and used to improve the quality of care. We saw evidence that complaints and concerns were dealt with openly and with transparency. Patients and relatives who used the hospital and specialist palliative care team for end of life care knew how to make a complaint or raise concerns and were encouraged to do so through written information available.
- Patients were treated compassionately and given the help and support they needed to make a complaint and those complaints were handled effectively and confidentially. Outcome were explained appropriately to patients and relatives. Examples of learning included, the specialist palliative care team acting on relative's feedback and this information was shared in matrons meetings to change or reinforce existing practice.
- During our inspection we were aware of an ongoing investigation into a complaint about use of side rooms. Some learning about how to prioritise for transfer elsewhere had already been discussed which would improve the experience of people close to those dying. One aspect of the discussion was that each patient had to be considered on need.
- Other examples of complaint outcomes included what staff should do when a patient receiving end of life care refused treatment and relatives complain that treatments are not in place. Staff acknowledged that patients with mental capacity to make decisions can refuse treatment but explanation to relatives and documentation of decision making was important.
- In another complaint a patient's relative raised a concern about not being told when the patient had been moved from a ward. This had caused anxiety on their return to the hospital. Staff had already implemented learning to improve communication on the ward. We were aware of one complaint relating to care planning. The end of life care was described as good but family felt they were not told of the implications of the diagnosis until very late in the patient's life.

End of life care

Are end of life care services well-led?

Good

We rated well led as Good.

The leadership of end of life care was evident at all levels. The service had a clear vision and strategy to provide good quality end of life care, and leaders recognised where progress was still needed.

The governance framework ensured that responsibilities were clear through the contractual and supervisory arrangements. There was clarity between lead roles within the trust and the specialist palliative care team linked to the hospital via a detailed service level agreement.

Quality and performance were well understood by the medical director, the consultants in end of life and the specialist palliative care team. The risks to end of life care in the trust and the specialist end of life care service were anticipated and planned for in advance. They were recorded through a comprehensive plan of actions. However we did not see detail as to risk or impact on service delivery if actions were not achieved. There were issues identified in the action plan which could pose a risk to current and planned service delivery if not achieved on time,

The trust encouraged openness and transparency and promoted good quality care. Patients, public and staff were engaged and involved in the delivery and development of the service.

Vision and strategy for this service

- The vision, values and strategy for end of life had been developed over several years starting with the establishment of the hospice on the hospital site in 1992 by a former trust medical director. Staff we spoke with were able to outline their understanding of the trust vision and values, the vision and values for end of life care strategy and their role in achieving it.
- The vision and strategy for end of life care was set out in a document End of Life Care (Adults) authored by the consultant lead for end of life care and the end of life nurse facilitator. The vision was for end of life care to be multi-agency informed, holistic and ultimately all relevant wards to be gold standard framework accredited. One senior leader described the strategy as an ambitious agenda following 'one chance to get it right' embodying the five priorities of care at end of life. The five priorities were that all staff recognised that someone was in last year of life. Patients were communicated with. Patients and those close to them were involved in their care; those close to them were listened to and where possible their needs were met and appropriate care plans put in place.
- The strategy was supported by the non-executive lead for end of life, the trust board chair, the executive member for end of life care (the medical director). The consultants for end of life, the two end of life lead nurses, the mortuary manager and the chaplain implemented the strategy.
- The end of life strategy was shared with trust staff through education opportunities and monitored by the specialist palliative care team, chaplaincy, mortuary staff and the medical director.
- The strategy throughout the hospital was recorded in the Work programme for the Royal Devon and Exeter End of Life Steering Group work plan (6 October 2015). We saw evidence of this throughout the hospital. For example, observations of care that embodied the principles of end of life care and gold standard accreditation,

Governance, risk management and quality measurement

- There was an effective governance framework to support the delivery of the strategy and good quality care. Staff were clear about their roles in end of life care and understood what they were accountable for. The consultant, who led end of life care, said that the teams involved including the mortuary service and chaplaincy were good at identifying risk and forming action plans to address the issues. Any risk identified for end of life care service provision led to management plans recorded in the specialist palliative care team action plans. We did not see any formal assessment of risk if actions were not achieved. We were not able to understand implications for service delivery and reputation if actions not met.
- There were no risks entered into the corporate or local risk register relating to end of life care. We spoke with the medical director about this and they acknowledged

that there were a number of issues that could be considered as a risk to the end of life service provided. Some staff we spoke with had a concern about a lack of palliative care input at consultant level across the trust.

- The work programme action plan document was a standing agenda item at the end of life steering group which met regularly to review implementation of end of life care strategy. This in turn reported to and was monitored by the clinical effectiveness committee chaired by the medical director. The responsibility for the action plan was held by the medical director, the lead consultant and lead nurse for end of life with other specialist palliative care team members identified as responsible for actions as well as the chaplain and the mortuary manager. Of the 56 actions in the programme we saw most were progressing, four were red. One of the red rated actions - establishing end of life training in induction of all staff - had recently been completed. Another red rated action was advanced communication skills to be re-launched in the trust. This would enable more effective mechanisms for identifying those who are approaching end of life.
- While the specialist palliative care team governance and supervision arrangements appeared complex, the working arrangements within it and with partners and third party providers in end of life care were well managed. For example the link between the hospice and the trust was a very functional link. The end of life care team were clear that the governance framework demonstrated that responsibilities were clear. Quality, performance and risks were understood and managed through the arrangements of honorary and trust contracts for the specialist palliative care team. We saw clear expectations for delivery and governance outlined in the service level agreement.
- The governance framework and management systems regularly reviewed the service and improvement was demonstrated through outcome of audits, rapid discharge rates and mostly positive feedback from bereaved relatives.
- End of life care performance measurements were posted on the specialist palliative care team and mortuary services comm cell boards. The information was monitored daily and weekly by team members at handover. Ward link nurses ensured that ward staff had information shared through their 'comm cell' meetings.

Leadership of service

- The medical director was the executive lead for end of life care on the trust board. The chair of the trust had recently been appointed the non-executive lead for end of life care. The consultant oncologist was clinical trust end of life lead and worked with the consultant in palliative care.
- The Chaplin was the pastoral care lead who worked closely with the mortuary and bereavement services lead manager.
- There were two nurse leads one for the hospital and one for the hospice and there were end of life link workers who led on end of life care on all wards at the hospital. End of life care and project work was led by several members of the end of life team.
- The leadership and culture encouraged openness and transparency and promoted good quality care. During the inspection it was noted that leadership was evident at all levels of end of life care provision. Staff that demonstrated leadership included end of life care link workers, hospital ward staff, and chaplaincy staff mortuary staff. They demonstrated they had the skills, knowledge, experience and integrity needed to drive improvements in end of life care. Leaders had the capacity, capability, and experience to lead effectively.
- The Chief nurse was reported to do 'hands on care' regularly within the trust, other leaders such as the chaplain were known, approachable and visible as were the mortuary team. When we spoke with staff it was clear that a culture of appreciation and supportive relationships existed among staff. A senior leader commented that if you didn't try to look after your staff then you could not begin to look after patients well.
- The mortuary team was managed by the cellular pathology medical lead and cellular pathology laboratory manger. Day to day running of the mortuary was through the mortuary manager, a deputy manager, a senior anatomical pathology technologist who managed the two bereavement officers. The senior anatomical pathology technologist also managed another technologist and the Exeter and Torbay tissue donation officer.
- The chaplaincy was led by a senior chaplain who worked with the consultant for end of life to deliver strategy and actions in end of life care for the trust. The chaplaincy department was an equal member in end of life care decision making and practice.

Culture within the service

End of life care

- Hospital staff including the end of life team we spoke with felt respected and valued.
- The culture we observed was obviously centred on the needs and experience of the patients who used the end of life service and that of the hospital in general. The culture at the hospital encouraged openness and honesty in relation to end of life care and day to day running.

Public engagement

- Patients who used end of life services, those close to them and their representatives were actively engaged and involved in decision-making and staff encouraged them to contribute to patient notes, keep diaries of their experiences and share them with staff.
- A recent initiative was the bereaved relatives group, where recently bereaved participants had fed back to end of life team members their experiences and suggestion for change. Staff shared changes already implemented since the Liverpool care pathway had been discontinued. We saw minutes of a meeting where members of the group were keen for their anonymised experience to be used as teaching examples within the trust.

Staff engagement

- The staff in the specialist palliative care teams and others told us they were actively engaged in the development of the service as did ward staff. Their views were reflected in the planning and delivery of services and in shaping the culture. For example the chaplain as pastoral care lead had prepared and presented the spiritual care policy that met the NICE guidelines and NHS guidance on chaplaincy. Link workers who had ideas on how to improve care had been listened to and end of life practice had changed. Also the chaplain and the mortuary manager had developed guidance for medical and nursing staff on diversity and equality in connection with end of life care; the end of life education facilitator was co-author of the draft end of life policy.

Innovation, improvement and sustainability

- Sustainability was promoted through regular and varied audit with implementation of learning from audit and incidents.
- The palliative discharge team had recently recruited additional members following funding from the trust. This enabled the team to plan to do more. For example prescribing and supporting gold standards framework across more wards.
- The specialist palliative care team had been awarded money to support implementation of 'one chance to get it right' to target meeting spiritual and religious needs. This would fund a two year project from March 2015.
- Improvements to quality and innovation such as the 'Silver Box' containing end of life care information and tools supported implementation of end of life care. The trust had been recently been recognised through Gold Standards Framework accreditation for three wards with several others planned. The trust is one of only three trusts to achieve this in the country and has plans for accreditation of other wards.

Outpatients and diagnostic imaging

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

Information about the service

The Royal Devon and Exeter NHS Foundation Trust provided outpatient clinics at the following locations: Royal Devon and Exeter Hospital (Wonford), Heavitree Hospital, Exeter Mobility Centre, Axminster Hospital and Tiverton and District Hospital, Exmouth, Honiton, Sidmouth and Okehampton. Genetic services were provided by the trust as part of their Peninsula service at Plymouth, Trelisk, Torbay and North Devon.

This report is about the outpatient services at Wonford Hospital where the following were provided:

- The ophthalmology outpatient's service was held within the West of England Eye Unit.
- The orthopaedic outpatient's service was held in the Princess Elizabeth Orthopaedic centre. This included pre-operative clinics for orthopaedic surgery.
- The obstetrics and gynaecology outpatients' service was held in the Child and Women's Health Centre. This clinic area included an ultrasound, antenatal assessment unit, antenatal clinic, and gynaecology outpatient's suites.
- Surgical outpatients included specialties such as breast care, and plastic surgery.
- Medical outpatients included eighteen consulting rooms, which hosted specialties of gastro-intestinal, cardiology, cardiac rehabilitation, dermatology, renal, neurology, oncology, haematology and elderly care/ general medicine plus electrocardiogram and phlebotomy service.
- The Macleod diabetes and endocrine centre held outpatient clinics.
- All musculoskeletal physiotherapy was held at the Heavitree site and this location was not visited on this inspection.

Diagnostic imaging services were provided at Wonford Hospital and included a range of modalities including plain film imaging, computer tomography, magnetic resonance imaging, Ultrasound, breast screening and symptomatic mammography, fluoroscopy and interventional radiology. Diagnostics also included clinical measurements.

In the period January 2014 to July 2015, 48 specialties held appointments for consultations in the outpatient's service. Of the ten most common specialties, there were 719,055 outpatient and diagnostic service appointments during 2014/2015, including ophthalmology, oncology, trauma and orthopaedics, general surgery, gynaecology, obstetrics, ear nose and throat, clinical physiology, plastic surgery, and cardiology. Of these, 597,490 patients were seen at Wonford Hospital site. Routine outpatient appointments were offered Monday to Friday with some clinics offering extended opening hours during the week. Occasionally clinics were scheduled on Saturdays in response to high demand.

Outpatients and diagnostic imaging

Summary of findings

We rated the outpatients and diagnostic imaging services as requiring improvement overall. Safety required improvement as in some clinics, patient records were not always stored securely and this meant that the confidentiality of patient information could not be guaranteed. We saw that staffing was a challenge for some teams. In particular, there was insufficient medical physics cover in radiology and nuclear medicine to provide consultation on patient dosimetry, quality assurance, and advice regarding radiation protection concerning medical exposures. The trust had temporarily mitigated this risk through provision of cover from a neighbouring trust. Staff were aware of their responsibility to raise safeguarding concerns and they understood their responsibility to report incidents.

We did not give a rating for effectiveness. We saw that some aspects of care in the outpatient service were not effective. there was no policy for clinical supervision for staff working in the outpatients service. There were forums for reflection available to outpatient staff. However, staff we spoke with did not identify these as forums they used and there was no policy for clinical supervision against which the trust could audit. However, outpatient teams were utilising a quality assessment tool to peer review the quality of care received by patients in the clinics. There was some evidence of best practice within radiology. Referrers to the radiology department were encouraged to use an evidence based referral system and the radiology service held accreditation with the Imaging Services Accreditation Scheme. However there was not a regular programme of review of the doses of radiation given to patients.

We rated the outpatients service as good for caring. Staff in all departments including those in managerial and clerical roles demonstrated a compassionate understanding of the needs of patients. Patients told us they were able to understand their condition because the nurses had taken time to explain it to them.

We rated the outpatients and diagnostics service as requires improvement for responsiveness. There were long waits for people who needed treatment for cancer. During 2014/2015, 115 patients had waited more than 62 days for their cancer treatment. There were also delays for treatment in ophthalmology, orthopaedics, and cardiology. Rapid access clinics had been introduced where needed and the teams had used creative ways to reduce the requirement for face to face consultations. In some clinics, the privacy and the safety of patients was not well accommodated by the environment, for example there was insufficient room in the ophthalmology department to fit adequately curtained vision aisles.

