

Royal Devon and Exeter NHS Foundation Trust

Quality Report

Royal Devon & Exeter Hospital (Wonford)
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This report describes our judgement of the quality of care at this trust. 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 trust

Good 

Are services at this trust safe?

Requires improvement 

Are services at this trust effective?

Good 

Are services at this trust caring?

Outstanding 

Are services at this trust responsive?

Good 

Are services at this trust well-led?

Good 

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.
- 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 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.

Summary of findings

- 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 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.
 - 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 Foundation Trust is one of only three trusts in the country with recognition in

Summary of findings

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.
- Ensure the use of medicines are in line with trust policies and best practice. For example; covert administration, storage and disposal of medicines.
- 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
- 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.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Royal Devon and Exeter NHS Foundation Trust

Royal Devon and Exeter NHS Foundation Trust (RD&E) operates two principal hospital sites: Wonford and Heavitree. The trust has a further 10 registered sites, including three satellite kidney units and the Mardon Neuro-Rehabilitation Centre. The trust has 838 inpatient and 131 day beds, of which 759 are general and acute beds with 57 for maternity services.

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 the 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

We also inspected The Mardon Neuro-Rehabilitation Centre

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 clinical governance 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 – 6 November 2015 and returned to visit some wards and departments unannounced on 10 & 16 November 2015. During the inspection we visited a range

of wards and departments within the hospital and spoke with over 300 clinical and non clinical staff and held focus

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groups to meet with groups of staff and managers. We observed how people were being cared for, talked with carers and family members and reviewed patients' records of their care and treatment.

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 inspection. We also received feedback people provided via the CQC website.

What people who use the trust's services say

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 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?

Facts and data about this trust

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 2014/15 the trust had 125,000 inpatient admissions, 350,000 Outpatient (total attendances) and 100,000 Accident & Emergency (attendances). Bed occupancy had been 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

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- August 2013 and found to be compliant with the three standards inspected
- November 2012 and found to be compliant with the seven standards inspected
- Tiverton Hospital:
 - February 2014 and found to be compliant with the five standards inspected
 - Mardon Neuro-rehabilitation centre:
 - July 2012 and found to be compliant with the five standards inspected

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>Overall, we rated safety of the services in the trust as ‘requires improvement’. For specific information, please refer to the individual reports for Wonford Hospital and Mardon Neuro-Rehabilitation Centre.</p> <p>The team made judgements about nine services. Of those, four were judged to be good and five as requiring improvement. Therefore the trust was not consistently delivering good standards of safety in all areas. There were some issues with confidentiality of records and the supply or administration of medicines by non-medical staff.</p> <p>There was a positive and open approach to incident reporting with staff trained in investigation. Findings and learning was fed back through a range of meetings and the ‘Comm Cell’ used by many wards and departments to communicate key messages.</p> <p>Duty of Candour</p> <ul style="list-style-type: none">• The trust had made preparations to meet the Duty of Candour Requirement (Regulation 20 of the Health and Social Care Act (Regulated Activities) Regulations 2014). The trust undertook a review of compliance with the new regulation which was reported to the Governance Committee in February 2015. The ongoing compliance with the regulation is monitored through the Incident Review Group.• The trust had a well-established approach of “being open” and had applied the principles of the Duty of Candour from August 2013.• The trust has implemented a robust process for the reporting and investigation of incidents. A sample of incidents was reviewed and immediate and thorough actions had been taken in all cases reviewed. The duty of candour had been addressed in initial letters to patients in incidents categorised as medium and high. Those letters contained a summary of the discussion with the patient. Investigations are completed and reports provided.• The trust policy had not been updated to show that the duty to be open had changed from a contractual to a statutory requirement; we were informed this was planned at the next review. <p>Safeguarding</p>	<p>Requires improvement </p>

