Northern Devon Healthcare NHS Trust

North Devon District Hospital

Quality Report

North Devon District Hospital
Raleigh Park
Barnstaple
Devon
EX31 4JB
Tel: 01271 322577
Website: www.northdevonhealth.nhs.uk

Date of inspection visit: 17 and 18 July 2018
Date of publication: 18/09/2018

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Following our last inspection of Northern Devon Healthcare NHS Trust in October 2017, we issued the trust with a warning notice under Section 29A of the Health and Social Care Act 2008.

The warning notice set out the following areas of concern, where significant improvement was required:

Regulation 12 Safe Care and Treatment

Maternity:

- Healthcare professionals were not always following guidelines and best practice. This had led to the mismanagement of some cases, resulting in harm or death to the babies.
- There was poor collaboration and multidisciplinary team working within the maternity unit. The negative culture did not promote safe care and treatment, or effective working within the department.
- The consultant obstetrician workforce was unstable. A number of consultants had their practice restricted, so they no longer covered the labour ward. There was a potential risk with consultants who had their practice restricted continuing to work in antenatal clinics.
- Medical staff were not up-to-date with training necessary to carry out their role. They consistently did not meet trust targets for maternity mandatory training.

Outpatients:

- Patients were not being seen in a timely manner in ophthalmology due to the limited capacity within outpatient clinics.
- In ophthalmology there were 20 patients who had gone past their follow-up dates with evidence of patient harm.
- New systems were not always implemented successfully. Following migration to a new electronc health record, which incorporates a new booking system, missing information about outcomes and follow-ups was identified.
- There was historical failure to act on issues identified from previous incidents of patient harm. The trust had also failed to act in a timely manner to complete actions identified in previous investigations.
- Clinicians across outpatient specialties were not always risk-assessing patients who had been waiting a long time.
- There were ineffective processes for monitoring patients on the cardiology waiting list.
- There were an increased number of patients who were lost to follow up across all outpatient specialities because of lost contact or IT failure.
- There was a lack of oversight of training completion for medical staff.
- There were not enough staff trained to administer chemotherapy in the oncology department.

Urgent and Emergency Care:

- Oversight of infection control within the emergency department was unclear, including actions required to improve cleanliness. The major injury department was not clean and was an infection risk.
- Poor infection control within the department reflected poor compliance with infection control training.

Regulation 17 Good Governance

Maternity:

Summary of findings

- There was not a robust and regular audit programme to monitor quality and safety within the maternity unit. Audits were reactive in response to incidents and poor performance metrics.
- The governance structure and risk management arrangements were not clear.
- There was no multidisciplinary approach to governance.
- Clear audit trails of actions generated and how these were monitored were not evidenced in all meeting minutes.
- Processes to discuss and learn between the multidisciplinary team required improvement. Round table reviews for serious incidents were not well attended by consultant obstetricians.
- The department of health's safer maternity care recommendations had not been implemented. There was no board level maternity champion or designated obstetrician and midwife to jointly champion maternity safety in the trust.

Outpatients:

- There was not an effective system to manage risks at a local level in outpatients. Risks were not being regularly updated or reviewed. Individual risks were not always being managed effectively.
- Managers did not receive feedback about themes and trends from incident data which were escalated to the clinical governance lead.
- The governance system did not support the delivery of good quality care and we could not identify who had overall responsibility for all outpatient areas at both clinic and board level.
- There was a systematic programme of audit, however not all managers were aware of what audits were being carried out.

End of Life Care:

- Systems did not operate effectively. There was a lack of oversight, audit and assessment of the end of life care service provided, and a poor governance structure.
- The trust had not addressed all the shortfalls in the 2015 National Care of the Dying audit.
- The end of life steering group had a list of actions at the end of each set of minutes but no timescales for when these would be addressed. The end of life strategy action plan included no timeframes.
- Local audits had taken place but there was no action plan to address the areas where improvement was needed.
- Systems for maintaining accurate and completed detailed records of patients using the end of life care service were not operating effectively. We did not see any advance care plans or an individual plan of care detailing patient choices for now and at the end of their life. Medical care plans were not complete.

We conducted an unannounced follow-up inspection on 17 and 18 July 2018. This inspection was focused solely on the improvements required as detailed within the warning notice. We did not review the ratings as part of this inspection.

The trust had made some progress in addressing our concerns and we had seen improvements. However, systems and processes were not fully embedded. The pace of change had been slow and there was further work needed to continue the improvements. The requirements of the warning notice had not been fully met.

In urgent and emergency care we found:

- There was still ineffective oversight and inconsistent cleaning in the emergency department. We identified a significant build-up of dust in some areas. However, the trust was undertaking a major building and redesign project at the time of our visit.

Summary of findings

However:

- The infection prevention control training compliance concerns had been addressed. Both clinical and non-clinical staff training compliance had greatly improved.

In maternity we found:

- Incident investigations had improved. Specialists from different professional groups contributed to reviews and identified improvements.
- The response of medical staff to requests to review patients' care needs had improved.
- We observed good communication and interactions between doctors and midwives.
- Leaders had begun to develop a vision and strategy for maternity care.
- An improved governance framework was in development to assure and evaluate the quality of maternity care.
- The leadership team were visible, approachable and supported staff to do their work.
- The culture within the service was improving. The results of a recent survey would be used to influence forthcoming organisational development.