We rated the outpatients and diagnostics service as good for well led. There was a vision for the remodelling of the outpatients service as a whole, and the challenges regarding lack of capacity within the ophthalmology service were being addressed by the planned relocation of the glaucoma practitioner service in January 2016. There was clear governance process around the risks associated with delays to treatment for patients living with cancer. The trust had a clear and focussed plan to reduce the time that patients had to wait for treatment for cancer and for other conditions. Key aspects of the plan were already in place with additional capacity fully commencing in December 2015. The trust was aware of the on-going risks regarding radiation protection medical physics expert cover and were actively seeking to ensure a sustainable level of cover. Leaders in the trust were well respected and staff told us they felt proud to work for the trust

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Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

We rated the safety of the outpatients and diagnostic imaging services to require improvement. In some clinics, we saw that patient records were not always stored securely and this meant that the confidentiality of patient information could not be guaranteed. However, patient records were consistently available in clinic and in the 16 sets of records we reviewed; the contents of the records were accurate and up to date.

We saw that staffing was a challenge for some teams. There was a shortage of cover from a medical physics expert within radiology and nuclear medicine. The Ionising Radiation (Medical Exposure) Regulations 2000 (IR (ME) R) require that a medical physics expert is available for consultation on patient dosimetry, quality assurance, and advice regarding radiation protection concerning medical exposures. At the time of our inspection, the lack of sufficient medical physics expert cover currently did not impact on patient safety due to a service level agreement for the protection of radiation protection from a neighbouring trust.

There was a high staff attrition rate for ophthalmology outpatients service and these vacancies had resulted in a loss of 305 appointments per week. We saw on staff rosters that some gastroenterology clinics were covered by one member of staff with up to 41 patients.

All teams in radiology had a radiation protection supervisor who helped staff to comply with the Ionising radiation regulations and the Ionising Radiation (Medical Exposure) regulations. These regulations outline important safeguards for keeping patients safe when they are being cared for in the radiology department. In the radiology service, there were written safety protocols and local rules available for staff to use. Staff were familiar with these documents.

Written checklists were used to monitor weekly checks of important safety equipment such as resuscitation equipment. However, we noticed that several items of equipment were past their due date for routine maintenance check or electrical testing. In one clinic, the emergency medicine for patients experiencing anaphylactic shock was not easily visible and the staff did not record the date of expiry for liquid medicines once opened. There had been low scores for hand hygiene in some outpatient departments but the matrons were addressing these issues.

Staff were aware of their responsibility to raise safeguarding concerns and some teams were trained in domestic abuse awareness. Staff understood their responsibility to report incidents. Learning from incidents was evident within teams but was not consistently shared outside of teams or divisions. Staff understanding of the duty of candour varied amongst teams.

Incidents

- There had been no recorded never events in the previous 12 months in the outpatient and diagnostic imaging departments. There had been 56 incidents reported in medical outpatients since January 2015.
- Staff understood their responsibilities to report incidents but not all staff reported incidents when they occurred. Staff gave examples of incidents that they had not reported, including: when a patient had become distressed by the layout of the waiting room in obstetrics and gynaecology, when a patient had been abusive to a member of staff, or when a clinic had been understaffed.
- Staff told us they had raised an incident report regarding a suction machine on medical outpatients because the machine did not allow suction strength to be adjusted. However, this incident report could not be traced by the trust.
- The radiology department had improved their processes for reporting incidents to external regulators such as the care quality commission. In April 2015, there had been a number of statutory notifications that the trust had not declared to the ionising radiation (medical exposure) regulations inspectorate within the expected timescale. This delay was addressed and all incidents that were classified as exposures 'much greater than intended' were identified and reported to the care quality commission. As a result, at the time of our inspection, incident reporting was robust.
- Radiology superintendent staff in each team investigated incidents and the divisional governance manager reviewed these. There was a new policy for governance of incidents in radiology and the trust

incident reporting system had been amended to clearly identify exposures that were 'much greater than intended'. The radiation safety group and the divisional lead regularly reviewed all incidents that were still open.

- Some outpatient departments had a matron who received the incident reports for their service. In medical outpatients, the senior nurse for each speciality in the divisions received incident reports relating to outpatients. Staff gave examples of learning from incidents within their team that had been shared in team meetings. In ophthalmology, the investigation of two serious incidents resulted in training of all junior staff, checking of laser safety rules, and the inclusion of a nurse during treatment to advocate for the needs of the patient if they felt distressed. Managers identified incidents when individual learning needs had been addressed with a member of staff, for example, in the health records team.
- However, staff were not aware of learning shared more widely to other teams. The quarterly trust newsletters were a forum where learning from incidents was shared across divisions; however, staff in outpatients were unable to identify any examples of cross-divisional learning posted in this newsletter. Staff told us that they received verbal feedback regarding incidents occurring in their department but not from incidents occurring in other outpatient clinics or on the wards.
- Incident reporting was not the only source of learning within teams. For example in orthopaedic outpatients, staff participated in a regular evacuation drill for the hydrotherapy pool situated next door to the clinic. Because of learning from these drills, the volume of the call bell was increased. In computer tomography service, concerns had been raised regarding the quality of the images obtained when patients needed a scan of their head following injury. The service completed an audit and the results showed that the quality was not acceptable. The medical physics team, radiologists, and radiographers reviewed the scan ranges and the parameters of the imaging protocols were adjusted in order to provide higher quality diagnostic images at the lowest possible dose.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a new 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. We asked 14 staff in outpatients to explain their understanding of the duty of candour. Nine of these staff were not able to explain what was meant by 'duty of candour'. When prompted they understood the need to be open in their approach to the investigation of incidents. There was no duty of candour training offered to radiology staff.

Cleanliness, infection control and hygiene

- Cleanliness in the outpatient departments scored highly in environmental audits carried out by the trust. Environmental audits for the period from September 2014 to August 2015 gave a percentage score to indicate the level of cleanliness of that location. The overall average for the twelve-month period were as follows:
  - clinical measurements service 93.9%,
  - West of England Eye Unit 94.8%
  - nuclear medicine 96.1%, x-ray 94.5%,
  - surgical outpatients at 97%, ophthalmic outpatients 92.3%,
  - medical outpatients 95.9%,
  - gynaecology and women's health 97.9% and 98.4%.
- We found inconsistencies in the standard of cleaning. Healthcare assistants showed us the cleaning schedules they completed in the outpatient clinics. In surgical outpatients, these room cleaning rotas were not consistently completed. One area not completed was wall-mounted fans, which a member of staff explained could not be cleaned because no one could reach them, the estates team were sometimes asked to clean the fans but this was not part of a regular schedule. In the orthopaedic outpatient clinic, we saw boxes and equipment were stored on the floor of a storage room and this meant that the floor could not be cleaned thoroughly.
- Audits indicated varied compliance with hand hygiene standards across the outpatient service. The most recent hand hygiene audits showed these results:
  - In May 2015The West of England eye unit was 88%, Fracture clinic 83%,dermatology 95% and Ear nose, and throat 100%
  - In July 2015 Endoscopy 61%
  - In August 2015 Princess Elizabeth Orthopaedic centre 79%.

- Within each department, results of hand hygiene audits fluctuated from month to month. The best results were seen in maxillofacial and surgical outpatients, which had seen an average of 96% over the last three recordings, the most recent being 100% in June 2015. The worst performing teams were in endoscopy and orthopaedic outpatients. Scores in the orthopaedic outpatient's department scores had dipped to 47% in June 2015. Recordings in the endoscopy department had also dropped by 31% since the previous audit. To address this, the endoscopy department had support from the infection control team and had trained three auditors, who monitored the department practices over a month period as opposed to doing a snap shot audit. The department was also completing weekly audits and the matron met with any staff identified as not being compliant. New hand hygiene posters had been put up.
- In medical outpatients, the staff nurse gave out cards for patients to observe and record staff hand-washing and record. The last audit of this kind was completed in September 2015 and a score of 75% compliance was achieved. The medical outpatient's teams were working with the infection control nurse specialist to complete a validation audit and further monitoring of staff working in the clinics.
- There were systems in place to protect patients from the risk of a healthcare associated infection. If staff knew from previous clinic, appointments that the patient had a communicable infection, they gave the patient an appointment slot at the end of the clinic. If the staff did not know whether, the patient had an infection prior to the patient arriving in clinic, the patient would be seen in a room removed from clinic and housekeeping would clean the room directly after use. The endoscopy unit and the eye unit screened patients for the methicillin resistant staphylococcus aureus infection prior to attending for procedures in hospital.

Environment and equipment

- There were inconsistencies in the assurance processes for maintenance of equipment in outpatients departments. We saw two automatic spyhgmometers in the orthopaedic outpatient clinic, which were overdue their safety check with tests due in February 2014 and December 2014. Two fans attached to the wall of a clinic room were due for their electrical test in March 2015. In the fracture clinic, a freestanding fan in a clinic room was due for testing in May 2014. In ophthalmology, a piece of equipment used to test for glaucoma was due for testing in July 2014. As a result of our pre-inspection enquiries, the trust acknowledged that further assurances were needed around the monitoring of maintenance checks for equipment.
- Storage of substances hazardous to health was not consistently monitored. In the fracture clinic, items such as hand sanitising gel, 'chlor clean' tablets, floor cleaner were stored in an unlocked room opposite an examination room.
- Staff had access to advice from the trust health and safety risk officer. Each department had a local risk assessor who was responsible for completing risk assessments of their clinical environment and sharing these with the team.
- Resuscitation equipment was readily available in the outpatient clinics. We checked the resuscitation trollies in all departments we visited and all the equipment and medicines were stocked and in date and staff regularly checked the suction machines. The trollies were accessible and staff knew where they were stored.
- Endoscopes used in the maxilla facial clinics could be traced to individual patients. Data recorded the length of time scopes were stored in the cabinet to ensure they were used within the timescales they remained sterile.
- Staff confidence in moving and handling techniques varied within the outpatient's service. Staff in outpatients departments borrowed moving and handling equipment from the wards when required. One member of staff told us that they were not using safe moving and handling procedures because they did not have adequate equipment available to them. However, we did not observe evidence of this during our inspection. In surgical outpatients, there was a hoist available which staff were trained to use. Standard operating procedures were attached to the hoist. Staff in the rheumatology clinic told us that they were not confident to use a pat slide or a hoist and would have to ask ward staff to help if a patient needed to be hoisted Staff in the fracture clinic felt confident to use moving and handling equipment.
- There was an adequate system for checking the safety of radiology equipment. The lead clinical technologist managed this system. Engineers employed by the trust maintained and serviced all the radiology equipment. The manufacturers of the specific equipment provided the training for these engineers

- There was a rolling programme of replacement of clinical equipment in the diagnostics service. If the team assessed a piece of equipment as at high risk of breakdown or was aging, this was prioritised for replacement however due to consistent and robust quality assurance no radiological equipment was unsafe for clinical use. Recently the trust had purchased a new ultrasound machine for the fertility clinic and a specialist dental computer tomography scanner for the emergency department.

Medicines

- In some clinics, medicines were stored safely. In the ophthalmology and surgical outpatient clinics, medicines were stored in a refrigerator and nurses checked the temperature of this refrigerator twice daily. These temperatures were recorded as within an acceptable range.
- However, we saw that the system for recording expiry dates of opened liquid medicines was not reliable in some outpatient clinics. In ophthalmology, a bottle of sodium chloride had been opened but the date of opening had not been logged.
- The storage of medicines in the ophthalmology clinic was compromised by a lack of space. In the 'clean utility' room, we saw several items stored such as training files, wrapping paper along with boxes of swabs stored on the floor and clinical dressings stored on the top shelf. The emergency box for patients experiencing a hypoglycaemic episode was stored beneath files and was not easily visible or accessible. In a room used to dress patient's wounds in the orthopaedic outpatient clinic, dressings were stored on the floor underneath shelving

Records

- Patient records were not consistently stored securely in outpatients departments. In the diabetic centre, we saw patient records stored on an open trolley opposite near to patient toilet facilities. This meant that the records were easily accessible to people who were not authorised to read them. In the orthopaedic clinic and the medical outpatients' clinic, patient records were left unattended on the front desk that was easily accessible to patients and unauthorised staff. In the orthopaedic outpatient clinic, we saw information slips left in a wooden box outside the x-ray room in a public corridor. The slips contained information that identified patients including names and addresses and information regarding what sort of x-ray they were having. In ophthalmology, patient records were left outside of a clinic room, on a wheeled table within arms-reach of a patient who was waiting to go into another room. In the fracture clinic, patient records were stored in unlocked trolleys. At the fracture clinic reception, a set of patient records was left on the ledge of the hatch to reception with patient identifiable information showing for five minutes, a patient was stood beside the notes for this time. In orthopaedic outpatients, patient-identifiable pre-operative swabs had been left on a worktop in an unlocked room that was easily accessible to the public.
- In radiology, storage of patient records was well controlled. Confidential information about patients was stored securely on two electronic record systems that were password protected.
- There was a reliable system for ensuring that patient records were available for clinics. The health records service was operational 24 hours per day seven days per week. Records staff responded to an emergency phone line when records were required urgently, for example for unplanned admissions. For routine appointments, the process of preparing health records for clinics commenced eight days before the appointment date. This process was delayed intentionally until eight days before the appointment to ensure that time was not wasted if patient cancelled their appointment. Preparing the records involved locating the records, collating all the referral information and ensuring all paperwork was securely inserted in the correct order. Records staff carried out spot check audits of the contents of notes prepared for clinics in November 2014 and only minimal items were missing such as patient identification stickers or additional copies of paperwork.
- The records team ensured that patient files did not become oversized. If a patient, had a particularly large folder of medical notes, records staff split those notes to make them more manageable for staff to access, and included a contents page to help staff to navigate between folders.
- There was a system in place to ensure up to date information was available to clinicians if the medical records were not available. When patients were due to attend more than one clinic in different locations on the same day, records staff made a temporary set of records. When patients had not attended a clinic in over four years, a new set of notes were prepared and the

previous notes were stored electronically on a system that staff could access if necessary. Staff knew how to access this system in the rare event that notes were not available for clinic.