Summary of findings

- Staff we spoke with were clear about reporting safeguarding. They understood their responsibilities and the trust's processes for reporting any suspected abuse.
- Safeguarding training for trust overall in October 2015 was 75.4% against the trust target of 75%, some areas were over 90% compliant.
- 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.
- The Medical Director was the executive lead for safeguarding. 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.
- Relevant 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. 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. There was a named doctor for child protection

Incidents

- The trust policy was comprehensive and detailed and clearly identified the duties and responsibilities of all staff, including the committees involved and where they report to. The policy includes a decision tree for scoring incidents, a process to follow for investigations and advice on how to write statements. There is a clear process for triangulation between complaints and incidents.
- The incident review group which reports to the Clinical Governance Committee reviews all incidents that are categorised as amber or red. Information and learning from incidents is discussed via divisional governance groups and the Information Governance steering group.
- The Governance team undertake random sampling of incidents to ensure actions are completed; the team sample 50 incidents every 6 months, they will go out to the relevant area to check for completed actions and review minutes of meetings.
- The inspection team reviewed six serious incidents categorised as being red or amber. In all cases the policy had been followed and it was evident that the incidents had been managed well. There was also evidence of good practice, for example all staff

Summary of findings

involved in an incident are offered counselling via the Occupational Health department. If it is a significant event then Occupational Health are asked to the ward to provide a debrief to staff. This is documented in the final RCA report.

- The majority of 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. Staff leading investigations received training in root cause analysis. Once reported incidents were reviewed by the appropriate clinical manager and where necessary investigated.
- There had been no reported never events since July 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
- Mortality and morbidity meetings were held regularly within the divisions and ensured learning was shared. The children services held paediatric mortality and morbidity meetings and minutes showed cases were discussed and learning points and actions taken were documented.
- 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.

Staffing

- At the time of our inspection nursing vacancies trust wide were around 60. Every six months staffing levels had been subject to regular reviews across all wards using the Keith Hurst acuity tool. 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.

Summary of findings

- The majority of wards and departments were staffed to establishment. In most outpatient services aside from gastroenterology and ophthalmology where there had been high staff sickness and turnover. The resulting vacancies equated to a capacity loss of 305 patient appointments per week.
- 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.
- Staff were supported by specialist teams for example the specialist palliative care team which had recently received funding to support recruitment and several staff were in the process of employment checks. Response time to referrals was good.
- Nurse to baby or child ratios were in line with the Royal College of Nursing (RCN) guidelines. Medical Staffing levels and skill mix were compliant with the Royal College of Paediatrics and Child Health (RCPCH) and the British Association of Perinatal Medicine (BAPM) standards
- The maternity dashboard demonstrated that in September 2015 the midwife to birth ratio was 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. 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.
- On the critical care unit 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 unit. There were alternative arrangements in case of an emergency, for example contacting another doctor from elsewhere in the hospital or calling the on-call consultant, but these were not immediate responses. There was therefore a continued risk to patients in the event of an emergency requiring immediate medical intervention, particularly advanced airway skills.

Summary of findings

- There were not always sufficient numbers of therapists such as speech and language therapists to provide care and support to patients to meet their rehabilitation needs at the Mardon neuro-rehabilitation Centre.
- A scheme to recruit overseas nurses was successful in recruiting with a programme of support for these nurses ongoing to improve their English language and adapting to working at the trust.
- Nursing and medical staff handovers were seen to be held at regular intervals and included relevant information for continuity of care and review of risk.

Records

- Patient records were not consistently stored securely in a number of wards and departments. This included outpatients departments where some records were stored or left unattended in public areas meaning they were easily accessible to people who were not authorised to read them.
- On the antenatal and postnatal ward and in the clinics and some surgical and medical wards, records were at times left in open trollies unattended and in offices which were not locked. This did not ensure the safe storage of the records and compromised patients' private and confidential information

Are services at this trust effective?