However:

- Incidents and other adverse events were not used as part of service risk assessments.
- Trust targets for mandatory and service specific training were not achieved.
- Medical staffing remained fragile whilst a long-term strategy for consultant job plans were developed.
- The trust was unable to demonstrate clinical practice complied with local guidelines.
- There was no audit programme. This meant assessments of care provision and risk control measures were not co-ordinated or evaluated as part of the quality management system.
- There was no clear ownership of the risk register.

In end of life care we found:

- There was improved oversight, audit and assessment of the end of life service. There were improvements in the governance structure. Most systems were operating effectively.
- Concerns and issues could be routinely identified, and improvements had been made to the service.
- The trust was participating in the National Audit of Care at End of Life.
- There were systems for maintaining accurate and completed detailed records of patients using the end of life care service.
- We reviewed three patient records, which included comprehensive advance plans of care. These individual plans of care detailed patient choices for now and at the end of their life. Patient care needs and preferences were known and met by the service.
- The end of life strategy was due to be ratified several days after our inspection on 30 July 2018. It covered the period 2018-2020.

However:

- The trust was still addressing remaining shortfalls from the 2015 National Care of the Dying audit.

Summary of findings

- Actions in minutes from local working group meetings were still without timescales.
- Several audits of treatment escalation plans did not have action plans.
- Audits of advance plans of care were not available as completion of the audit was not due until September 2018.

In outpatients we found:

- The trust was better sighted on waiting lists and those patients who had been waiting a long time to be seen. The referral to treatment time weekly meetings reviewed patients in detail.
- The trust was formalising their harm review process, with retired clinicians identifiedto complete this exercise.
- Specialities found it easier to gain approval for additional clinics, however this was dependent on capacity.
- The ophthalmology task and finish group were reviewing how they could improve the efficiency of the ophthalmology service through different project workstreams. However, there were still actions remaining and work required to move things forward.
- There was weekly monitoring of data quality issues. Outpatient managers were fully aware of any limitations with the electronic health record which incorporates the booking system.
- Governance processes were being improved, however they were not yet embedded for us to see the impact across the service.
- There was an improved system to manage and record risks at a local outpatient level.
- The ophthalmology action plan had a person responsible for each action.

However:

- Incident reports showed the culture for incident reporting in the Seamoor chemotherapy and day treatment unit had not improved. There was a back-log of incidents which had not been signed off by a ward manager, delaying the learning for staff.
- Mandatory training compliance for medical staff had improved but was still below the trust target for some modules. Compliance with resuscitation training was poor and safeguarding training needed improvement.
- There was not capacity for regular clinician reviews in some specialities. We were not provided with evidence to show the processes had improved in cardiology.
- The in-house competency assessments on the Seamoor chemotherapy and day treatment unit were not completed in a timely way. There was still a misunderstanding between staff and the unit's management team about what training was required to ensure competency. Some staff would soon be signed off as competent, however they were not always confident in their role.
- The trust was still underperforming against referral to treatment times and patients were waiting for long periods of time.
- Trauma and orthopaedics had a high number of patients waiting over 52 weeks. However, all patients waiting over 40 weeks were being formally reviewed and risk-assessed.
- There were concerns about the culture and morale of staff on the Seamoor chemotherapy and day treatment unit. Staff told us they had not been engaged since the issue of the warning notice with regards to the concerns raised about the unit.

Following this inspection, we told the provider that it must take some actions to comply with the regulations, and that it should make other improvements, even though a regulation had not been breached, to help the service improve.

Summary of findings

Importantly, the trust must:

- Ensure the emergency department is cleaned to a high standard and there is not a build-up of dust.
- Meet trust targets for mandatory and practical obstetric multi-professional training in maternity and ensure the training data produced centrally is accurate.
- Develop and undertake audits to measure the effectiveness of the maternity service against patient outcomes, policies and risks.
- Consider the concerns raised in the Seamoor chemotherapy and day treatment unit and ensure the skill mix is appropriate and staff are competent to deliver a safe and effective service. Competency assessment must be completed in a timely way to ensure a competent workforce.
- Improve mandatory training compliance for medical staff across the trust, particularly for resuscitation and safeguarding training.
- Formalise clinician review processes to risk assess patients waiting a long time to be seen or overdue follow-ups across outpatient specialities.

In addition, the trust should:

- Consider the accuracy and validity of the cleaning audits completed in the emergency department.
- Complete actions and shared learning from serious incidents in maternity in a timely way.
- Consider how adverse events in maternity may impact identified risks to patient safety.
- Make the responsibility for maintaining the maternity risk register clear and regularly identify and record risks.
- Plan to audit advance care plans in the end of life service..
- Review the Overarching End of Life Action Plan to Improve the Quality of End of Life Care Provision and consider the deadlines set and whether they ensure appropriate and prompt change to the service.
- Complete timescales for meeting minutes and action plans for the end of life service.
- Complete action plans for audits in the end of life service to identify learning and improvement, for example audits of treatment escalation plans.
- Engage with staff on the Seamoor chemotherapy and day treatment unit to support and improve the culture and morale. Gain assurance incidents are being reported and learning is shared with staff in a timely manner.

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services		Sufficient progress had not been made with regards to infection prevention and control within the emergency department.
Maternity (inpatient services)		There were signs of improvement, but change was ongoing and new systems were not yet embedded.
End of life care		Progress had been made in all areas of the warning notice. However, change was ongoing and some changes were not yet embedded.
Outpatients and diagnostic imaging		Some progress had been made in outpatients. However, processes were still not embedded and, in some areas, further work was required.