- In August 2015, the trust completed an audit of the availability of medical records. This audit confirmed that 99.9% of case notes were available for outpatient clinic appointments. Records staff delivered the patient records to the reception desk of each outpatient department by health record staff, the receptionist signed for each record and volunteer staff brought the notes to the relevant clinic within the department.
- The content of patient records was complete and up to date. A clinic letter audit carried out during our inspection demonstrated that 95% of clinic letters were printed within ten days. This information was collected manually and shared within divisions on a weekly basis.
- We reviewed eleven sets of medical records of patients who had recently been seen in medical, obstetrics and gynaecology, neurology, gastroenterology, maxilla facial, dermatology and colorectal outpatient clinics. All of these patient records were accurate, legible and information was easily located because the contents were filed appropriately and well secured within the folder. A stamp system detailed when a patient was seen, which member of staff saw patients, and who chaperoned that patient. We looked at five sets of notes of patient's seen in the obstetrics and gynaecology outpatient clinic. All of these notes had a malnutrition risk assessment completed correctly and all notes contained a stamp requiring staff to fill in when they had asked the patient about domestic abuse.

Safeguarding

- Staff we spoke with were aware of how to report a safeguarding concern. The telephone number was easily accessible being printed on the back of staff identification badge. Staff in the maxillofacial and ophthalmology clinic carried a credit card sized guide containing instructions for dealing with a safeguarding concern. Once per year, staff received a leaflet attached to their payslips giving basic information about raising a safeguarding concern. Junior staff told us they would pass on any concerns to a qualified staff member. One member of staff gave an example of an elderly man who had come to clinic with no shoes, unkempt and cold to touch. She raised concerns to the registrar who assessed the patient, arranged for the patient to be admitted because he was undernourished and then contacted social services to raise a safeguarding alert.
- Some teams were focussed on keeping people safe from domestic abuse. Staff in gynaecology clinics were all trained to observe for signs of abuse when helping patients to undress. In the obstetrics and gynaecology outpatient clinics, patients were seen on their own for their first appointment and asked if they had any concerns about being safe. Nurses repeated this question at pre-operative assessment and on admission. In December 2014, this process was the subject of an audit that identified that only 40% of patients were asked these questions. As a result, the teams introduced measures to improve their compliance including using team meetings to reinforce the importance of the question at team meetings and removal of old paperwork that did not include a prompt for this question. The teams were re-audited in March 2015, and the results indicated 75% compliance.

Mandatory training

- The trust was unable to provide data regarding the mandatory training compliance of specific outpatient departments, with the exception of surgery and gynaecology. This was due to the staffing structure used in the outpatient service, which employed staff who were primarily based within the inpatient services. The data provided showed good compliance with mandatory training. Although data for the gynaecology outpatient service did not refer to falls prevention or conflict resolution training, there was 100% compliance in seven of the thirteen courses listed. Moving and handling training was the only outlier with an average of 86% staff having completed this course. In surgical outpatients, there was 100% compliance in ten of the fifteen courses listed, with an overall average of 98.4% staff up to date with their training with no outliers.
- Some data on training attendance was available from the notice boards called 'com cells' which were used to display important information for staff teams. In orthopaedic outpatients, 16 staff were between 85 and 100% compliant with mandatory training. In ophthalmology, 11 out of 25 staff were not up to date with moving and handling training, 5 out of 25 staff were not up to date with fire training. In radiology, staff mandatory training was up to date which included

dementia, safeguarding, learning disabilities, and mental capacity act training. To address these shortfalls the matrons were using the 'comm cell' meetings to emphasise the importance of mandatory training and to highlight the training requirements of individual staff.

- In therapy services, the overall average compliance with mandatory training was 96% for occupational therapy and 97.1% for physiotherapy. However, there were some gaps evident. Compliance with domestic abuse training was 61.4% for occupational therapy and 68.2% for physiotherapy, but it was acknowledged that this was a new training requirement and more sessions had been planned to meet staff requirements. Compliance with conflict resolution training was 86.5% for physiotherapy.

Assessing and responding to patient risk

- It was trust policy that nursing staff did not routinely carry out physiological observations, vital signs, for every patient attending outpatient services. If a patient was recognised as being unwell, staff told us they would complete a full set of observations and calculate an 'early warning score 'if they were competent to do so. Depending on the patient's condition, this could lead to escalation to the medical team in the department, the Medical Emergency Team or if the patient were stable but needing urgent attention, nurses would transfer the patient to the Emergency Department.
- Staff in outpatients used a system of early warning scores to help them to determine if a patient was likely to rapidly become unwell. In surgical outpatients, all clinical staff were trained in how to calculate early warning scores for patients who were displaying symptoms of deterioration. In the fracture clinic, staff were not trained to calculate early warning scores but felt confident to ask the doctors to review any patients for whom they had a concern. In medical outpatients, band 2 staff were competent to take observations of patients but they felt they were not skilled to interpret those results. Identification of patients at risk of deterioration required the staff member to feedback their concern to the doctor in clinic or to the nurse on the ward. In the diabetic centre, a technician noticed that a patient was presenting with warning signs of a detached retina, this was discussed with senior staff, images of her eye were taken and reported on, and a diagnosis of retinal detachment was confirmed. Immediately a referral letter was written and a telephone call made to the emergency department to inform them that the patient was on their way.
- Radiology staff were required to comply with the Ionising Radiation (Medical Exposure) Regulations 2000 (IR (ME) R). These regulations ensure the health protection of patients who are exposed to radiation during diagnostic procedures. The regulations require that employers set out written protocols that staff must follow in order to keep patients safe during treatment. In the diagnostics service, these documents formed an essential part of the governance framework. All clinical staff we spoke with were aware of how to access these documents. Exposure charts were displayed in each room as well as being pre-programmed on the equipment
- In radiology, there is a legal requirement for the staff to follow 'local rules' which are a set of guidelines under Ionising Radiation Regulations 1999 that protect staff and members of the public from the dangers of radiation. Staff in radiology were familiar with these documents, which were securely stored in the department.
- The radiology policies and procedures in radiology were in the process of review. The managers used the electronic quality management system to alert staff to new policies and updated procedures. Radiology staff were able to locate these documents. Managers ensured that only the latest version was available to staff. This was important because it meant that staff used only the most up to date guidelines for radiology.
- All the teams in radiology had a radiation protection supervisor appointed under the Ionising Radiation Regulations 1999, who advised staff about radiation protection in their areas. The radiation protection supervisor also helped the staff to comply with the requirements of the Ionising Radiation (Medical Exposure) regulations 2000. These regulations outline important safeguards for keeping patients safe when they are being cared for in the radiology department.
- In radiology, patient waiting areas were well lit and well signposted, these signposts informed patients about areas where radiation exposure took place. There was clear floor signage to each area that was coded by colour and symbol. This helped patients to find their way safely around the department.

- Staff in radiology ensured that core safety checks were completed before patients were imaged in the interventional radiology rooms and in computer tomography intervention. They did this using an interventional radiology checklist adapted from the World Health Organisation surgical safety checklist. An audit of the use of the checklist indicated 100% compliance over a one-month period. This checklist allowed for safety checks including correct patient, correct timing and correct laterality as well as all IR(ME)R requirements including pregnancy status of females.

Nursing staffing

- Specific staffing data for outpatients departments was not available because staff were shared between the ward and outpatient locations. Staffing on the wards had increased since August 2014 from 1385 registered nurses in August 2014 to 1492 in August 2015; 718 unregistered nurses in August 2014 to 837 in August 2015. Staff in most outpatient services told us they had sufficient staff to cover the workload. However, this was not the case in gastroenterology and there had also been significant capacity challenges in ophthalmology related to staff sickness and turnover. The resulting vacancies equated to a loss of 305 patient appointments per week. This had resulted in a potential increased risk to patients requiring macular review.
- Nursing staffing requirements were calculated six weeks in advance based upon the number of clinics occurring each day. We saw that this method of planning staffing was not reliable in all clinics, particularly gastroenterology. During our inspection, staff from other clinics told us that staff in the gastroenterology clinics often struggled to cover the requirements of supporting patients, chaperoning and running the administration of the clinics.
- We checked staff rotas for gastroenterology clinics. These rotas did not specify the recommended versus actual numbers of staff required to cover the clinics. The following examples illustrate that there were times when one member of staff was solely responsible for high numbers of patients: on 26 October 2015, one nurse was responsible for 41 patients in four different clinic rooms, on; on 22 September 2015, one nurse was responsible for 31 patients in three clinic rooms, on 23 September, one nurse was responsible for 29 patients in three clinic rooms.; on 10 September 2015, one nurse was responsible for 28 patients in three clinic rooms. On seven other occasions during October 2015, one nurse was responsible for more than 20 patients.
- We were informed by the trust that these staffing challenges had been resolved, however, on the morning we visited the gastroenterology clinic, we saw that one bank nurse had been asked to cover three clinics with 30 patients in one morning, fourteen of which were female and all three doctors were male. This nurse did not have experience of managing the clinic and was not familiar with the booking system or the system for accessing support, for example to cover chaperoning duties. The bank nurse tried repeatedly to access support from the ward staff, a member of staff from the ward was sent to help approximately 45 minutes after clinic had started. The trust did not audit the availability of chaperones in outpatient's clinics.
- In other teams, staffing was more effectively planned. For the gynaecology clinic, there was always one clinic coordinator and a nurse chaperone for each doctor. In ophthalmology, two staff knew in advance that they were the identified team members who would stay behind with patients if clinics overran as they frequently did. The breast care team meet weekly with radiography manager to look at peaks and troughs in demand over the following eight weeks and allocate staff to cover clinics.
- Use of agency or bank staff varied across the divisions. In the Princess Elizabeth Orthopaedic Unit outpatients department, lowest use was in May 2015 recorded as 2.1%, and the highest use was recorded in September 2014 at 7.7%. In surgical outpatients, the lowest use was recorded at 3.4% in May 2014, rising to 15.3% in May 2015. In gynaecology and women's health, lowest use was 0% in May 2014 but had risen to 4.1% in February 2015. In the fracture clinic, the lowest use was recorded at 0% but had risen to 10% in March 2015. Agency staff were not used on surgical outpatients. Bank staff were readily available and these staff regularly offered to work.
- Vacancies were affecting the workload of the staff responsible for booking patient appointments. Delays in the induction process had delayed the start dates of new employees, for example, booking managers had interviewed for a member of staff in August 2015, but the new employee had not been able to start until the end of November 2015.

Outpatients and diagnostic imaging

Medical and other professional staffing

- In the diagnostics service, staffing levels and skill mix were not sufficient to provide adequate medical physics expert cover. Following an internal work force review and the recent vacancy for a trust radiation protection advisor (RPA), a service level agreement was established with a neighbouring trust for the provision of radiation protection advice. This contract was limited to provision of advice under the ionising radiation regulations. It did not include the additional medical physics expert advice required under the IR (ME) R regulations. The medical physics cover was provided one day a week by the head of radiation protection at a neighbouring trust with additional support from their Radiation Waste Advisor. Teams could access additional advice on an ad hoc basis as required.
- A member of staff had been temporarily contracted to provide cover for the provision of medical physics expert advice in nuclear medicine and they provided medical physics expert cover in plain film, and fluoroscopy. An experienced and senior medical physics clinical technologist had sustained all routine quality assurance activities on the radiological equipment.
- A newly qualified clinical scientist was in post, however, this member of staff was too inexperienced to undertake much of the cover that was required, and there remained no cover for medical physics expert advice in symptomatic breast screening, cardiology, computer tomography, and interventional radiology despite vacant posts being advertised. The medical physics expert is a necessary requirement under IR (ME) R and is involved as appropriate for consultation on optimisation, including patient dosimetry and quality assurance, and to give advice on matters relating to radiation protection concerning medical exposures, in all other radiological practice. The understaffing for medical physics support affected their capacity to commission new radiology equipment and there was no capacity to cover staff sickness or periods of extended leave.
- An experienced and senior medical physics clinical technologist sustained all routine quality assurance activities on the radiological equipment. An external review of radiation protection services at Exeter was commissioned by the trust in December 2014. This made a number of recommendations in regards to the understaffing of the service including the lack of medical physics expert cover including the need for a review of staffing levels, the reinstatement of the post of the head of diagnostic radiology physics and the introduction of traineeships for medical physics. Despite a recent recruitment drive, the gaps in medical physics cover for essential services remained and this risk had been escalated to the board.
- Staffing levels in radiology was safe. There had been a recent workforce review and skill mix requirements identified to ensure the department was staffed according to needs at any given time. There was a radiologist available for all specialities including paediatrics. There was a low sickness and staff turnover rate within radiology. There was a low use of agency staff and the department utilised the in-house bank service when required. All agency staff underwent a local induction and had received training on the use of the equipment but were not allowed to work out of hours. At the time of the inspection no agency staff were employed.
- The radiologist consultant rota was fully staffed and consultant led support was available 24 hours per day, seven days per week. The rota covered all specialities with nine radiologists sharing the workload. In addition to this there was interventional radiology support shared with a neighbouring hospital. The radiology registrars were in the process of undergoing a workforce and banding review. This was proactively focussing on ensuring radiologists were available to cover colleagues workload following on-call work.
- Radiographers were able to examine patients without interruptions because the department employed 21 imaging assistants, working across all types of imaging services. The imaging assistants we spoke to were highly knowledgeable about the areas where they were worked. They acted as coordinators for clinical lists; they prepared patients for examinations and dealt with enquiries and emergency referrals.
- In ophthalmology, the team was trialling a new way of working to improve clinic-waiting times. Three junior doctors completed the consultations but a supernumerary consultant was available in the clinic, sharing his time between these doctors according to the complexity of needs presented by the patients. The clinic was able to accommodate more patients and junior doctors had an opportunity to develop their skills and benefit from teaching.