Overall we rated effectiveness of the services in the trust as 'good'. Effectiveness in A&E was rated as outstanding. For specific information, please refer to the individual reports for Wonford Hospital and Mardon Neuro-Rehabilitation Centre. This means that people have good outcomes because they receive effective care and treatment that meets their needs.

The team made judgements about eight services. Outpatient services are not currently rated for effectiveness. Of the services rated, seven were judged to be good and one outstanding in A&E. This demonstrated that services provided care, treatment and support that achieved good outcomes, promoted a good quality of life and were based on the best available evidence.

Evidence based care and treatment

- The use of evidence based guidelines was evident in all core services and teams we visited. Staff were able to access up to date policies and guidance and adhered to relevant NICE and professional guidance.
- In the emergency department a range of clinical care pathways and proformas had been developed in accordance with

Good



Summary of findings

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. Regular review and audit against these was in place.

- The emergency department only partially satisfied the requirements of the national “Standards for children and young people in Emergency Care settings”. Although there were sufficient staff with specialist qualifications and experience to treat and care for children, there was a lack of specialist facilities.
- 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.
- 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.
- The trust gathered data regarding the quality of the service offered to outpatients. This 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.

Patient outcomes

- Outcomes for patients receiving treatment at the Trust were generally above or in line with national benchmarks and standards.
- 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.
- The hospital performed well in outcomes for surgical patients who reported on the outcome of their surgery for groin hernias, hip replacements, knee replacements, and varicose veins. In the Patient Reported Outcome Measures (PROMs) for April 2014 to March 2015. 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.

Summary of findings

- The critical care unit achieved consistently good results with patients who were critically ill and with complex problems and multiple needs. Patients were also supported with their rehabilitation on after discharge from the unit.
- There were audit programmes in all divisions which contributed to monitoring of patient outcomes with actions to improve any aspects being put in place where required.
- 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.

Multidisciplinary working

- There was evidence of good multidisciplinary working across all wards and departments.
- Staff worked with internal and external professionals such as physiotherapists, social workers and GPs.
- Examples of particular cohesive MDT working were seen in the emergency department when staff had agreed with the ambulance service that crews would radio ahead to tell staff 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 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%.
- Specialist and trust wide teams such as the specialist palliative care, renal medicine and cystic fibrosis liaised with staff across the divisions and were reported to respond and work well when their input was required. We observed a good example of this working between the emergency department and palliative care team.
- Where patients required specialist care or treatment at another hospitals in the South West staff ensured regular and timely liaison with other teams.
- In some outpatient 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.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

Summary of findings

- Consent processes were undertaken appropriately and patients were supported to be involved in decision making regarding their care and treatment.
- Staff we spoke with had sound knowledge about consent and the application of the Mental Capacity Act 2005. Appropriate guidelines were used to obtain consent for children who were afforded the opportunity to make their own informed consent.
- 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.
- The majority of 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.
- A programme of regular audit for capacity assessments in relation to decisions to resuscitate had identified some gaps in information recorded which were being addressed and re-audited.

Are services at this trust caring?

We judged caring as outstanding overall. We saw some outstanding care and support for patients and their families and relatives in a number of areas. We rated medicine, surgery, children and young people, outpatients and diagnostic imaging, maternity and gynaecology and end of life care as good. The emergency department and critical care were rated as outstanding.

Feedback we received prior to and during the inspection was overwhelmingly positive and staff in many areas went above and beyond to ensure people had a good experience and were able to be involved in their care while receiving support for their needs and those of their families and carers.

Compassionate care

- There was a strong, visible person-centred culture in the emergency department. 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.

Outstanding



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- 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.
- 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.
- In some outpatients areas privacy and dignity of patients was not always met due to staff not ensuring conversation were held in closed rooms. At times use of curtains for eye examinations did not afford sufficient space between patients and conversations could be heard.
- 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.
- Women attending the gynaecology clinic were treated with respect and their dignity promoted. We observed the women were asked if they wished the student to stay during their consultation before they entered the consulting room and in a way that enabled women to be able to ask any student leave.
- In critical care 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. We were shown photographs of a birthday party that had been held on the unit for one patient, and 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
- 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".
- 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%.