North Devon District Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Maternity (inpatient services); End of life care; Outpatients and diagnostic imaging;

Detailed findings

Contents

Background to North Devon District Hospital

Background to the trust

Northern Devon Healthcare NHS Trust primarily provides acute and community services for the populations of Torridge, North and Mid Devon. They also provide some services in East Devon and Somerset.

The main hospital site, North Devon District Hospital, is in Barnstaple and provides a full range of acute services, including an emergency department, critical care, end of life care, general medicine, maternity, cancer services, outpatients, and children and young people services.

Ear, nose and throat services are delivered in partnership with the Royal Devon and Exeter Hospital, as are cancer services as part of the cancer network. The trust also works with Musgrove Park Hospital for vascular networking, and Derriford Hospital for neonatal networking.

Inspection and Enforcement

In October 2017, we conducted an unannounced inspection of the trust as part of our new phase of inspections. This included four core services: outpatients, maternity, end of life care and urgent and emergency care. We identified serious concerns in terms of safe care and treatment and good governance. We took enforcement action, serving a warning notice under Section 29A of the Health and Social Care Act 2008, and the trust was required to submit an action plan setting out how it would make improvements. We received regular updates from the trust and this inspection was undertaken to review the progress made.

Our inspection team

Our inspection team consisted of a lead CQC inspector, two further CQC inspectors, one CQC assistant inspector and one specialist advisor, a head of midwifery.

The team was overseen by Mary Cridge, CQC Head of Hospital Inspections.

Detailed findings

How we carried out this inspection

We conducted this unannounced focused inspection on 17 and 18 July 2018. We spent time talking with managers and staff for outpatients, maternity, urgent and emergency care, and end of life care services.

We used evidence provided to us prior to the inspection, as part of the trust's action plan in response to the Section 29A Warning Notice, and requested additional data following the inspection.

During our visit we spoke with 49 staff. We also spoke with one patient and their relatives. We reviewed 18 patient care records.

Facts and data about North Devon District Hospital

The trust provides a full range of acute clinical services, as well as community hospital, therapy and integrated health and social care services.

From January to March 2018, the trust's capacity included:

- 273 general and acute beds
- 12 maternity beds
- 17 critical care beds
- 109,448 bed days
- 2,578 staff, including 275 medical staff and 650 nursing staff.

The population served is approximately 165,000; however, during the summer holiday period this can increase significantly.

From March 2017 to February 2018, the trust's activity included:

- 42,836 inpatient admissions
- 429,185 outpatient attendances
- 56,693 accident and emergency attendances
- 1,322 baby deliveries
- 743 deaths

Urgent and emergency services

Safe

Overall

Information about the service

The emergency department at North Devon District Hospital provides a 24-hour service, seven days a week to the people and visitors of northern Devon.

Facilities include 10 treatment cubicles for major illness and injury and three for minor illness and injury. The resuscitation bay has four beds, one of which is equipped for paediatric emergencies. The hospital does not have a separate children's emergency department but does have a second waiting area used for children.

Patients attend the department either by walking into the reception area or arriving by ambulance at a dedicated entrance. Patients who do not come by ambulance report to reception. Once booked in by reception a triage nurse assesses the patient and directs them to the most appropriate clinical area.

The emergency department had seen over 56,000 patients from March 2017 to February 2018, of which 11,434 were under 16 years old.

We last inspected the service in October 2017 and rated the service as requires improvement overall. Requires improvement ratings were given for safe and effective, with good in caring, responsive and well-led. Following the inspection, the trust was issued with a warning notice under Section 29A of the Health and Social Care Act 2008. The concerns identified in the emergency department related to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and were breaches of regulation 12: safe care and treatment. The warning notice required the trust to make significant improvements to their infection control systems in the emergency department. This inspection was carried out to look at the improvements the trust had made as required by the warning notice.

During this inspection we spoke with seven staff. This included the assistant director of operations, the emergency department matron, doctors, nurses, the in-house cleaning contract manager, the in-house cleaning operations manager and a housekeeper.

Summary of findings

This was a follow-up inspection of urgent and emergency services to assess whether the trust had made sufficient progress in response to a warning notice issued under Section 29A of the Health and Social Care Act 2008.

Although we found some improvements, insufficient progress had been made to fully meet the requirements of the warning notice.

We have not rated the service following this inspection because it had a very limited focus.

We found:

- There was still inconsistent cleaning and ineffective oversight in the emergency department. We identified a significant build-up of dust in some areas, however audits had not identified these concerns.

However:

- Infection prevention and control training compliance had improved for both the clinical and non-clinical staff groups.

Urgent and emergency services

Are urgent and emergency services safe?

At our last inspection we were concerned about the cleanliness of the emergency department. There was a lack of oversight of infection control and poor mandatory training compliance for infection prevention and control.

We found:

- There was still inconsistent cleaning and ineffective oversight in the emergency department. We identified a significant build-up of dust in some areas, which had not been identified by the trust's assurance processes. However, the trust was undertaking a major building and redesign project at the time of our visit.

However:

- Infection prevention and control training compliance had improved for both clinical and non-clinical staff groups.