Outpatients and diagnostic imaging

- In cardiology, there was sufficient medical staff to meet the current demand but in response to the anticipated future increase in demand for cardiology services the trust were proactively recruiting for a consultant. In the fracture clinic, the consultant told us that medical staffing was sufficient to meet the needs of patients.

Major incident awareness and training

- Matrons from outpatient teams were aware of their team's role in a major incident. However, there had not been recent training or exercises to practice this. In surgical outpatients, a grab bag was available for staff to collect and this was kept in matron's office and checked weekly.
- Staff on surgical outpatients were aware of a contingency plan for managing endoscopes if the power supply was disrupted or if paper records were misplaced.
- A major incident policy for radiology existed and was in the process of review. The radiology major incident plan was practised annually.

Are outpatient and diagnostic imaging services effective?

We did not give a rating to the effectiveness of the outpatients and diagnostic imaging services.

We saw that some aspects of care in the outpatient's service were not effective. Clinical supervision was not offered to nursing staff. All of the nursing staff we spoke with told us that they did not participate in one to one clinical supervision. This affected upon patient care because it meant that staff were not regularly reflecting on their performance in terms of the quality of care given to patients. Therapy staff were participating in supervision but the frequency of this was not audited.

The radiology department had adopted national diagnostic reference levels, which are a necessary requirement under IR (ME) R. However, at the time of the inspection radiology did not demonstrate a regular dose audit programme, which would allow them to adopt local diagnostic reference levels, this in turn would better reflect local practice and allow for further optimisation of medical exposures. This was in part due to the understaffing in medical physics.

There was evidence of effective practice in radiology. Referrers to the radiology department were encouraged to use an evidence based referral system, which was written in conjunction with the Royal College of Radiologists. The radiology service held accreditation with the Imaging Services Accreditation Scheme.

There was less evidence of effective practice in the outpatient's service. Staff completed thorough assessments of pain using pain tools. However, the staff in the orthopaedic outpatients department were not completing malnutrition screenings because they were unable to access equipment to take patients height and weight. Outpatient services had responded to increased demand by offering extended hours on certain days, and occasional clinics on Saturdays. However, none of the outpatient clinics offered a seven-day service.

The outpatient services were auditing the quality of service offered. The teams participated in peer reviews using the trust designed 'outpatient quality assessment tool'. Therapy teams made excellent use of outcome measures to evaluate individual patient progress and to demonstrate the effectiveness of the therapy service.

Evidence-based care and treatment

- In radiology, there is a legal requirement for a regular programme of review of the x-ray doses given to patients. This is called a 'dose audit'. The aim of the review is to monitor and revise the doses to keep them as low as reasonably practicable. This review system was not in place at the trust due to issues with the provision of medical physics cover. An external review of radiation protection services was commissioned by the trust in December 2014. Managers in radiology were aware that this review had recommended the need to implement a 'dose audit' programme especially in teams where patients received high doses of radiation. Managers informed us at the time of the inspection that this would be a priority for them once the medical physics workforce became more stable.
- The interventional radiology team had reviewed the doses of radiation given to patients and there was a skin dose policy that staff were able to use to monitor and reduce the potential for patients to develop skin erythema following examinations. The policy required that all examinations that reached a threshold for radiation dose were reported to medical physics for a specific assessment of the dose given. The patients'

notes were required to include details of the dose and any side effects experienced by the patient. On the day of our inspection, no examinations reached this threshold.

- Radiology services have a legal requirement to adopt 'diagnostic reference levels', the radiology department had adopted national reference levels but at the time of the inspection did not have a locally derived set. It is acceptable to adopt the national reference doses. However, a local set enables local practice to be reflected and is considered best practice.
- The trust followed clinical pathways that set timelines for radiology procedures for patients who had had a stroke. This pathway ensured that requests for scans were authorised rapidly. Patients who required a three-dimensional scan were seen within the recommended timeframe.
- The radiology team encouraged referrers to use the 'I-refer' system. This system was an electronic guide which included evidence based criteria for selecting investigations. Referrers were able to receive feedback if their request was not deemed appropriate
- Matrons and nursing staff in outpatient teams were unable to identify how the care given to patients was guided by evidence or best practice such as recommended in guidelines produced by the National Institute for Health and Care Excellence

Pain relief

- Staff in the ear, nose, and throat service asked patients to describe their pain using a scale that incorporated a picture, number and word based description of pain. Staff told us that the pictures of sad and happy faces were useful when asking children to describe their pain.
- Staff in the fracture clinic described the factors they would consider when assessing a patients pain. The plaster technicians were aware that pain might indicate complications such as an immobilisation device not fitting or the possibility of infection occurring. The consultant described pain as an important factor in diagnosing patients and he emphasised the need for a holistic approach when considering a patients pain

Patient outcomes

- The outpatient's service did not routinely gather data regarding the outcomes of the consultations that patients received. However, the trust gathered data regarding the quality of the service offered to outpatients using an internal peer review clinical quality assessment exercise. This assessment that looked at a wide range of factors such as communication, infection control, pain management, respect and dignity, self-care, safe environment, mental health and record keeping. This quality assessment tool had been specifically adapted for use in outpatients and all teams had participated in the process the outcome led to a bronze, silver, or gold rating. Teams were re-audited between two and six months later according to the level of risk as identified in the rating previously obtained. Medical outpatients, orthopaedic outpatients, and x-ray achieved bronze standard, ear nose and throat, maxilla facial, surgical outpatients, ophthalmology, and oncology achieved silver standard. The results of these assessments were communicated to the patient experience committee in September 2015.
- Low scores would indicate that aspects of the patient journey required improvement and the trust re-assessed these services at more frequent interval to determine if improvements had occurred. Specific results from these quality assessments highlighted areas for improvement. In September 2015, the percentage scores for medical outpatients were 53% for patient care, and 81.2% for staffing. The plan to address this included communication with teams using the communication book to emphasise the importance of several issues, such as infection control, allocation of a specific infection control nurse, a senior nurse to monitor compliance with cleaning and safety checks of equipment and the assessment identified a lack of a safety briefing at the start of the outpatient clinic, and this was highlighted as requiring further consideration at divisional level as there was no band 6 or 7 member of staff to lead these meetings. The orthopaedic outpatients department scored 63% for documentation and 69% for patient care.
- The Imaging Services Accreditation scheme is a patient-focused assessment and accreditation programme that is designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments. The radiology department was accredited by this scheme in 2013. At the time of our inspection, the trust was undertaking a review across all of the standards as part of re-accreditation.

Outpatients and diagnostic imaging

- The Royal College of Pathology Survey audited the satisfaction of users of the pathology service during August to October 2015. This survey rated the phlebotomy service in second place out of 64 hospitals. Overall, 97.5% of users of the pathology service said they would recommend it; this placed the trust 24th out of 64 hospitals.
- The trust had participated in the National Cancer Patient Survey in 2014. In haematology, 98% of patients had rated their care as excellent or very good. The haematology service scored higher than the national average for three categories; 74% of patients felt that the hospital and community staff worked well together, 93% of patients felt they were given the right amount of information and 89% of patients felt they were not treated like a set of cancer symptoms. However only 17% of patients were given a written care plan compared to a national average of 24% of patients The trust were addressing this in a number of ways including the development of end of treatment care plans. In the urology cancer service, shortfalls identified in the audit centred on access to information for patients and access to the cancer nurse specialists. The action plan to address these issues had been completed.
- The therapy teams used seven different outcome measures to indicate changes in patients' well-being, perceptions of disability, ability to complete personal functional tasks, fear of movement and general physical ability. Managers used the 'comm cell' to communicate the data from these outcome measures on a monthly basis. Therapists also reported daily the reasons why patients had not been seen. Outcome measures for therapy demonstrated that 93% of musculoskeletal therapy patients improved following completion of treatment, 88% of lower limb patients, and 91% of upper limb patients showed a significant functional improvement. In women's health, 74% of patients improved to some degree. In the respiratory service, 100% of patients demonstrated a significant improvement. In pulmonary rehabilitation, 54% of patients showed an improvement in their breathlessness, 61% demonstrated an improvement in their fatigue, 91% described an improvement in their emotional well-being, and 65% demonstrated an improvement in their management of their condition and 81% showed an improvement in mobility.

Competent staff

- All staff we spoke with told us that they had had an appraisal. In therapy services, 91.7% of occupational therapists had received an appraisal, and 97% of physiotherapists. All radiologists had job plans, which were reviewed five years ago. All staff in radiology had a recent appraisal
- The trust did not have a clinical supervision policy for staff working in the outpatients service. The trust informed us that there were forums available for reflection on practice. However, the 17 staff we spoke with did not identify these as forums they used and without a policy, the trust could not audit the effectiveness of these as a strategy to fulfil supervision requirements as recommended in guidelines published by the Care Quality Commission. The exception was the specialist nurses in breast care who received one to one supervision one week in seven from a clinical psychologist. Occupational therapy and physiotherapy staff did receive one to one supervision but the frequency of this was not recorded or monitored
- We looked at a sample of training records across all grades in radiology and all operators had been trained on the equipment they operated with specific competencies relevant to their service, such as x-ray, ultrasound. There was a preceptorship scheme for new members of staff and they were supported and integrated into the department, this extended to agency and locum staff
- In radiology, staff were encouraged to complete learning projects to meet their continuing professional development requirement. Radiologists carried out audits and presentations for peers and also for radiographers at staff meetings
- In radiology, there was a student supervision policy in place which was specific to each year of training and related to the clinical assessments that they had undertaken and been signed off as competent. Specialist practitioners in radiology were trained in the radiology department. Trainees were part of the Peninsula Radiology Academy. They were supported by consultants and gained a wide range of access to all imaging specialities
- Clinical radiology staff demonstrated a sound understanding of the radiation regulations and were aware of their legal duties. Radiology staff had a sound knowledge of the procedures relevant to their

department and had good awareness of the guidelines they must use to monitor the dose of radiation given to patients including the national 'diagnostic reference levels' that have been adopted locally.

- Band 2 nursing staff completed a two-week induction process known as the 'apprentice scheme'. This covered a range of knowledge and practical skills required for the role including for example, infection control, tissue viability, comfort rounding. Some band 2 staff and health care assistants had participated in additional training to extend their competencies. The band 2 nursing staff member from the respiratory team was trained to complete spirometry for outpatients and on the respiratory wards. Band 2 nursing staff from the outpatient's service were encouraged to complete their National Vocational Qualification level 3. This had sometimes resulted in staff being promoted to band three dependent upon service requirements.
- New healthcare assistants completed a staff induction. A health care assistant in obstetrics and gynaecology outpatients had visited theatres in order to learn about the surgery that patients were having. They felt this helped them to talk to patients about their experiences. A healthcare assistant in the rheumatology clinic told us they had undertaken extended training for their role such as long-term oxygen assessment training and nebuliser therapy training. Band 2 and 3 nursing staff in medical outpatients oversaw the informal local induction of staff covering medical outpatients from other areas.
- In ophthalmology, staff rotated through outpatients, theatres, and inpatient teams to keep all skills updated. The matron acknowledged that she was unable to provide the clinical expertise to supervise and develop all the staff. Two clinical leads had been appointed and their role included this responsibility.
- There were two Administration of Radioactive Substances Advisory Committee (ARSAC) licence holders, one of whom was a consultant radiologist from Kings College Hospital in London. This member of staff worked at the trust for one day a week. For the rest of the week the ARSAC licence holder was available for telephone consultation and was able to report on scans remotely but this was hindered by slow speed of data transfer. The department had employed another clinician who was undertaking the diploma in nuclear medicine and may in future take on the ARSAC licence holder role.