Summary of findings

Understanding and involvement of patients and those close to them

- We observed staff in all areas listening to patients and ensuring they, their relatives and carers were involved in their treatment and be able to understand decisions.
- 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.
- 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. Staff used information available on 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.
- The emergency department result 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.

Emotional support

- 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. This 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.
- 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.

Are services at this trust responsive?

Overall, we rated the responsiveness of the services in the trust as good.

The team made judgements about the responsiveness of nine services across two locations where services were provided. Of those, eight were judged to be good, and one required improvement.

Good



Summary of findings

For a period of several months prior to our inspection the trust had failed to meet the access times for 31 and 62 day cancer referral to treatment. A number of initiatives had been put in place which were in progress with the trust aiming to be back on track by December 2015.

Service planning and delivery to meet the needs of local people

- Plans were well advanced to expanded resuscitation facilities in the emergency department in order to meet increased demand.
- 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.
- 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.
- 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 model had improved the patient flow in the emergency department and also in ward areas.
- Access to Child and Adolescent Mental Health Services (CAMHS) services were not managed by the trust. A scheduled email was forwarded to the CAMHS team 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. 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.

Summary of findings

- The environments of some outpatient clinics were not arranged to optimise the privacy and dignity of patients. Some clinics had limited space meaning access to rooms for discussions was limited. Some eye examinations were taking place with little privacy as only curtains were between patients and chairs placed very close together.
- 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.

Meeting people's individual needs

- All patients over 75 years were assessed for the early signs of dementia this included at admission to the emergency department. 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
- 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 “Twiddlemuffs” 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 noticed a marked reduction in the agitation that can often result when people with dementia are in unfamiliar surroundings.
- We saw noticeboard in the emergency displaying up-to-date information for staff regarding dementia. It included information about nutrition and hydration, assessing and treating pain and community support.
- 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.
- Kenn 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.
- Learning Disability Nurses who were employed by an external provider and had honorary contracts with the trust. The learning disability specialist nurse would follow up any patients admitted and develop an assessment and care plan and would

Summary of findings

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 who was able to stay on the ward with the patient and continue to be active in their care. Staff in recovery told us how they cared for patients with a learning disability. 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.

Access and flow

- During the winter of 2014/15 the emergency department had not quite achieved the 4 hour target for patients being admitted, transferred or discharged within four hours. 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.
- 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. Extra waiting list initiatives were underway with consultant gastroenterologists working weekends to meet the backlog.
- 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.
- 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.
- There was no discharge lounge or facility 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.

Summary of findings

- 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.
- Despite issues with access and flow due to bed pressures in the hospital and elsewhere in the health economy, the critical care 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.
- The trust was not consistently meeting performance measures for all patients with cancer and had not met these targets since the spring of 2014. In the months of July, August and September 2015, there had been 477 patients referred onto the first treatment urgent GP referral pathway; 112 of these patients had waited longer than the target and this equated to a performance of 76.5% against the target. In the same period, there had been 42 patients who had waited too long for subsequent surgical treatment, equating to a performance of 85.8% against the target.
- There were fast track clinics for all patients with cancer. Patients referred for urgent radiology 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.

Learning from complaints and concerns

- The trust had a comprehensive complaints policy and procedure in place. The policy identifies complaints as a valuable source of feedback and states a key priority in handling complaints is to create a culture that welcomes feedback, in which there is prompt and open dialogue throughout the process and beyond which supports the complainant.
- The duties and responsibilities of all staff are clearly identified. The trust has an internal target of completing complaints within 45 days. An acknowledgement letter is sent to the complainant

Summary of findings

within three working days of receipt of the complaint. In this letter the complainant is provided with information about the Independent Health Complaints Advocacy (IHCA). Final response letters are sent by the Chief Executive.