Cleanliness, infection control and hygiene

- Cleanliness and infection control was not promoted in the emergency department. There was inconsistent cleaning and ineffective oversight in the emergency department.
- At our last inspection we were concerned about the safety of patients due to the lack of clear oversight of infection control within the emergency department, or the actions required to improve cleanliness. Senior staff were unable to provide evidence of cleaning audits undertaken in the department. There was a significant risk the emergency department was not a safe or suitable environment for patients to receive care and treatment.
- During this inspection we remained concerned about the quality of the cleaning in the department. We found a significant build-up of dust in a number of areas, including:

- Majors area: the bump rails next to the fluid store, the door closers on the department's main door, the fluid store sign holder, and the wooden lip of the linen store.
- Majors bay two: the suction lid, the screening rail and the shelf behind the trolley bed.
- Majors bay three: the suction lid, the sharps bin lid and the trolley bed.
- Majors paediatric room: the monitor arm, the trolley bed and the bump rail.

- We were concerned cleaning regimes were not effective. Although the department was undergoing some significant building works leading up to and at the time of our inspection, in some areas the dust was more than simple building dust and appeared to have built-up over time. Staff told us the building work and resulting dust kept their focus, which meant they had a shorter time for cleaning other areas.
- Cleaning checklists were completed routinely but did not reflect our observations. The checklists had been completed by nursing staff and in-house cleaning staff to verify cleaning had been undertaken, but a build-up of dust was evident in areas signed off as having been cleaned.
- Since our last inspection additional housekeeping capacity had been allocated to the emergency department. A further five hours had been distributed between the evening and early morning shifts. Although these additional hours assisted the team throughout the early evening and early morning shifts, it did not appear to reduce the strain on the housekeepers during the busiest times within the department, at times when the majority of the deep cleans were undertaken.
- In January 2018 the department underwent a deep clean. An agreement had been made for quarterly deep cleans of the department, but these had not started. Although the finances had been secured, to date no further deep clean had been booked.
- The department had introduced new trolleys to keep supplies and equipment free from dust and reduce the risk of infection. These trolleys replaced the previously open-fronted trolleys, which we observed during our last inspection.
- We were not assured of the accuracy of cleaning audits, which identified the department was compliant. The cleaning audits were completed by the in-house cleaning company and showed the department was meeting the required standards. Data between November 2017 and July 2018 showed compliance was consistently better than the 95% service level agreement target. We reviewed the cleaning audits for May, June and July 2018. There

were eight areas of audit failure, relating to dust and dirt. We requested action plans for these audits but they were not provided to us. There was no evidence of any actions being taken to address the failures identified in the audits. We also requested any audits completed by the trust that provided them with assurance the cleaning company's own audits were accurate. However, we were not provided with these and therefore were not confident the trust had adequate oversight and assurance processes in place.

- Unannounced spot checks of the emergency department were completed by the infection prevention and control team. We were provided with evidence to show the lead nurse for infection prevention and control had visited the department on the 12th June 2018 to do an infection prevention and control walk round, following a previous spot check. They had found that infection prevention and control standards were much improved. They discussed their findings with the infection prevention and control practitioner and the co-ordinating sister.
- The infection prevention and control committee, held monthly, discussed the progress in the emergency department and monitored actions. We saw a copy of the minutes from May 2018 where the infection prevention and control team had picked up on a continued issue with visible blood splashes on blood gas machines and sharp bins. When they visited on the 12th June 2018 this had improved although there was still some blood splashes. The committee discussed how this was the responsibility of all those using it, however it was not clear what actions were taken to ensure this contamination did not happen.
- A recent patient led assessment of the care environment (PLACE) had been completed. We reviewed this during the inspection and identified this did not pick up on the high levels of dust in some areas.
- Leaders in the department felt they had an improved oversight of infection control and said this was discussed regularly. Matrons reviewed cleaning audit results and discussed them as part of their monthly matron meetings. However, we found this oversight was still inconsistent and ineffective. We spoke with departmental managers and in-house cleaning managers. While the department managers were aware of the level of building dust, they were unaware of the level of other types of dust.

Mandatory training

- Training compliance for infection prevention and control had improved since our last inspection in October 2017.
- At our last inspection we found poor compliance with infection control training was reflected in our observations of infection control practices within the department. In October 2017, training compliance was at 63% for non-clinical staff and 0% for clinical staff.
- Since our last inspection, training compliance had increased:
- Clinical staff: 97.7%
- Administrative staff: 100%
- Medical staff: 65%
- The matron explained the trust was compliant (100%) for medical staff training being delivered through e-learning. However, they told us the delivery of the infection prevention and control training had recently changed to a face-to-face method. This meant the medical staff were not fully compliant under the new style of training.

Maternity (inpatient services)

Safe	
Effective	
Well-led	
Overall	

Information about the service

Northern Devon Healthcare NHS Trust provides community and acute hospital-based maternity services. A team of community midwives offer care to women in north, east and west Devon, and in north Cornwall. The acute service is provided by midwives and obstetric doctors within the Ladywell Unit at North Devon District Hospital.

The service delivered 1,322 babies from March 2017 to February 2018.

The maternity facilities include:

- A delivery suite with six ensuite delivery rooms, including two birthing pools.
- A dedicated obstetric theatre alongside a second gynaecology theatre.
- An antenatal and postnatal ward (Bassett ward), with 18 beds, including one side room.
- A day assessment unit in the entrance of Bassett ward with two beds.
- An antenatal clinic with two clinical rooms, one additional room and two ultrasound rooms.