Multidisciplinary working

- Medical staff from the diabetic centre, the ophthalmology, and the orthopaedic outpatient teams attended multidisciplinary meetings and reported that they found these useful. Radiology staff attended all multidisciplinary team meetings and cover was available for sickness and annual leave. In the diabetic centre, separate multidisciplinary meetings focussed on different patient needs such as obesity, insulin pumps, and thyroid problems. A consultant in orthopaedics told us they felt well supported by the multidisciplinary meetings. In orthopaedic outpatients, patients who presented with hip and knee problems had a full assessment including physiotherapy and occupational therapy
- In some specialities such as diabetes, maternity, urology, orthopaedics, obstetrics, and gynaecology there was a one-stop shop approach to patient's appointments. Patients were able to see the consultant and receive treatments on the same day. For example, the occupational therapist, the physiotherapist, the consultant and the plaster technician could see patients in the trauma and orthopaedic outpatient department, and if a patient required a blood transfusion that could also be arranged. In obstetrics and gynaecology, patients could have their scan, an ultrasound, talk to a clinician about their diagnosis on the same day, and leave the clinic with knowledge of the date of their operation. There was a dementia outpatient service. Patients were pre-booked into clinic and prior to being seen were sent for a head computer tomography scan. The images and report were then available on the same day when the patient attended the clinic.
- The interventional radiology team worked well with the multi-disciplinary team. We observed the radiographer and imaging assistant and nursing staff working together to coordinate the appointment list and prioritising additional referrals.
- We saw the 'comm cell' working effectively in radiology to facilitate communication between radiology porters, radiographers, nurses, in-house engineers and admin and clerical staff. The comm cell was used to raise concerns around service delivery issues as well as feedback results of audits and incidents. Through these meetings band seven staff were made aware of immediate staffing concerns. During the inspection we

witnessed a comm cell meeting in radiology where staff reported colleagues who had phoned in as sick and unavailable, and an engineer who requested clarity on fault-reporting on a piece of equipment
- The radiology department encouraged referrers to use the electronic guidelines for referral set out by the Royal College of Radiologists. This resulted in increased safety for patients because the guidelines helped referrers to work within established scopes of practice. There was no open access for GPs to refer to computer tomography and magnetic resonance imaging scans. The department management had taken the view that they would not be able to achieve targets for waiting times if they offered an open access service. However they explained they did accept 'reasonable' GP referrals for certain procedures
- Radiology was said to be well regarded by clinicians throughout the Trust and the assistant medical director stated that radiology were at the hub of all clinical pathways and decision-making. The radiology service had participated in an audit that looked at perceptions of radiology amongst the wider multidisciplinary team. The audit reported good feedback for report turnaround times, good feedback to GP's and other clinicians and useful clinical guidance given.
- The radiology department had a reliable system to ensure that patients did not wait too long for their test result or scan to be interpreted or reported on by a consultant. Local targets were consistently met. When there were over 100 outstanding reports, the clinical lead shared the workload between consultants to ensure patients did not wait too long. When it was not possible to bring reporting within local targets, additional funding was available to pay consultants to provide this service. Data provided by the trust indicated that the department was less efficient at prioritising the magnetic resonance imaging reporting for patients referred by their GP. Additional reporting capacity was being assessed in order to prevent this area becoming an on-going concern

Seven-day services

- The radiology service provided emergency cover across all specialities twenty-four hours per day, seven days per week. This included computerised tomography, magnetic resonance imaging, interventional radiology, and ultrasound.
- The radiology team staffed the static magnetic resonance imaging unit seven days a week from 8am until 8 pm. Radiology teams staffed the computer tomography service at weekends from 9am-5pm to reduce the urgent inpatient workload.
- The outpatient service operated from Monday to Friday. Sometimes extra clinics were scheduled on a Saturday to address an increase in demand in a particular speciality but this was not routine.

Access to information

- In radiology, staff used a radiology information system and a picture archiving and communication system to store and access patients' radiological images and records. These systems interfaced well with one another and with the main hospital information system and were available across the southwest. Staff could instantly access information about patients from anywhere in Devon and Cornwall and this meant that patient care was consistent and reports were readily accessible. GPs were not able to access these systems but reports were sent electronically back to GP surgeries.
- The radiology department regularly audited their reporting turnaround times. Local targets stated that inpatient and emergency department examinations were reported in less than 24 hours, GP referrals were reported in less than 48 hours (working days), and outpatient referrals were reported in less than 5 days. The departments aim was for targets to be met 90% of the time and audit figures over three years had showed that this target was never lower than 87% compliance.
- In outpatients, typing turnaround time was monitored. When we reviewed patient records, administrative staff had typed all letters within one week of their appointment and 50% of letters had been typed within 48 hours.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff in outpatients were aware of their responsibility to gain consent from patients. Nurses gained verbal consent and documented this in the patient record. In orthopaedic outpatients, doctors gained consent from patients using a different form for each specific surgery. In the fracture clinic, the consultant explained the method for assessing the mental capacity of a patient who was unable to consent and the process by which

the team would consider a best interests decision. We saw in patient records that nurses first gained consent from the patient before labelling the patient record to indicate special requirements such as hearing impairment, visual impairment, physical disability, falls risk
- Staff in therapy services were routinely asking patients for their consent. The therapy services had completed an audit of records and this indicated 99% compliance with documentation of consent.

Are outpatient and diagnostic imaging services caring?

Good

We rated the outpatients and diagnostic services to be good for caring. Staff encouraged patients to become involved in their care and took time to explain symptoms and conditions to patients. Managers, administrative staff, and nurses spoke of genuine empathy for patients attending the clinics.

However, there were improvements that could be made to the patient experience, particularly regarding privacy and dignity. Staff did not always maintain the privacy of patients attending clinics. The lack of rooms available in some outpatient clinics meant there were limited opportunities to offer emotional support to patients on a one to one basis.

Compassionate care

- We saw that nurses in the outpatients department paid attention to the experience of the patients attending clinics. If patients needed to go home on patient transport, clinic staff in the orthopaedic clinic prioritised appointment slots so that transport would not be delayed. We saw a nurse in surgical outpatients talking to the patients in the waiting room, explaining that the clinic was delayed, apologising, and checking if anyone had any specific concerns. If clinics were delayed, staff wrote the estimated delay on the whiteboard in the waiting room. We saw that staff in reception areas were courteous and friendly when talking to patients.
- In our interviews with senior staff responsible for meeting cancer targets, they communicated a clear sense of understanding of the pathway from the patient's perspective and showed compassion for patients whose treatment had been delayed. This was despite the necessary emphasis on the validation of data.
- Staff working in the records department felt they were able to make a difference to the patient experience. They stressed the importance of preparing patient records correctly and said, "The notes are our patients".
- In radiology, patients booking in at reception were treated with dignity and the clerical staff maintained the privacy of patients. In X-ray rooms, confidentiality was maintained and no patients were identified in public areas. Patients we spoke with told us that all the staff were friendly and informative.
- However, in several outpatient clinics we observed situations where the privacy of patients was not well maintained. We saw one patient sitting in the main corridor of the orthopaedic clinic in a hospital gown. In the fracture clinic, we observed a doctor explaining options for treatment to a patient whilst she sat in a public corridor. In medical outpatients, we saw two patients having consultations with nurses with the door wide open.
- Staff in phlebotomy admitted that they sometimes did not use the screen to separate patients who were having blood taken in the same clinic room.
- Staff in all outpatient clinics report that there were always staff available to chaperone patients in clinics, sometimes it was necessary to ask ward staff, or research nurses to cover this. One member of staff told us that it was not always possible for her to chaperone patients. The chaperone policy was not audited.

Understanding and involvement of patients and those close to them

- Staff in outpatients encouraged patients and their carers to become involved in the decisions about their care.
- Two patients told us they were able to understand their condition because the nurses had taken time to explain it to them. We observed a consultant explaining diagnosis and options for treatment and allowing time for the patient to ask questions. A patient told us that she usually saw the same doctor. In ophthalmology, the matron was in regular contact with a patient who felt unable to attend the busy ophthalmology clinic due to anxiety. She explained how staff often telephoned carers to find out the best way to support patients with specific needs.

Outpatients and diagnostic imaging

- Nurses tried to put patients at ease before and during consultations. Patients told us that nurses and doctors listened to them. In radiology, staff informed patients about their appointment, getting changed, what would happen during their examination and how to access results, and what to do if results appeared to be delayed

Emotional support

- Staff in the busy clinics offered emotional support when needed. In surgical outpatients, matron acknowledged the need to keep clinics flowing but had to balance this with patient's need for emotional support when they had received difficult news.
- In ophthalmology, patients could attend support groups run by the macular society and the ophthalmology team; however, there were no quiet or calm areas for patients to discuss concerns on an individual basis.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated the outpatients and diagnostic services as requires improvement for responsiveness.

Some patients experienced delays for cancer treatment. During 2014/2015, 115 patients had waited more than 62 days for their cancer treatment. The patients who waited longest for their first appointment were those who had a suspected tumour that was being treated by the urology, upper gastro intestinal and lower gastro intestinal specialties. However, patients waiting for subsequent anti-cancer medicine treatments were seen within the recommended timescales and all imaging for patients on a cancer pathway was completed within one week. There was a comprehensive remedial plan in place to reduce waiting times.

There were also delays for treatment in ophthalmology and orthopaedics. Rapid access clinics and extra clinics were scheduled to meet demand wherever possible. The teams had introduced creative ways to reduce the requirement for face-to-face consultations and therefore reduce the inconvenience for patients.

The clinic environments were not always planned to be responsive to patient's needs. For example in ophthalmology outpatients, the small size of the cubicles was too small to accommodate the vision aisle. There were no call bells in the patient changing rooms in the orthopaedic outpatient clinic and this was a risk to the safety of patients who may have required assistance. The waiting room facilities for children were sparse, and the systems for patients waiting whilst in the clinic were not designed for the convenience of patients.

The outpatient service had systems in place to identify patients with individual needs requiring special attention whilst in the clinic. Staff responded to these needs appropriately particularly those patients living with dementia. However, we saw that only limited adaptations had been made to accommodate the needs of people with sensory impairment.

Service planning and delivery to meet the needs of local people

- The environments of some clinics were not arranged to optimise the privacy and dignity of patients. In obstetrics and gynaecology outpatients, women who had a miscarriage shared the same waiting room as patients who were heavily pregnant. Staff told us this had led to some patient's feeling distressed. Staff had not reported these as incidents. The opportunity to offer emotional support to patients was challenging in the surgical outpatients clinic because the counselling room had been out of action for approximately four weeks due to building works. Staff tried where possible to find quiet areas to talk to patients but this was difficult when all rooms were utilised for consultations.
- The breast care team and services were not co-located resulting in patients having to walk down a long public corridor following mammograms, ultrasounds, and biopsies before they had been informed of their results. Since the removal of carpets in the clinic areas staff had recognised this affected privacy and had added extra insulation to the edge of clinic doors.
- The confined space of the phlebotomy clinic room compromised the privacy of patients and confidentiality of information. A risk assessment completed in January 2013 recommended that only one patient and one phlebotomist used the clinic room at any time. The phlebotomists told us that two phlebotomists and two patients frequently used the room concurrently. Access for patients, especially those using a wheelchair was limited and staff were at risk of injury from moving and

handling loads. In surgical outpatients, the waiting room furniture could be moved around to make space for wheelchairs but this required heavy moving and handling and there was limited space available when the waiting room was busy.

- In the orthopaedic clinic, patients used small changing rooms to undress. These rooms had no call bells. This meant that patients using these rooms could not alert staff if they needed help. In radiology, changing cubicles were easily accessible to the elderly and disabled. In medical outpatients and the fracture clinic, administrative staff checked patient demographics at reception; but this was audible to other patients in the queue. Nurses in orthopaedic outpatients recorded patient's height and weight measurements in the corridor, although a screen could be pulled around, the consultation was still easily heard by passers-by.
- Patients having vision tests in the ophthalmology outpatients department sat in very small curtained areas that were not long enough to accommodate the distance required for the test, this meant that patient's chairs pushed out past the line of the curtain and two patients were sat very close to each other with their chairs touching the dividing curtain. These curtains were ineffective at preserving privacy. The trust privacy and dignity policy stated that curtains should be floor to ceiling. In ophthalmology, patients had eye drops administered to their eyes behind a screen in a public corridor. A health and safety assessment of the West of England Eye Unit in February 2015 did not identify the lack of facilities to accommodate the privacy of patients.
- Flexible arrangements for patients parking at the hospital were inconsistent across the outpatient clinics. In the orthopaedic outpatient clinic, staff were able to arrange for excess parking charge to be disregarded if the clinic was running late or if the patient was unavoidably delayed. In the diabetic centre there were six parking spaces designated for patients. In obstetrics and gynaecology, nurses had been told not to contact the car-parking attendants if clinics overran. All patients were required to walk to the car park to update their ticket if it had expired regardless of their ability or condition or the weather conditions.
- None of the clinics we visited operated a pager system for patients waiting for an appointment in clinic. In the phlebotomy clinic and the ECG clinic, patients were required to sit in a queue in the corridor, moving up chairs as their turn came nearer. This meant that patients would lose their place in the queue if they needed to vacate their seat, for example to use toilets. Although it was acknowledged that a ticket system would be better for patients, this had not been actioned.
- In some clinics, facilities for children were adequate but in other settings, the waiting rooms did not meet the needs of children. In the maxilla-facial clinic, there was a large children's area with toys. In the orthopaedic clinic, children's play equipment was located in the corridor. In the obstetrics and gynaecology clinic, the children's area consisted of a small table with a toy and a fish tank. In the orthopaedic clinic, there was no separate waiting area for children, and staff explained that if breast-feeding mothers requested a private room, staff would show them to the disabled toilet/ infant changing station where no chair was available.
- There were adequate facilities for patients to meet their hydration and nutrition needs whilst awaiting appointments in clinic areas. In the diabetic centre, a hot drinks machine and chilled water dispenser was available. If clinics were delayed, staff could obtain snack boxes for patients. A café was available in the orthopaedic outpatients department
- The trust had identified 470 young people who would need transition services. The trust had appointed a transition nurse and set up a transition steering group to take this work forward. A training package had been identified for staff.
- Some clinics were using alternatives to face-to-face consultations to meet the needs of patient. In the diabetic centre, patients were able to email blood results to the consultant who then gave advice regarding how to manage their condition. The ophthalmology service was trialling a new arrangement. Patients attended the department for a scan. Consultants then looked at the scanned pictures and decided which patients needed to attend for injection and/or consultation. This meant that fewer patients needed to attend for face-to-face appointments with the consultant. Tele-dermatology was in use. This benefitted patients because they did not need to attend for a face-to-face consultation and this facilitated greater access to available appointments. During August 2015 to October 2015, an average of 80 patients per month was treated using this method.