- There is clear and accessible information on the wards about how to complain with leaflets entitled “Your experiences count” and “Help”.
- There is a quarterly report to the board and a divisional quarterly review, governance committee, engagement and experience committee, patient and careers experience groups and the incident review group. The incident review group triangulate emergent themes from both complaints and incidents. There is dissemination to the wider organisation but the method for this is not clear in the policy.
- The team reviewed five complaints files. The complaints reviewed were all responded to within the 45 day target and all complainants had received an acknowledgment letter. The policy had largely been followed and overall the standard of complaint investigations and responses was high but there were areas for improvement.
- Not all complaints had an identified action plan even though learning was identified. Evidence of completion of actions identified in the action plan was not evidenced on datix. This means the Governance team do not have sight of evidence of all actions being completed. The connection with Duty of Candour needs to be considered as part of the process.

Are services at this trust well-led?

The leadership, governance and culture promote the delivery of high quality person-centred care. There is a clear statement of vision and values with safety and quality as the top priorities. There is a current strategy which is clear and work on a future strategy is underway. The vision and strategy is underpinned by clear values which are known and understood by staff. The academic vision for the trust was not as strong as might be expected in a teaching trust. The values have been developed into a set of expected behaviours which were developed in consultation with staff.

Governance, risk and quality measurement systems work well and provide reliable and timely assurance. Financial pressures are managed so that they do not compromise quality of care. The leadership of the trust is strong and visible and the board has the experience, capacity and capability required to deliver the vision and strategy. Work is needed to develop the future strategy with pace and to do that through improved partnership working. The trust culture is strongly focused on quality and safety with patients

Good



Summary of findings

being the absolute priority. Alongside this is a commitment to openness and continual improvement. There was tangible evidence of the culture in trust policies and procedures. The Connecting Care way of working is an effective and highly inclusive way of engaging all staff across the trust with improvements in care and was considered by the inspection team to be an area of outstanding practice.

Vision and strategy

- The trust has a vision and a clear set of values that has quality and safety as the top priorities. The trust states its long term vision is to provide “safe, high quality, seamless services delivered with courtesy and respect”.
- The trust has set out three key strategic objectives, grouped under three themes of Respond, Deliver & Enable in their strategy for 2011-2016. These objectives encompass delivering safe care to high standards, delivering against national and local targets, recognising and responding to the views of patients and the communities served, cost effectiveness, high quality teaching, research and innovation and developing and supporting staff.
- At the time of the inspection the development of future strategy was underway. The trust recognised the need to improve partnership working as part of that. They also recognised the constraints on their vision and strategy caused by their current financial challenges and the wider challenges in the wider system with Devon. This being part of the success regime (recognised by the Department of Health as one of the most challenged health economies in England and subject to a programme of intense scrutiny and support).
- The strategic objectives are underpinned by the Trust’s values. These were developed as part of the process of becoming a foundation trust in 2004. There are four values as follows:
 - Honesty, openness and integrity
 - Fairness
 - Inclusion and collaboration
 - Respect and dignity
- The trust has more recently developed a “Values and Behaviours Charter”. This was launched in the summer of 2014. The purpose of the charter is to help put the vision into practice by providing guidance on behaviour. Over 200 staff were involved in the discussions leading to the charter. There are six statements for each of the four values, for example “I don’t ignore people or fail to listen” (fairness) and “I don’t appear unapproachable or moody” (inclusion & collaboration).