To ensure women are cared for in the correct environment for their health needs, all referrals are triaged to midwifery-led care or, if risks are identified, women are seen by medical staff at the Ladywell Unit.

We last inspected the service in October 2017 and rated the service as requires improvement overall. Requires improvement ratings were given for safe, effective and well-led. The service was rated good in caring and responsive. Following the inspection, the trust was issued with a warning notice under Section 29A of the Health and Social Care Act 2008. Issues in maternity relating to non-compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified under regulations 12: safe care and treatment and 17: good governance. The warning notice required the trust to make significant improvements. This inspection was carried out to look at the improvements the trust had made as required by the warning notice.

During our inspection we spoke with 18 members of staff, including three senior managers, three doctors, 13 midwifes (including specialists), and a maternity care assistant. We reviewed 15 patient records to evaluate the assessment and management of patient needs.

Maternity (inpatient services)

Summary of findings

This was a follow-up inspection of maternity services to assess whether the trust had made sufficient progress in response to a warning notice issued under Section 29A of the Health and Social Care Act 2008.

Although we found improvements had been made, change was ongoing and new systems were not yet embedded.

We have not rated the service following this inspection because it had a very limited focus.

During this inspection we found:

- Incident investigation had improved. Specialists from different professional groups contributed to review and identify improvements.
- Medical staff responses to requests to review patients' care needs had improved.
- Good communication and interactions between doctors and midwives.
- Leaders had begun to develop a vision and strategy for maternity care.
- An improved governance framework was in development to assure and evaluate the quality of maternity care.
- The leadership team were visible, approachable and supported staff to do their work.
- The culture within the service was improving. The results of a recent survey would be used to influence forthcoming organisational development.

However:

- Incidents and other adverse events were not used as part of service risk assessments.
- Trust targets for mandatory and service-specific training were not achieved.
- Medical staffing remained fragile while a long-term strategy for consultant job plans were developed.
- The trust was unable to demonstrate clinical practice complied with local guidelines.
- There was no audit programme. This meant assessments of care provision and risk control measures were not co-ordinated or evaluated as part of the quality management system.
- There was no clear ownership of the risk register.

Are Maternity (inpatient services) safe?

At our last inspection we were concerned about the safety of patients due to limited incident investigation, poor compliance with mandatory training, the management of risks associated with maternity care, and medical staffing.

During this follow-up inspection we found:

- A risk management meeting provided oversight of incidents and complaints, including identifying trends and performance issues.
- There was a multi-disciplinary approach to incident investigation, including obstetric contributions at the initial incident review and in serious adverse events.
- Staff we spoke with felt the response of medical staff to review patients had improved.
- We observed good interactions between the medical and midwifery team across the maternity service although there was no dedicated multi-disciplinary forum to discuss patients' clinical care.

However:

- We found incident trends and themes were not used to identify risks to patient safety or areas for service-wide improvement.
- Actions and shared learning from serious incidents were not always timely.
- The service had not met the trust target for mandatory and practical obstetric multi-professional training.
- Medical staffing was not stable, although future workforce plans were in development.

Incidents

- The overall management of incidents had improved. When we inspected the service in October 2017, we found a good reporting culture amongst midwifery staff and processes for the investigation from adverse events to ensure learning. However, we identified doctors were not always participating in incident investigations and we were unable to identify how learning was shared with the medical workforce.
- At this inspection we found improved oversight of incident management within maternity services. However, this was not considered along with the

management of risk. A fortnightly risk management meeting was held to review all open incident reports. The group identified trends and performance issues and highlighted any adverse events which required a deeper level of investigation. We observed a meeting which was attended by senior midwives, the group management team and two consultant obstetricians. The group ensured all incidents had an assigned investigator, which included an obstetrician to support the investigation. Actions were agreed and tracked at the meeting, however there was no consideration that adverse events may impact identified risks to patient safety. For example, adverse events relating to the documentation of a medicine in obstetric theatres was discussed as there was a potential for the medicine to be given twice. However, there was no consideration this should be added to the risk register.

- We found improvements to the incident investigation processes for events which resulted in low or moderate harm. Investigations were now conducted by senior midwives, including the ward manager and team leaders. This meant they could quickly identify and implement changes to practice, and feedback directly to the multidisciplinary team. We observed an open, non-blame approach to investigation, which included specialist input from other professionals such as pharmacists. Staff felt able to openly share their view of events without fear of blame. They felt involved in investigations and part of finding solutions to prevent re-occurrence.
- The group agreed actions with clear ownership for each element where trends were identified. Following a trend in incidents regarding the interpretation of cardiotocography (CTG) (a test to monitor the fetal heart and contractions of the uterus) a dedicated meeting had been established as part of wider learning. The meeting offered a forum to discuss CTG cases and enhance staff skills. Midwifery and medical staff told us they found the meeting useful and felt it had improved their practice.
- There were processes to manage concerns related to individual performance. Where the possibility of poor practice was identified, it was assigned to a member of the management team for onward handling in line with trust policy. However, when good practice was identified, direct feedback was provided to the individual and employee recognition schemes were used.
- At our previous inspection we raised concerns that obstetricians were not involved in serious incident investigation. We reviewed one serious incident investigation following an event which occurred in February 2018. The investigation was conducted by the risk midwife and a consultant obstetrician who identified remedial actions. The investigation was approved by the trust Serious Incident Review Group in July 2018. Four of the six actions had been completed. The remaining two actions related to obstetric on-call arrangements and fetal monitoring and these were still outstanding. Despite requesting information, the trust was unable to provide a timeframe for this action.