Access and flow

Outpatients and diagnostic imaging

- Some patients were experiencing delays for their treatment. There is a national set of waiting time performance measures that are used to hold trusts to account for the length of time that patients with cancer wait to have treatment. These include the following 'pathways':
  - A maximum two-week wait to see a specialist for all patients referred with suspected cancer symptoms and for all patients referred for investigation of breast symptoms, even if cancer is not initially suspected.
  - a maximum 31-day wait from the date a decision to treat is made to the first treatment for all cancers;
  - a maximum 31-day wait for subsequent treatment such as surgery; radiotherapy or anti-cancer medicines (three separate pathways)
  - a maximum 62-day wait for the first treatment from the date of referral from an NHS cancer screening service, from urgent referral for suspected cancer or from a consultant's decision to upgrade the priority of the patient (three separate pathways)
- The trust was not consistently meeting these performance measures for all patients with cancer and had not met these targets since the spring of 2014. Performance was encouraging for those patients referred on to the two week pathway. During July, August and September 2015 the trust had achieved an average of 93% patients being seen within the two weeks. However, there had been 889 patients accepted onto the 31 day first treatment pathway; 61 of these patients waited more than 31 days for their treatment and this equated to a performance of 93.1% against the target of 96%. In the months of July, August and September 2015, there had been 476 patients referred onto the first treatment urgent GP referral pathway; 113 of these patients had waited longer than 62 days and this equated to a performance of 76% against the target of 85%. In the same period, there had been 294 patients accepted on to the pathway for subsequent surgical treatment; 41 patients who had waited longer than 31 days for subsequent surgical treatment, equating to a performance of 85.5% against the target of 94%.
- In some specialties, such as urology, lower gastro-intestinal, and upper gastro-intestinal, patients who required treatment for cancer waited longer than others.
- During July 2015 to September 2015, 52% of patients on the 62 day pathway for urology had waited longer than 62 days for their treatment. During the same period, 52% of patients on the 31 day subsequent surgery pathway for urology specialty had waited longer than 31 days. The 48% performance achieved by the trust during this time for the 62 day pathway was below the national 78% performance for this specialty during 2014/2015.
- During July 2015 to September 2015, 40% of patients on the 62 day pathway for lower gastrointestinal treatment had waited more than 62 days. The 60% performance achieved by the trust during this time was below the national 73% performance for 2014/2015.
- During July 2015 to September 2015, 26% of patients on the 62 day pathway for upper gastrointestinal specialty had waited more than 62 days for their treatment. There were no figures available to compare this with national averages at a speciality level.
- In contrast, only one patient referred onto the pathway for radiotherapy waited longer than 31 days for treatment. This equated to a performance of 99.7% against the target. Similarly, only one patient referred onto the pathway for anti-cancer medicine treatment waited longer than 31 days, equating to a performance of 99.7% against the target.
- In 2014/2015, 28 patients had waited longer than two weeks for investigation of breast symptoms. However, 27 of these patients had declined the appointment offered to them due to a range of reasons, which resulted in them waiting longer than the timescale required to meet the target. With patient choice factored out, the performance of this team was 99.9% against the target.
- In 2014, there were 893 patients who waited longer than two weeks for their first appointment, but 560 of these patients chose to wait longer than the first appointment offered to them.
- During 2014/2015, 115 patients had waited more than 62 days for their cancer treatment; ten of these delays were a result of patient choice. A lack of outpatient capacity was the reason for two of these. In urology, there had been 66 patients who had waited longer than 62 days for their cancer treatment; five of these were due to patient choice. In lower gastro-intestestinal medicine, 18 patients had waited longer than 62 days for their treatment for cancer; two of these delays were due to patient choice. In some specialities, the cause of the delay was shared with another trust. This was

evident in upper gastro-intestinal cancer patients, 20 of whom had waited longer than 62 days for treatment in 2014 but eight of these delays were shared with another trust.

- There were fast track clinics for all patients with cancer. Any patients on a cancer pathway who required imaging services were seen within one week. If a camera stopped working in nuclear medicine, patients were immediately contacted to rearrange and were transported to other venues for scans if they had already been injected or if their scan was urgent. Additional clinics on a Saturday were arranged to respond to fluctuating increase in demand. In urology, two urgent slots for fast tracked patients were reserved on each clinic. When extra clinics were needed to meet demand, this was constrained by availability of staff rather than financial resource. In cardiology, doctors were aware that one week in ten they were expected to work flexibly to meet urgent needs of patients. This included cover of two rapid access clinics and one emergency laboratory session.
- A comprehensive remedial action plan had been developed to address the shortfalls in response rates for patients diagnosed with cancer. The team developing the remedial plan had consulted with the NHS Elective Care Intensive Support Team to gain assurance of the validity and feasibility of the new timed pathway for cancer patients. Managers told us there had been a 28% increase in referrals to the 62-day pathway that had not been anticipated at a strategic level.
- The remedial plan was developed taking into account the planned public health programmes and anticipated future rise in demand. It included the following actions: recruitment of two specialist pathologists, review of the multidisciplinary meetings to ensure capacity to review required number of patients, a new cancer data tracking system, physical expansion of the infrastructure such as increased capacity for theatres and endoscopy. The plan also included liaison with the clinical commissioning group to ensure GP's give patients sufficient information to have a realistic expectation of the treatment on the gastro-intestinal pathway and the need for endoscopy.
- To address the delays for patients waiting for cancer treatment, the trust had invested in endoscopy facilities and theatres at Heavitree hospital to allow eight additional theatre sessions for urology and orthopaedics specialities per week. This was anticipated to build resilience into the system. These would be open in December 2015. The trust had already recruited additional gastroenterologists and nurse endoscopists who were covering extra clinics and these were all recurrent posts. Three pathologists had been recruited since November 2013. The cancer team were working with neighbouring hospitals to share knowledge and encourage collaboration.
- In September 2015, the ophthalmology service described a 'backlog' 821 patients waiting for a follow up ophthalmology appointment. In September 2015, there were 475 patients waiting to see the glaucoma nurse for a follow up appointment. During 2014/2015, the longest wait for ophthalmology had increased from seven to eleven months, with 41 patients waiting since 2014. Three patients had been identified as having experienced potential harm because of the delays for appointments. At the time of our inspection, we were informed that all the patients who had been waiting since 2014 had now been offered an appointment
- In some specialties, there was a delay for patients referred to community clinics. For example, there was a monthly colorectal clinic, so when a clinic was cancelled patients were required to wait at least a month. The next available clinic for the community colorectal service was February 2016.
- The length of time that patients were waiting to be seen once they had arrived in the clinic was not audited in any speciality. This was because the electronic patient administration system could not record this data.
- There were good examples of responsive care. Most patients were able to access appointments up to three months in advance through the 'choose and book' system, but there were sometimes delays in answering the telephone calls. Staff answering calls aimed to answer calls within five rings and if waiting time went beyond 3 minutes, the access team would inform the service manager. The booking teams received 3800 calls in October 2015. Of these calls, 468 patients waited five to ten minutes, 64 waited ten to fifteen minutes, and 20 patients waited 15-30 minutes. We spoke with five patients in radiology and they were very satisfied with the booking process and were impressed with the short waiting time for appointments.
- In the diabetes centre, patients could access an advice service 24 hours per day. New patients diagnosed with type one diabetes were seen in clinic within 24 hours and urgent referrals for endocrine disorders were seen within one week. Urgent referrals to gynaecology were

always seen within two weeks. Inpatients that needed a computer tomography for urgent reasons such as aspiration, drainage, or biopsy were booked into an open appointment slot that was available each morning. This list was overseen by a consultant and had ensured that patients could receive rapid treatment as required. The colorectal team had changed their process for management of referrals in response to an audit that identified many patients had been sent for unnecessary tests. Consultants screened all referrals daily and patients were allocated to an appropriate clinic or sent direct for testing such as endoscopy.

- Rates of non-attendance at outpatient clinics varied across divisions but were generally lower than the national average. During 2014, an average of 5% of patients did not attend for their outpatient appointment. With a low of 4.9% recorded in speciality, services outpatients and a high of 7.9% recorded in Medical outpatients during December 2014. For physiotherapy, the annual figure was 9.1%. The Devon Referral Support Service monitored whether referrals were appropriate. The access policy stated that if a patient did not attend an appointment or if they cancelled their appointment twice, they were discharged from the service and the GP was informed. In radiology, when patients did not attend for an appointment, their appointment slot was offered to another patient who had agreed to be contacted at short notice.
- The outpatients' service was responsive when the needs of a patient changed. If the patient contacted the bookings team to request an earlier appointment because their needs had changed, staff advised them to contact their GP who would then be responsible for informing the team of a change to the urgency of the referral. Consultants were responsible for grading of referrals and deciding how quickly patients needed to be seen. Administration staff told us that clinics were usually only cancelled due to sickness and if a clinic was cancelled within six weeks due to a planned reason, this had to be approved by the cluster manager. Following an outpatient appointment, clinical staff completed an outcome form that identified follow up care to be completed. Audits showed 100% compliance with completion of outcome forms within 24 hours.
- Musculoskeletal physiotherapy was carried out at Heavitree hospital, but there were 29,814 patients seen in physiotherapy outpatients on Wonford hospital during 2014/2015. Therapists aimed to triage all clinic referrals within 30 minutes of receipt, assess 95% urgent referrals within 10 working days of receipt of referral, and assess 95% of routine referrals within 8 weeks of receipt of referral. The average waiting time to see a physiotherapist in outpatients was 15 days; this data did not specify whether these were urgent or routine referrals.

Meeting people's individual needs

- The needs of patients with sensory impairment had not been comprehensively considered within the environments of the outpatient clinics. Patients who owned deaf or blind assisting dogs were encouraged to bring them to outpatient clinics. However, information displayed on notice boards did not conform to clear print guidelines and was not designed to be accessible for patients with a visual impairment, even within the ophthalmology clinic. Patient information leaflets were not readily available in large print or different languages but staff felt confident they could request these versions if needed.
- One member of staff told us how she paid attention to the needs of people with visual impairment by going to speak to them individually if clinics were running late. There was variable availability of hearing loops within clinics. A hearing loop was available at the medical outpatient clinic. There was no hearing loop at the ear nose and throat clinic. There was a hearing loop at the fracture clinic but there was no sign to inform patients that this was available.
- Clinical staff put patient alerts on to the patient record system. Every set of notes had 'Alert look inside' printed on the front to prompt staff to check for specific alerts. This system highlighted patients with visual impairment, hearing impairment, learning disability, and dementia. If patients were known to present a risk of violence, this was identified on their notes with an alert. For patients living with dementia, a forget me not alert symbol was indicated on their notes. Patients at risk of falls were not specifically identified. The matron of one department was not sure how this system worked, and a staff nurse in another department was not aware of this system. In the audit using the outpatient quality assessment tool completed 24 September 2015, staff in the orthopaedic outpatient clinic were not aware of the flagging process or the specific requirements identified by the system.

- Staff in clinics received the patient records approximately 12 hours before the start of clinic. This meant that unless the staff already knew those patients from a previous appointment, they would not be aware of alerts flagged on the notes before this point and therefore staff were not able to prepare in advance for new patients who may have had special requirements.
- Some outpatient teams made special efforts to adapt their approach to meet the needs of individual patients. These included the scheduling of theatres and rearranging of appointment times to ensure patients who may become stressed by waiting would not be delayed too long. In surgical outpatients, nurses used a 'hospital communication book' that contained information and pictures to support patients with communication difficulties.
- For patients living with dementia, staff in surgical outpatients encouraged patients to complete a 'hospital passport' that identified important information under headings such as things you need to know about me, things that are important to me and my likes and dislikes. Staff in the obstetrics and gynaecology outpatients used a booklet 'This is me' when working with patients who were living with dementia. Nurses gave carers of people living with dementia a small wallet sized card that identified them as a carer and gave permission for them to visit when required. For patients who were carers of people living with dementia, staff in the obstetrics and gynaecology clinics liaised with the local authority on their behalf to ensure care was available if a patient carer was admitted to hospital. Staff in ophthalmology outpatients explained how they would adapt their communication with a person living with dementia.
- For patients with learning disability, there were two learning disability nurses employed by the local mental health trust with honorary contracts with the trust. The learning disability lead contacted the individual clinics to inform them when a patient was due to attend and was sometimes able to attend clinic with the patient. In surgical outpatients, there was a patient information leaflet describing the hospital stay that was printed in 'easy-read'. The trust did not audit the care given to people with a learning disability in outpatients.
- For patients who were diagnosed with cancer or had a suspected diagnosis of cancer, the radiology service used a colour coded appointment card system to signal to staff that these patients needed to be prioritised for treatment. There were appointment slots set aside for these patients.
- In obstetrics and gynaecology, staff used interpreters approximately fortnightly; they did not use family members as interpreters. Staff could access the language line via switchboard. In the ear nose and throat outpatients department, an emergency communication book was available which provided a written translation of important questions in several languages.
- We reviewed a sample of patient information leaflets in every outpatient department we visited. All of these except one were out of date for review for example, the leaflet explaining total hip replacement was due for review in December 2012, the leaflet explaining screening for the methicillin resistant staphylococcus aureus infection was due for review in February 2012. This meant that the patient could not be assured that the information was in accordance with the latest evidence or best practice.

Learning from complaints and concerns

- We looked at the complaints register for the months from April 2015 to July 2015. There were no complaints relating to radiology. There were 71 complaints that related to outpatients. Several of these complaints related to communication issues, including the manner in which staff talked to patients and lack of clarity regarding appointments. Several complaints were related to the length of time that patients were required to wait for an appointment or for treatment or to be seen once arrived in the department. Actions were recorded for most of the complaints documented and these included education of staff, ensuring reasons for delays were communicated effectively and reviewing administrative procedures.
- All clinics displayed the completed patient feedback cards. Matrons told us that the majority of complaints related to delays in clinic and car parking concerns. To reduce complaints and enable patients to have better information, a notice board in each clinic displayed the approximate length of delay. As a result of complaints, outpatient teams recognised that car parking concerns were important to patients and they negotiated where possible for patients to not incur additional expense if outpatient clinics were delayed.