Summary of findings

- Staff across the trust at all levels spoke positively about the values and how they were embraced. Staff felt the charter had set out expectations more clearly. The values were embedded in the Trust's recruitment and appraisal processes.
- Staff were aware of the strategy in terms of the focus on delivering high quality staff and doing the best for patients. Staff at all levels including those not directly involved in patient care displayed a passion and commitment to this. Some staff, especially those in senior roles, were aware of developments linked to future strategy such as the ICE project (integrated care in Exeter).
- At Board level there was clear insight and understanding of the internal and external challenges but at the time of the inspection the strategy to deal with those had not been fully developed or articulated.
- The trust monitors and reports progress in delivering their strategy.
- Given that the trust is a teaching trust and the main site for Exeter medical school the inspection team considered that improvement was required in terms of an academic vision.

Governance, risk management and quality measurement

- The trust has a good governance framework. The board and other levels of governance work effectively and interact with each other appropriately. The arrangements are set out in the trust's governance, operations and performance system which is set out clearly and which is well embedded and clearly understood. Systems appeared to focus on the services provided at the main Wonford site and it was not clear that issues such as those identified at the Mardon Neuro unit would be flagged at trust level. We also had a concern about support to the critical care unit achieving adequate overnight medical cover.
- The trust has taken a minimalist approach to the committee structure with just two board committees (aside from the remuneration and charity committees) that meet regularly. The audit committee and governance committees are both chaired by non-executive directors with the chair of the governance committee also sitting on the audit committee. The Governance Committee has five sub committees reporting to it covering clinical effectiveness, patient experience, safeguarding, workforce and safety and risk. All committees have clear terms of reference that are regularly reviewed and which spell out their relationships and interdependencies.

Summary of findings

- There is a good integrated performance report which is clear and concise and is driving the business. The report is fed by service line reporting taking the scorecard approach. Assurance reporting was strong.
- There were sound risk management processes and procedures in place. The risks on the corporate risk register reflected the risks that the senior leadership team discussed with the inspection team and was further reflected in committee and board minutes.
- The format of the Board Assurance Framework (BAF) followed Monitor's guidelines. In terms of content risks were identified and both executives and non executives felt that it served their needs well. The inspection team considered that the BAF contained too much operational, rather than strategic risk, and was not sufficiently differentiated from the corporate risk register. Whilst the arrangements are apparently serving the trust well this is an area that could be further improved.
- There is a programme of clinical and internal audit. Board members described the current internal audit programme as the best yet although there were some concerns about capacity as the audit programme was not always delivered in line with the plan. The outputs of both clinical and internal audits were influencing committee discussion and decisions appropriately.

Leadership of the trust

- The leadership of the trust is stable and strong. 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 non executives had a wide range of commercial, financial, academic, public sector and social care experience. There was an intention to recruit a clinician to a non-executive post when the opportunity arose. The non executives displayed energy and focus alongside a good grasp of the issues, both internal and external, facing the trust.
- When seen individually and collectively members of the leadership team emphasised their commitment to continual learning and challenge. There was evidence of this in the very thorough appraisal for all board members; considered by experienced executives on the inspection team to be the best they had seen anywhere. Individuals were able to give specific examples of tough feedback being given, being well received and being acted on. There was evidence of succession planning for senior leadership roles with development programmes in place.

Summary of findings

- The leadership of the trust prioritises safe, high quality and compassionate care. Board members described their commitment to quality ahead of financial concerns. The challenge of the competing demands on resources and capacity had been discussed and priorities agreed in a formal “hierarchy of priorities” to help inform strategic decision making. Five priorities had been agreed and in joint first places was safety & quality and outcomes. These were followed by risk, financial viability and enhanced quality. Decisions on investments and disinvestments were informed by these principles.
- Key leaders in the organisation were visible and were described to the team as approachable. The location of the executive offices in the heart of the main hospital were felt to have helped this with many opportunities for corridor conversations. A number of staff across the organisation mentioned this and gave examples of issues raised and followed up. Staff talked about seeing the executives out and about. The chief executive held a well attended Team Brief and wrote a monthly blog.
- The leadership team were strong on supportive and appreciative relationships and modelled this approach.
- There was a strong and effective Governors Council who were directly involved with the leadership of the trust, for example sitting on Board sub committees and appointing the external auditors. Feedback from both governors and senior leaders indicated that arrangements were mutually beneficial.