Mandatory training

- Compliance with mandatory training mostly met the trust's target, although this was not the case for medical staff. We previously raised concerns that medical staff were not up-to-date with the training necessary to carry out their role. They consistently did not meet the trust targets for mandatory training. We found this was still the case on this inspection. Compliance with training for medical staff was 78%, against a target of 85%. There was an improvement in resuscitation compliance for mothers and neonates from 63.6% to 83.3% at this inspection. Completion of fetal monitoring training has also improved from 0% to 27.8%. However, fetal growth compliance had worsened from 63.6% at our previous inspection to 16.7% at the time of this visit.
- Since our last inspection, the group manager had monitored training compliance across the service through a dashboard. We were told the data produced centrally was inaccurate and therefore a local record was being maintained. The group manager used the record to identify when staff were due for renewal and ensured they were booked to attend.
- Completion of practical obstetric multi-professional training (PROMPT) had improved, although still did not meet the trust's target. PROMPT uses simulated obstetric emergencies so staff can practice clinical skills and teamwork. There was a new process for facilitating attendance at mandatory training and PROMPT sessions. Staff were booked in advanced and the clinical workload adjusted to ensure they were able to attend. Of the 16 obstetric staff who required training, 11 staff (69%) had completed the session. We saw plans for the five remaining staff to be compliant by 5 September

2018. This was an improved position from 45.5% at our previous inspection, however still fell short of the 80% target described in the Training Needs and Delivery Strategy in Maternity Services Guideline (July 2017).

- We heard of a trust-wide process for linking non-attendance at mandatory training with performance management. Where non-attendance or non-compliance was unexplained, employees were sent a letter to remind them of the importance of mandatory training. However, we were told this process had not needed to be used within maternity services.

Assessing and responding to patient risk

- There were processes to evaluate patients' clinical status using observations, previous medical history and the identification of known risk factors. At our inspection in October 2017 we found a number of serious incidents investigations had identified missed opportunities to act in response to patient observations. At this inspection we found processes had been strengthened to ensure observations were completed regularly and any deterioration was responded to quickly.
- Medical staff responded promptly when called by the midwifery team. At our last inspection we found medical staff were not responding to clinical concerns raised by midwives. At this inspection we reviewed a number of patient records and found timed entries with a clear rationale for requesting a medical review of the patient. The medical response was timely, and documentation reflected a clear assessment of the patient, actions to be taken and expected outcomes. We found plans were made with the patient and involved the midwifery team. For example, changes to medicines, the frequency of observations and referral to support services, such as increased scanning and smoking cessation. The service had an escalation process for instances when medical staff did not respond to calls. However, midwifery staff told us they did not need to use this process as the response times had improved.
- Patients' clinical, mental and social needs were assessed throughout maternity care. We reviewed 15 sets of records for patients receiving care, to identify if risk factors were identified, reviewed and acted upon. We found the service had introduced new stickers for recording cardiotocography (CTG) tests. These stickers prompted staff to escalate results which indicated a deteriorating patient. We saw records of multi-professional involvement with clear management plans, and care was given in accordance with these plans.
- Patient safety briefings were used to minimise the likelihood of adverse events in theatre. Patient safety briefings allow the whole theatre team to prepare a plan together before an operation. We observed communication between the team and the patient who was encouraged to express their wishes. The briefing was documented as part of the World Health Organisation (WHO) safety checklist process. This is a global initiative to improve surgical safety. The trust audit for use of the WHO safety checklist in June 2018 was 100%.
- We observed regular conversations between midwives and medical staff although we did not see evidence of a dedicated multi-disciplinary team meeting where inpatient care needs were jointly discussed by clinical teams. For example, the medical records of expected admissions to the delivery suite were jointly reviewed to consider potential care needs and agree care priorities on admission.

Medical staffing

- Medical staffing within the maternity service was still a challenge however, actions had been taken to mitigate risks to reduce any impact on patient care. At our last inspection in October 2017, the trust raised concerns regarding the competency of some of the consultant workforce. This had resulted in the restriction of several consultants, which meant they were not able to work on the labour ward and delivery suite. This restriction was still in place which meant there was a significantly reduced level of permanent medical staff.
- Long-term locum staff had been providing medical care alongside consultants from other local NHS providers and those employed by the service. The trust was in the early stages of devising a strategy for the medical workforce, which incorporated rotation to other maternity units as part of a local maternity system. It was hoped this would provide broader experiences for medical staff and support their professional development.

- Staff felt the accessibility of medical staff had improved since our previous inspection. Medical ward rounds were now conducted twice a day by the consultants working within inpatient areas to provide senior clinical oversight of patient care.

Are Maternity (inpatient services) effective?
(for example, treatment is effective)

At our last inspection we were concerned that a multi-disciplinary approach was not used to deliver effective patient care. Evidence-based practice was not always followed, and obstetricians were not consistently involved in developing local policy. Patient outcomes were not routinely measured to identify areas for improvement or highlight potential gaps in clinical skills. There was a breakdown in team work, which had caused a divide between the medical and midwifery team.

During this inspection we found:

- The guideline group, responsible for authorising policies and procedures, had not met since April 2018 and documents were still awaiting approval.
- Audits to measure the effectiveness of the service through patient outcomes were not planned or co-ordinated. There was no link to policy compliance or the risk register.
- The maternity service did not meet 10 of the 21 targets identified on the performance dashboard.
- Staff training had partially improved; however, topics such as fetal monitoring and growth still did not meet trust targets.