Outpatients and diagnostic imaging

- We observed a clinic sister explaining to the patients in the waiting room that a surgical clinic was delayed by one hour and she offered to help patients with anything they needed including resolving car parking issues. The nurse offered to talk individually with patients about their concerns.

Are outpatient and diagnostic imaging services well-led?

Good

We rated the outpatients and diagnostics service to be well led. The future direction for the outpatient service was guided by a vision to remodel the delivery of services to be more focussed on care closer to home. This vision had not yet progressed to a measureable plan. Operational challenges around clinic space in ophthalmology were being addressed as part of a plan to relocate the ophthalmology service in January 2016 to a more suitable location and this would increase capacity.

There was a detailed plan to address the delays for cancer treatment. The trust maintained close oversight of all delays for cancer treatment with a robust system for monitoring the risk to those patients waiting. The trust had identified some challenges in the administrative processes within cardiology but there was a detailed plan to address these.

The staff were connected to the trust values and felt supported by the executive team. Staff in the outpatients and diagnostics services praised their teams, their managers, and the trust as a good place to work. There was strong leadership in the diagnostics service. Leadership and governance of the outpatients service was not managed in a consistent way across all specialities, and this lead to a disjointed approach to the oversight of service as a whole. There were some concerns around leadership and accountability in the medical outpatient's service. The matron did not have sufficient resources to lead the service and action to address this had been stalled whilst awaiting the implementation of the redesign of the outpatient service.

Vision and strategy for this service

- There was a strategic plan to redesign the whole outpatient's service. The plan was focussed on a more integrated outpatient service with more care closer to home.There were three phases to this plan, phase one and two had been completed prior to our inspection. Phase three had not yet commenced. At the time of our inspection, a timetabled programme of actions to complete for the next phase was not available.
- A proposal to relocate the' glaucoma outpatient service to a location at the West of England School and College for Partially Sighted Children was drafted in January 2015 in response to the demand for ophthalmology services. The project had been delayed but the teams now planned to relocate in January 2016.
- In therapy services, the vision was to integrate with community services to create a continuous pathway for patients with an emphasis on a 'discharge to assess' approach.
- Staff we spoke with were aware of the trust values and felt that these were evident in their practice.

Governance, risk management and quality measurement

- Patients waiting too long for their treatment for cancer were at risk of deteriorating health because of the delay. The trust had given careful and comprehensive consideration to reducing this risk. The trust governance system maintained a clear oversight of the delays in treatment.
- Twice weekly, information was sent out to the administrative and managerial teams about those patients who were diagnosed with cancer or had a suspected diagnosis of cancer that might be at risk of waiting too long for treatment. On a day-to-day basis, cluster managers informed clinicians of potential future breaches approximately two to three weeks before they occurred. Senior clinical staff and administrative staff reviewed every individual breach of cancer waiting times on a weekly basis at the patient-tracking meeting. Each breach was researched and discussed to determine whether these had been classified correctly, where the cause of the breach occurred for example if there had been a delay at a particular part of the pathway and the degree of potential harm to the patient. If potential harm was identified, this was investigated and was recorded as a root cause analysis that linked electronically to the governance processes of the trust. We checked serious incident investigation reports and saw that breaches of waiting time targets were investigated and lessons were learnt. For example,

following an incident of delayed treatment in urology, the investigation highlighted the need for 'one-stop' clinics in urology, and the need to carefully examine the process of receiving and grading of referrals.

- The associate medical director for cancer services reviewed the top 10% of breaches as an additional quality assurance measure for those patients who had waited too long for treatment on the 62-day pathway. This review was carried out to provide independent senior clinician oversight and to identify any possible harm for those patients who have waited longer for treatment. This clinician confirmed that no patients had come to physical harm because of waiting too long for cancer treatment, but he was unable to quantify harm to patient's psychological well-being.
- If any patients had waited too long for their treatment for cancer, staff reviewed these delays at the monthly validation meeting. These reviews aimed to ensure that the reason for the delays were known and recorded, any avoidable aspects of the delays were noted, and relevant actions were taken to reduce the risk of recurrence. At a monthly performance assurance meeting, divisional leaders were asked to account for any failing performance areas. Managers were required to communicate their plan to remedy these areas of concern.
- A serious incident investigation report dated April 2015 identified that the degree of urgency for a patient to be seen was not consistently evident on the waiting list system. This meant that the waiting list co-ordinator was unable to prioritise patients, high-risk patients may have been missed, and subsequent tracking of those patients may have been affected by omission of this step. During our inspection, booking staff told us there was a delay in the grading process by which referrals for cardiology were screened by a consultant to determine their degree of urgency. This process is referred to as 'grading'. The cluster manager for the cardiology service had undertaken a detailed review of all of the patients categorised as waiting for an appointment and this process had identified a shortfall in the governance of the grading process rather than the brevity of response by the consultants.
- Patient pathways in cardiology were incorrectly labelled as awaiting grading when in reality the patient had been referred for tests or had been booked directly for inpatient treatment without outpatient consultation. The governance of these processes was hindered by two factors. Firstly, the lack of communication between the electronic patient administration system and the electronic choose and book system. Secondly, cardiology operated a unique system for processing the grading of referrals, which made it difficult to audit. There was a detailed improvement plan for cardiology, which highlighted the need for clarity regarding the governance of the waiting list. This plan included the recruitment of a bookings clerk for cardiology to allow the process to be standardised. The team held weekly meetings to review patients on the waiting list. The cluster manager met weekly with the service director to report on progress with the improvement plan and it was anticipated that governance could be assured within the next four to six weeks.
- The management of the outpatients service was not consistent across all specialties. In surgical outpatients, there was a matron in charge who provided strong leadership to the team, took an active role in governance and oversight of staff performance and ensured the smooth running of the clinic. However, the governance of performance and staff competency in medical outpatients was the responsibility of the ward teams and this meant that oversight on a day-to-day level in the outpatients department was not assured. This was acknowledged in the outpatient quality assessment tool. The smooth running of some clinics in the medical outpatient service relied upon very experienced band two staff that completed duties such as risk assessments and informal induction of ward staff to the outpatient area. These staff were line managed remotely by the senior nurse on the ward.
- The risk of patients developing permanent sight loss because of delays in ophthalmology was on the divisional risk register. The plan to mitigate this risk included advising the patients regarding the monitoring of their eye condition, advising patients to attend their optician, GP, or emergency department if symptoms worsened, change to the outpatient timetables to increase capacity, consultant review of all patient records to ensure correct triage of risk and regular review of the risks outlined.
- Day to day management of the diagnostics service was well organised. The nuclear medicine department was in the process of reviewing the safety protocols required under the Ionising Radiation (Medical Exposure) Regulations. These documents were last reviewed between 2011 and 2013. Both the old and the amended

protocols were available for clinical staff. This was a risk because some of these protocols were not up to date. The time frame for completion of this review was not specific.The risk register in radiology was reviewed monthly and action plans taken forward by divisional governance leads. However, there was a lack of clarity regarding the mitigation of a risk in radiology that was recorded on their risk register as 'high risk'. The risk related to an x-ray machine in the emergency department that staff described as subject to frequent breakdown and needing immediate replacement. Managers were unsure whether the funding for this equipment had been approved or suspended.

- The risks associated with radiation protection and on-going concerns around the provision of medical physics expert cover were a standing agenda item on all governance meetings. At the time of our inspection, the trust had mitigated this risk through provision of medical physics expert cover from a neighbouring trust, but the trust executive team understood that sustainability of this arrangement was not guaranteed. A radiation safety group met quarterly, chaired by the associate medical director for the division. We reviewed the minutes of these meetings and saw that participants discussed the issues surrounding the medical physics service provision and were aware of the additional work around radiation protection that was required. The associate medical director also sat on the Trust safety group and used this forum to escalate radiation protection advice and concerns. The radiation safety group identified the need to replace the radiation protection advisor and a review of clinical scientist job descriptions was underway.

Leadership of service

- The leadership of the medical outpatients' service was complicated by the accountability structure. There was a senior nurse for medical outpatients who also covered the emergency department. There was not a reliable system for ensuring cover for the clinics during unexpected absence of staff such as staff sickness. For example, if a nurse was absent, the ward staff from that speciality would be informed but this did not reliably filter through to the senior nurse for medical outpatients. In some clinics within medical outpatients, specialist nurses were present in the clinic and they offered leadership to the outpatient staff. In other specialities such as gastroenterology, there were no specialist nurses available in the clinic. Senior managers were aware that leadership and accountability was a concern in medical outpatients. Managers had delayed addressing these concerns because they wanted to incorporate the redesign of the outpatient service into any amended staff structure.
- Nurses and matrons said that when they raised concerns with the executive team, those concerns were listened to. Staff of all levels felt able to ask for help and to challenge those staff of more senior grades. For example, one matron explained how she had spoken with a consultant because his inflexibility regarding use of clinic rooms was affecting the smooth running of the clinic. The issue was then quickly resolved.
- In radiology**,** there was clear leadership at consultant level and the consultant body worked cohesively. Managers offered an open door policy and staff were encouraged to present ideas and suggestions. There was a 'shop floor' presence of the radiology services manager who was approachable and well informed of current issues.
- The divisional director and the associate medical director were well regarded by radiology staff and outpatient consultants. Staff described them as proactive, approachable, and knowledgeable.

Culture within the service

- During the week of our inspection, the occupational health team visited surgical outpatients to offer support to staff. Staff in all teams felt supported by their managers and their teams, especially when dealing with challenging situations. Staff told us that they enjoyed working at the trust. This commendation included staff of different grades and roles such as administrative staff, health and safety officers, therapists, nurses, consultants, radiologists.
- Staff went out of their way to tell us how much they enjoyed working for the trust. Staff felt able to ask other teams for advice and that collaborative approach enabled them to solve problems. One consultant in medical outpatients told us that "you can hear people smiling down the telephone" Staff told us they felt privileged to work at the trust and one staff member who had worked at the trust several years told us that she arrives at work 90 minutes early every day because she loves her job.

Outpatients and diagnostic imaging

- There was a culture of openness and honesty within the radiology department and staff were encouraged to report incidents in a non-blame environment. Radiology staff described the trust as an excellent place to work

Public engagement

- Outpatient services actively sought patient feedback and discussed this at team meetings. Yellow feedback forms were available in all outpatient departments and completed on one day per month. These forms were not readily available in different languages or in large font. Feedback forms were displayed on welcome boards in each outpatient department. Reception staff offered Friend and families surveys to all patients but these were less popular with patients than the yellow cards.
- Patient feedback had highlighted the lack of privacy at reception in surgical outpatients and in response; a new reception desk was being built.

Staff engagement

- The trust had initiated a structured approach to team meetings that made use of a 'comm cell' board. This large notice board displayed pertinent information relating specifically to the team where it was located. We saw the 'comm cell' meeting working effectively in surgical outpatients. Leaders used this forum to identify coordinators for all the clinics, discuss staffing, discuss learning from recent incidents, mandatory training requirements, support for revalidation of nurses. A communication book recorded all items discussed in the comm cell meeting and absent staff were required to sign the book to indicate that they had read these minutes. In surgical outpatients, each clinic met with the matron once per week to raise any specific concerns.
- .Staff feedback forms were displayed on these boards. The forms included details of what staff felt had worked well and what they felt would be better if done differently. Managers told us these ideas for improvement were discussed at 'comm cell' meetings.
- Staff told us they valued the 'members say' and 'staff say 'meetings where they were able to speak to a member of the executive team. The ophthalmology service had an annual staff engagement meeting.