Culture within the trust

- The trust culture is strongly focused on quality and safety with patients being the absolute priority. Alongside this is a commitment to openness and continual improvement. 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. Examples include the Connecting Care system, described below, and the positive approach to improvement discussions known as “What went well, even better if...”. This had started as a means of real-time patient feedback within ward areas with the idea of enabling issues to be resolved promptly and for staff to learn about what matters to patients. It has since become the adopted approach for reviewing performance in many areas and was used by the chief executive in her presentation to the inspection team.
- In January 2014 the trust introduced a new way of working called Connecting Care. Taking the principles from manufacturing and covering both clinical and non-clinical areas

Summary of findings

Connecting Care is a way of staff working together with a more joined up approach to ensure all staff have opportunities to find new and better ways of working, from making both small incremental changes to much larger scale improvements. Staff were provided with access to training in the use of continuous quality improvement methodologies and teams were given a suite of tools and techniques. The objective is to improve communication, better understand team performance and to build further capability.

- There was a strong physical manifestation of the process in the Connecting Care Communication Cell, known as the “Comm’s Cell”. This was a wall mounted board containing a snapshot of key performance and staffing information. Staff of all grades would gather around the board to discuss and update the information, review performance and spot and aim to resolve problems. The frequency of the discussions varied in different areas from once a shift, daily, twice weekly or weekly depending on the areas. Without exception staff in all areas were enthusiastic about the process with some describing how they became converted from initial cynicism but seeing how well it worked. Staff talked about the strong emphasis on shared learning, problem solving and teams coming together on a regular basis. Examples of issues tackled included faulty doors, numbers of staff on duty and changes to pathways. The inspection team observed a number of these discussions in different areas and all were position and solution focused.
- The trust has signed up to the “Hello my name is” campaign and staff were observed to be introducing themselves appropriately throughout the inspection.

Fit and Proper Persons

- The trust had made preparations to meet the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. This regulation came into force in November 2014. There had not been any new executive or non-executive appointments since then and there were not any vacancies at the time of the inspection.
- A review of compliance with the new regulation was undertaken and reported to the Governance Committee in February 2015 and to the Board in March 2015.
- The trust had a recruitment and selection policy created in September 2009 and last reviewed and updated in July 2014. The policy includes a section on the recruitment of board members. This did not make any reference to the FPPR even

Summary of findings

though it was last reviewed eight months after the new regulation came into force. It was explained that a further update of the policy was planned and that this update would include a reference to the regulations.

- The team were shown a document entitled “Fit & Proper Persons – Director Level Positions” which detailed the process to follow when recruiting to director level positions. This was a comprehensive process, reflecting current best practice, dealing with the checks to be applied to internal and external recruitment and those at appraisal and upon reappointment. This was an internal document prepared by the Human Resources department. It was undated and it was not possible to establish when it had been signed off and by whom. It was confirmed that it had not been seen by the Board or the Governance Committee.
- We reviewed the files of two non-executive directors. These demonstrated that FPPR was part of the appraisal process and involved a combination of self declaration and checks. The appraisal process was itself very thorough and included 360 degree feedback within the Board. This feedback process required board members to comments on whether colleagues were fit and proper. From the files reviewed the finance checks had been ordered in October 2015 and the self declarations had been signed on 28 October and 1 November 2015; a matter of days before the inspection.

Public engagement

- The trust has some 24,000 members and the focus on engagement with the public is through the membership and the Council of Governors. The trust holds annual “Members Say” events which are usually attended by around 200 people. These days are a combination of presentations including presentations on medical topics by trust clinicians, exhibitions and activities designed to capture views. Recent events have sought views on priorities, on the allocation of resources and on future developments. The events are evaluated and receive very positive feedback from those who attend. The output from the event is captured in report to the trust board and governors.
- The trust also surveys members using a combination of email and paper based surveys. In 2014 the trust surveyed 3,500 members electronically on redesigning outpatient services and sent paper surveys on exploring options for care in older age.
- There did not appear to be a strategy for engaging with members of the public in service development and design

Summary of findings

outside the membership scheme and formal consultations. There were however many opportunities for patients and their carers and families to give feedback and to raise any concerns they had.