However:

- Working relationships between consultant obstetricians and midwives had improved since our and staff described positive interactions.
- Plans were in development for new ways of working to broaden staff skills and experience.

Evidence-based care and treatment

- The trust could not be assured local guidance and nationally recognised practices always informed care and treatment. At our previous inspection, we identified healthcare professionals did not follow locally developed guidelines and best practice. This had been recognised during incident investigations. Although we observed effective practice during this inspection, the trust could not supply evidence of compliance, for example through audits. Policies to cover areas such as reduced fetal movement, highlighted following our previous inspection, were not yet developed. Minutes from the maternity patient safety forum (July 2018) described how policies were now awaiting urgent approval and were unable to be incorporated into clinical practice.
- Policies and procedures used in maternity services were developed to reflect best practice guidelines. Documents were developed by doctors and midwives. During our inspection we observed a consultant and midwife reviewing national guidance to update the local protocol. A monthly guideline group approved documents for use. The group required representation from midwifery, obstetric doctors and other specialists such as pharmacists and microbiologists, as required. However, the group had not met since April 2018 due to non-attendance by an obstetric representative. A plan was made to prioritise document approval at the newly formed Maternity Governance Forum in August 2018.
- All documents approved for clinical use were stored on an electronic document library, which was accessed via the trust intranet site. Staff were notified of changes to policies via email, a maternity newsletter, and bulletins from the intranet site. Staff we spoke with told us they felt updated and knew where to access the local policies and national guidance. During the inspection, we observed staff accessing the documents to ensure the care they provided reflected local policy.
- In the 15 patient records we reviewed, we found care was delivered in accordance with national guidelines such as National Institute for Health and Care Excellence (NICE) guidelines for intrapartum care for healthy women and babies (CC190). We saw risk factors were identified and managed, and observations such as fetal heart rate and cardiotocography were promptly acted upon. This was an improvement since our previous inspection. However, actions to be taken when reduced fetal movement was identified had been a factor in serious incidents as practice had not followed the NICE guidance. A further incident in February 2018 highlighted a policy to guide professionals was still required.

Maternity (inpatient services)

Patient outcomes

- The maternity service did not have a strategy for organising audit activity across the service. This meant audits were not co-ordinated or targeted to provide assurance of compliance with local policies. This was highlighted following our previous inspection and found to still be the case at this inspection, although work had started to develop this. We saw a draft audit plan, which included national key performance indicators alongside local audits, designed to review the effectiveness of systems and processes. We were also told of plans to employ an audit lead to deliver the plan over the next 12 months. The trust continued to capture patient outcome data to benchmark performance. However, we found there was still no oversight of audit activity to provide assurance that patients received appropriate care and treatment.
- Audits continued to be undertaken in response to issues identified by the service. For example, midwives were conducting an audit to understand the accuracy of fetal growth and weight measurements. In May 2018, the trust had conducted a fetal growth audit, which identified variations in ultrasound scanning accuracy and referral for additional scanning in 'small for gestation' pregnancies. Staff were aware of the audit, and further work was already underway to audit measurements taken at the ultrasound scan and check growth charts to ensure appropriate referrals had been made.
- Patient outcome measures showed varied performance. The maternity service used a dedicated dashboard to monitor patient outcomes. The 24 metrics within the dashboard reflected national audit programmes aimed at reducing risks to mother and babies. The service had identified targets for 21 of the quality measures. It had failed to achieve 10 of the targets set within the dashboard. The dashboard for April to June 2018 showed some performance measures had declined since our previous inspection. The percentage of eligible women offered a Down's syndrome screen had deteriorated from 98.9% to 61.3%, against a target of 100%. The caesarean rate had improved slightly since our previous inspection from 29.4% to 27.1%, although this was still not meeting the target of 24%. The emergency caesarean rate had improved to 11%, which was better than the target of 12%. The service continued to meet targets for the percentage of antenatal home bookings before 12 weeks (91.1% against a target of over 90%) and for home births (3.4% against a target of more than 3%).

Competent staff

- The service had taken steps to improve the competency of staff and acted when potential practice issues emerged. A change in the leadership team had facilitated closer working with other NHS organisations to provide development opportunities for staff.
- We were told of plans to address our concerns regarding the professional development of medical staff in the maternity service. There were arrangements to create a shared workforce with another NHS provider to allow the rotation of medical staff to another maternity service. The other provider had a higher number of births and was also able to provide care to women with high risk factors. The rotation would provide continual professional development for the medical workforce and would also provide a professional support network across the local maternity system.
- The service was developing plans to broaden staff knowledge and skills by visiting neighbouring NHS providers. We spoke with several staff in specialist roles across maternity services who had all begun working closely with colleagues in Devon to widen their experience and develop skills.
- There was a new process to escalate concerns regarding competency. When concerns regarding the practice of staff members were raised, performance was promptly evaluated through a review of case notes and escalated to the appropriate management level. We observed the discussions and agreement of benchmarking standards between clinicians and managers to allow comparators to be identified.
- Competency-related training completion varied, which meant staff may not have had up-to-date skills. During our previous inspection we had raised concerns regarding competency assessments in new born life support and fetal monitoring. Completion of new-born resuscitation training had improved, with 15 of the 18 staff (83%) having completed this training. However, of the 18 staff required to complete the fetal monitoring training, only five (27%) had done so. The fetal growth

e-learning package had been completed by only two of the 18 staff (11%). There had been no improvement within these elements of training since our previous inspection.