Innovation, improvement and sustainability

- The orthopaedic outpatient matron was leading a project to develop a trust wide recording system for height and weight so that patients did not need to experience this repeatedly and nurses would have the information readily to hand.
- The ophthalmology outpatients' team recognised that improvement was needed to the clinic environment but staff felt this would not be addressed because the clinic may be relocated. Meanwhile, the team were waiting for delivery of new electronic tablet devices, which they hoped would ease the pressures on clinic space because practitioners could use the electronic tablet device to test vision instead of the usual visual aisle.
- Future projects to reduce the number of patients needing to attend for outpatient appointments included a focus on 'rapid referral review', which involved clinicians reviewing referral and then advising the GP how to proceed with further support available if needed.
- The 'Discharge to assess' project in therapy services was moving into the second stage of development, the 'start up and test' phase. The project was working in conjunction with the Integrated Care for Exeter, which was a strategic alliance of public voluntary, and community sector organisations. The project aimed to provide a seven-day service from a team of doctors, nurses, therapists and social workers plus a care co-ordinator and a volunteer coordinator. The focus of the project was twofold: to improve the delivery of community services for adults with complex needs by joining up services into a single pathway with a focus on helping more people to be cared for in their own home, and to streamline care so that people only stay in hospital as long as is necessary.
- The radiology service was waiting for an upgrade to the reporting information system that would enable the department to audit inappropriate requests for imaging. The teams planned to use the audit process to highlight inappropriate imaging requests to the executive team and to educate referrers including GP's. The teams hoped this would encourage understanding of the criteria for imaging, especially for patients requiring urgent diagnosis of cancer symptoms. The trust had a quality improvement academy, which supported junior staff to carry out quality improvement through audit, presentations, and publications. Radiology teams hoped to use this academy for their continuing education around quality and oversight of inappropriate imaging referral

Outstanding practice and areas for improvement

Outstanding practice

- The emergency department had agreed with the ambulance service that crews would radio ahead to tell staff that that they were bringing a patient with a suspected broken hip. This gave nurses the time to inflate a pressure relieving mattress for the trolley on which the patient would be treated. In this way, pressure ulcers would be prevented but X-rays could still be carried out without moving the patient.
- Opportunities to avoid admitting people to hospital were explored whenever possible. We observed the treatment of a patient with an unusual type of dislocated joint. Usually this would have to be treated under general anaesthetic as an in-patient. However the department is equipped to administer general anaesthetics and so two emergency department consultants were able to treat the dislocation in the department. The patient went home as soon as he had recovered from the anaesthetic.
- The computer system would alert staff when a child with a long-term illness arrived in the emergency department. Care plans for each child were immediately available so that they received treatment and care that was specific to their condition.
- One patient told us that he had been travelling through Exeter when he experienced sudden and severe pain and had to attend the emergency department. Immediate treatment was given but he had to return the following day to see a specialist and therefore could not continue his journey. One of the receptionists spent time finding him a nearby a hotel to stay in and arranged a taxi to take him there. She also arranged for the taxi to bring him back the following day. He was impressed by the care and helpfulness provided.
- We saw staff members who provided leadership in their localised areas. This leadership promoted change of practice to support patients' needs and inspired other staff.
- The site management team demonstrated an excellent understanding of the hospital as a whole. This understanding was reflected in how bed management and flow of patients through the hospital were managed.
- One of the consultants had been appointed as Care Champion and regularly carried out "Care rounds". After introducing himself to patients he asked "How have we, as a department, cared for you today". The feedback gained from patients and those close to them was fed back to staff in two ways. Immediate feedback is given verbally at the following staff handover session. Any problems were discussed and resolved. Written feedback was contained in the monthly "Care and compassion newsletter". This looked at trends and described new developments aimed at improving care further.
- The publication of the Francis report in 2013 caused staff in the emergency department to reflect on the meaning of compassion in hospitals. In 2014 senior staff produced a 42 point response to the report with relevance to urgent and emergency care. This was shared and discussed with all staff in the department and has been used to enhance the care provided.
- Staff in the emergency department realised that relatives often had many questions to ask following a sudden death. Therefore, next of kin were sent a letter of condolence and an invitation to return to the department so that their questions could be answered by one of the consultants. We were told that about 20% of families took up the offer. In preparation for the meeting the consultant would gather information from the ambulance service and the post-mortem results. This meant that as much information as possible was available in order to answer the families questions. If a need for bereavement counselling was identified at this meeting a direct referral could be made.
- In order to prevent patients, who were often elderly, spending hours waiting staff had implemented "Elective Colles reductions". Patients would be given effective painkillers and the arm would be placed in a splint and a sling. They would be asked to return the following day when a specialist team would come to the department to anaesthetise the arm and reduce the fracture.
- The emergency department ran an initiative called "Spotlight". Staff who had "gone the extra mile" would receive a letter written by the management team which would be sent to their home address. Managers

Outstanding practice and areas for improvement

said this added a more personal and meaningful touch to commending the good work of staff. Staff that we spoke with said that they appreciated this and that it made them feel special. Up to four of these commendation letters were sent each month and the names of staff and the reasons behind it were shared in the monthly newsletter.

- Frontline staff and senior managers were passionate about providing a high quality service for children and young people with a continual drive to improve the delivery of care. Senior clinical managers were strong and committed to the children, young people and families who used the service, and also to their staff and each other.
- The care being provided by staff in the critical care unit went above and beyond the day-to-day expectations. We saw patients' beds being turned to face windows so they could see outside, staff positively interacting with all patients and visitors and evidence of staff going out of their way to help patients. Patients and visitors gave overwhelmingly positive feedback.
- An advanced critical care practitioner role (ACCP) had been introduced into the permanent critical care workforce. The nurse consultant supported nursing and medical staffing, bridging the gap between the two groups. They worked as part of the medical rota and attended emergency calls throughout the hospital on behalf of the critical care team.
- In the critical care unit we found a programme of public and staff engagement that was supported and encouraged by managers. We saw improvements made as a result of feedback and suggestions, and managers had a genuine intention to continue a programme of improvement using feedback from staff and visitors. The recruitment of volunteers to assist at the front door to the unit in the afternoons came about as a result of a visitor suggestion.
- All staff in the critical care unit, including managers, took a genuine interest in each other's' wellbeing. There was a section dedicated to staff wellbeing on the staff noticeboard, including numbers for the trust's counselling service. A survey was established and carried out in April and May 2015 to identify key stressors for unit staff from January 2015. Working with a local university, the practice developers looked to identify areas where they could have a positive impact. The survey was planned to be repeated in early 2016 to see if any impact had been made, and how further work could be completed.
- Patients who used the maternity service were consistently respected by the staff and encouraged and enabled to be involved in the planning and decision making regarding their care and treatment. Staff provided patients with information and supported them to make decisions. Their individual preferences and choices were consistently reflected in how the care was delivered. Feedback from women and their representatives was consistently positive and in many cases exceeded their expectations.
- Staff were overwhelmingly positive about their comments regarding working at the trust. Midwives were exceptionally proud to work on the maternity unit.
- A member of staff was on duty at the reception area of the maternity wards to ensure the security and safety of the wards, women and babies. One member of staff employed through an agency to provide security was spoken of highly by patients and staff alike. They commented on their unfailing cheerfulness, politeness and support to them during visiting times and when staying in the hospital. Women and their partners had also reflected on the Facebook page how they had valued the presence of this member of staff during their stay on the maternity unit.
- Royal Devon and Exeter NHS Foundation Trust is one of only three trusts in the country with recognition in achieving the Gold Standards Framework for end of life care, with three wards accredited and one deferred. Plans to extend the gold standard to further wards demonstrated an outstanding commitment by ward staff and the specialist palliative care team to end of life care. The trust carried out many audits and acted on their results to improve practice and inform future provision of effective care. The trust worked effectively with an integrated multidisciplinary approach to end of life care with other providers, such as the onsite hospice and other providers such as general practice services.
- A significant training programme 'opening the spiritual gate' had been invested in and had been rolled out to medical, nursing and allied health professional staff to offer spiritual care, especially around the end of life. The Trust was finalising a spiritual care policy to

Outstanding practice and areas for improvement

support good practice for all patients and ensure that the 2015 hospital chaplaincy guidelines 'Promoting Excellence in Pastoral, Spiritual & Religious Care' were followed.

- The cancer service was leading a project centred on the 'Living with and beyond cancer' programme. This programme wasatwo year partnership between NHS England and Macmillan Cancer Support aimed at embedding findings and recommendations from the National Cancer Survivorship Initiative into mainstream NHS commissioning and service provision. Patients in the cancer service who were deemed to be at low risk, were discharged and given open access to advice. In the gynaecology clinic, clinicians contacted patients by telephone to follow up treatment and in haematology; this process was done by letter. Results showed that 94% of patients who were participating in the programme rated it as good or excellent.

Areas for improvement

Action the hospital MUST take to improve

- The trust must take action to ensure that facilities for children in the emergency department comply with the national Standards for Children and Young People in Emergency Care Settings 2012.
- Ensure patient information remains confidential through appropriate storage of records to prevent unauthorised people from having access to them in medical, surgical and maternity wards and outpatients departments.
- Ensure staff have access to current trust approved copies of Patient Group Directions (PGDs) that only permitted professional groups of staff, as required under the relevant legislation, work under these documents.
- The critical care unit must ensure adequate medical staff are deployed at all times. Current overnight levels did not meet the ratio of one doctor to eight patients, as recommended by the Core Standards for Intensive Care Units (2013).
- Chemicals and substances used for cleaning purposes that are hazardous to health (COSHH) were observed in areas that were not locked and therefore accessible to patients and visitors to the wards. The trust must ensure that cleaning materials including chlorine tablets are stored safely.
- Ensure that adequate medical physics expert cover is available in the radiology and nuclear medicine service on an on-going basis
- Ensure there are sufficient staff deployed to meet demand in ophthalmology and gastroenterology outpatient clinics

  Ensure patient privacy in outpatient clinics is maintained.
- Ensure the steps put in place to reduce the length of time that patients living with cancer must wait for treatment are sustained to deliver services in accordance with the 'cancer wait' targets set by NHS England.

Action the hospital SHOULD take to improve

- Ensure that there is sufficient space to treat patients requiring resuscitation and major treatment in the emergency department.
- Ensure that all patients in the emergency department waiting room can be observed by staff at all times.
- Ensure that there is band 7 nurse in charge of the emergency department on each shift in line with NICE recommendations.
- Ensure that accurate, complete and detailed patient records are maintained.
- Medicines must be stored securely and safely at all times. Intravenous fluids should be stored securely so as not accessible to the public and patients.

Outstanding practice and areas for improvement

- Ensure that appropriate measures are put in place on admission to the AMU for patients who are at risk from attempting suicide. This should include the appropriate assessments of risk for staff to follow and a suitable and safe environment for patients.
- Ensure where patients between the ages of 16 and 18 are admitted to the AMU that this agreed as to the most appropriate environment for them.
- The maternity service should review and record the staffing levels to ensure all maternity wards are safely staffed at all times including theatre and recovery

- Ensure that all areas used by children are child friendly and should particularly consider improving the environment for children in the outpatients department and theatre recovery rooms.
- Ensure staff on the critical care unit are fully aware of their duty to report incidents, including near misses and no-harm incidents.
- The critical care unit should review compliance against the Department of Health's building note HBN 04-02
- Resuscitation trolleys in the critical care unit should be tamper-evident.
- Staff in the critical care unit should have a thorough understanding of the Deprivation of Liberty Safeguards.
- Mandatory training updates and annual appraisals for critical care staff should meet trust targets.
- There should be access to a follow-up clinic for patients discharged from the critical care unit.
- The hospital should improve the access and flow of patients in order to reduce delays from critical care for patients being discharged to wards and reduce occupancy to recommended levels.
- Screening of patients who were admitted as an emergency to hospital for gynaecology care and treatment should consistently be screened for MRSA.
- Action should be taken to address the shortfalls identified in staff hand hygiene audits in the maternity services.
- The labour ward should ensure that emergency resuscitation equipment was checked regularly and a record maintained to show it was ready to use.
- Care plans should be consistently completed to provide staff with full detail regarding the patients' assessed care needs. End of life documentation in patient records is completed consistently.
- The trust should take action to ensure compliance with national guidelines regarding baby identification labels.
- The maternity service should provide evidence to demonstrate women received pain relief in labour within appropriate timeframes. Sufficient equipment should be available, for example pumps to self-administer analgesia, for women during labour.
- Ensure all decisions around 'do not attempt resuscitation' status and treatment escalation plans are communicated at nurse-doctor handovers
- Review the leadership and accountability structure of the medical outpatient service
- The hospital should review the facilities available for children in the outpatient service.
- Ensure staff in the orthopaedic outpatients department are able to access equipment to take patients height and weight.
- Ensure that all clinical staff receive adequate clinical supervision to support them in their role

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 The HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. 12(1) and 12(2)(g) The provider did not protect service users against the risks associated with the proper and safe management of medicines Patient Group Directions (PGDs) were not all approved by the trust and staff who were not permitted under The Human Medicines Regulations 2012 were working using these documents. Medicines were not stored securely at all times on the wards. Medicines were left unattended on the nurse's station and medical notes trolley on Wynard South and in an unlocked refrigerator on the labour ward. They were therefore accessible to patients and visitors to the ward. 12 (2)(a) Assessing the risks to the health and safety of service users of receiving the care and treatment 12 (2)(b) Doing all that is reasonably practicable to mitigate any such risks Chemicals and substances that are hazardous to health (COSHH) were observed in areas that were not locked and therefore accessible to patients and visitors to the wards. Cleaning materials including chlorine tablets were in the sluices, which were unlocked. Each room had lockable cupboards but the solutions and materials were not locked away for safety.

This section is primarily information for the provider

Requirement notices

On the AMU razors were also accessible. The AMU was the ward used for vulnerable patients who may have mental health risks and the access to these chemicals and razors did not support their safety.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 The HSCA 2008 (Regulated Activities) Regulations 2014 Staffing 18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. In the critical care unit there was insufficient resident doctor cover overnight to keep people safe at all times. Only one doctor was resident overnight on this 15-bedded critical care unit. The Core Standards for Intensive Care Units (2013) recommend a resident doctor ratio of one doctor to eight patients. The critical care overnight resident doctor was also responsible for attending the hospital-wide medical emergency team calls. This meant there were periods when a doctor was not present on the critical care unit. Three incidents had been reported relating to overnight medical cover in the critical care unit, which highlighted a risk to patient safety. Overnight critical care doctor cover had been on the divisional risk register for over one year and remained on the risk register. Funding to provide adequate overnight doctor cover had only been agreed in part following a business case being presented. This meant increasing the overnight doctor cover could still not be achieved. Mitigating arrangements were not robust and there remained a risk to patient safety.

This section is primarily information for the provider

Requirement notices

There had been a high attrition rate in ophthalmology related to staff sickness and turnover. The resulting vacancies equated to a loss of 305 patient appointments per week.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance The provider had not operated systems or processes to: 17(2)(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. The management of patient records did not ensure patient's details were safe and that confidentiality was assured. We saw patient records were accessible to other patients, staff from other areas and the public. Trolleys used for records storage were not secured or placed away from public access in medical, surgical and maternity wards and outpatients departments.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 15 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Premises and equipment

15 (1) (c)

There were not enough dedicated children's treatment rooms for the number of children being seen each year in the emergency department. They were not separate from adult areas and access was not controlled. Equipment in the rooms was not always arranged to ensure the safety of small children