Staff engagement

- The inspection team met with over 300 staff at focus groups and drop in sessions and met with many more in meetings, on wards and during observations of care. The overwhelming majority of staff felt well engaged with the trust, were positive about working there and felt they would not have any problems raising concerns.
- The Connecting Care programme, described above, was described to the team as one of the main ways that staff felt engaged in having a say about the services that they were involved in delivering and being able to influence improvements and developments.
- The staff side felt they had access to management and reported good engagement with the director of transformation and organisational development.
- The trust runs a reward scheme, called the Extraordinary People Awards, to recognise individual staff and teams. Staff are able to make nominations for these awards which take place every quarter. Awards were displayed around the hospital and it was clear that the scheme was appreciated and valued.

Innovation, improvement and sustainability

- The trust hosts a Research Innovation Learning and Development Centre (RILD) on its main hospital site. This is in partnership with the University of Exeter medical school. The objective is to be a centre of excellence for clinical research and the South West clinical research network operates from there. Staff were positive about the recruitment to research studies across the trust which is 46th in the list of NHS trusts in England for participant recruitment.
- The trust had a clear focus on improvement as evidenced by the Connecting Care way of working as described above. The trust had also set clear priorities, enshrined in the hierarchy of principles, also described above. It appeared that these principles had been adhered to and there was no evidence that financial pressures had compromised care.
- The trust recorded a deficit in 2014/15 and predicts a deficit for the current and following year. Cost improvement plans are in place and the non executives described the challenge they had given to these plans to ensure that they were realistic rather than aspirational. The financial position of the trust and the

Summary of findings

financial challenges in the wider system in Devon are such that the sustainability of services is a very significant challenge. The board was aware of this but at the time of the inspection a strategy for this was not in place.

Overview of ratings

Our ratings for Wonford Hospital

	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

Our ratings for Mardon Neurological Rehabilitation Unit

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

Overview of ratings

Our ratings for Royal Devon and Exeter NHS Foundation Trust

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

Notes

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 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 emergency department 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 emergency department 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

Outstanding practice and areas for improvement

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 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.
- 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

Outstanding practice and areas for improvement

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 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 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.

- The Connecting Care way of working is an effective and highly inclusive way of engaging all staff across the trust with improvements in care and was considered by the inspection team to be an area of outstanding practice.

Areas for improvement

Action the trust 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) and that only permitted professional groups of staff, as required under the relevant legislation, work under these documents.
- Ensure the use of medicines are in line with trust policies and best practice. For example; covert administration, storage and disposal of medicines.
- The critical care unit must ensure adequate medical staff are deployed at all times.
- Chemicals for cleaning purposes must be stored securely and safely in all areas accessible to patients and the public.
- 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 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. Ensure steps put in place to reduce the

Outstanding practice and areas for improvement

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.

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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12 The HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.</p> <p>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</p> <p>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.</p> <p>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.</p> <p>12 (2)(a) Assessing the risks to the health and safety of service users of receiving the care and treatment</p> <p>The management of covert medicines was not managed safely and effectively. Patients' rights were not respected. Policies and procedures were not followed for the safe management of medicines.</p> <p>12 (2)(b) Doing all that is reasonably practicable to mitigate any such risks</p>

This section is primarily information for the provider

Requirement notices

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.

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

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

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

This section is primarily information for the provider

Requirement notices

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.

In gastroenterology and there had also 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

Treatment of disease, disorder or injury

Regulation

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

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Requirement notices

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

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