Multidisciplinary working

- Multi-disciplinary relationships between the consultant obstetricians and the midwifery team had improved since our previous inspection. We had previously found poor collaboration and a lack of teamwork between professional groups and raised concerns this was negatively impacting patient care. At this inspection, midwifery and medical staff told us relationships between the staff groups had improved because of changes in the medical workforce and midwifery leadership team. Multi-disciplinary teaching sessions had been held, which made inter-professional discussions easier and led to more joined up ways of working.
- Staff we spoke with felt able to discuss their patient care with colleagues and challenge clinical decision making when they felt it compromised patient safety. Staff on Bassett Ward and the Day Assessment Unit described working as a team and feeling more confident in their work. This was an improvement since our last inspection.
- We heard existing relationships had also been strengthened. For example, a multidisciplinary team meeting was now held within antenatal care. The meeting was attended by midwives, sonographers and administrative staff to look at running outpatient clinics more efficiently. The next meeting was planned to consider how the patient experience could be improved and obstetricians were invited to attend.
- Throughout our inspection we observed multi-disciplinary working within the clinical environment and in the service delivery meetings we attended. There was a good rapport between the midwifery team and the doctors, and we observed them working together throughout the service.

Are Maternity (inpatient services) well-led?

At our last inspection we were concerned that there was no clear oversight of governance and risk management within the service. We raised concerns that risk management processes were confusing and meetings were not documented to provide an audit trail which held action owners to account. During this inspection we found:

- A new leadership team had recently been appointed and were beginning to re-design quality assurance systems.
- The service was in the early stages of developing a vision and strategy for maternity care provided.
- An improved governance framework was in development which would enable service leaders to evaluate the quality of maternity care.
- Staff felt the leadership team were visible, approachable and supported them to do their work.
- Although in its infancy, the culture was improving as the leadership team started to develop the service.

However:

- We found confusion regarding the risk register, potential hazards were not always identified and the responsibility for maintaining the register was not clear.
- An audit programme had not been put in place since our previous inspection, we saw a draft schedule which was planned to commence later in 2018.

Leadership of service

- There was a clear management structure and staff felt it supported them to do their work. In the weeks leading up to our inspection in July 2018, there had been a change in the senior leadership team within the trust board and in maternity services. This appeared to be having a positive impact, although it was too early to assess its ongoing effectiveness.
- The management team had the experience, skills and qualifications to lead the service. A director of midwifery had been appointed to provide professional and operational leadership. This was a joint appointment with NHS hospital trust in Devon. The director of midwifery was supported by a maternity manager, based at North Devon District Hospital. A part-time lead obstetrician had started three days before our inspection. The lead obstetrician also worked at a neighbouring NHS hospital trust but reported to the clinical director for women and children and the medical director for Northern Devon Healthcare NHS

Trust. The group manager for women's and children's services had oversight of the specialities and monitored all aspects of the service, including performance, finance and quality assurance.

- Despite the short space of time some of the senior leadership had been in their roles, staff we spoke with felt they were visible and approachable. Staff said they felt empowered to speak up about their concerns and put improvement suggestions forward. They told us prompt, encouraging responses were given to their proposals. Staff spoke highly of the group manager who had supported the workforce through the transition of leadership teams.
- The maternity manager was supported by experienced midwives, including the delivery suite co-ordinators, team leaders, a ward manager and an antenatal lead midwife. Specialist roles operated across the service, for example there were dedicated midwives for practice development, risk management and antenatal screening. The responsibilities of these management roles were evolving to include incident investigation, investigating complaints, and ensuring staff received positive feedback.
- The maternity manager and obstetric lead had been appointed as board champions for maternity services. Daily situational reporting had continued following our last inspection and additional forums had been set up for staff to meet directly with the director of nursing and midwifery during the leadership changes.
- The model for maternity services for the population of Northern Devon was still evolving. Staff we with spoke expressed some concern that service changes may be made without consultation with staff who had the organisational knowledge and understood the needs of the local population.

Vision and strategy for this service

- A vision and strategy for the service was in the early stages of development. We had previously identified the service did not have a strategy which informed how the needs of patients would be met in the coming years. The new medical and midwifery leadership team were in the early stages of developing a strategy and vision for the service. Overall, staff talked positively about the future and could describe their contribution to the developing strategy.
- Midwives within specialist roles told us they had met with the director of midwifery to talk about the development of their service, including priorities for the next 12 months. They talked excitedly about the future for mothers and babies at North Devon District Hospital and new ways of working to improve care pathways. An away day was planned on 1 August 2018 for all senior midwives as part of creating the vision and strategies.
- The newly appointed obstetric lead had been in post for three days at the time of our inspection and was still meeting with medical colleagues. However, discussions had started about the vision for medical provision and workforce development.

Governance, risk management and quality measurement

- The service was in the process of implementing the new trust-wide governance framework intended to improve risk management from patient to board. Although we could see progress since our previous inspection, governance arrangements were not yet finalised or embedded due to the recent leadership changes.
- A new framework for the maternity service was in the process of being developed to provide a clearer oversight of governance. The meetings held within the service had been assessed and a new maternity governance forum had been established to provide a monthly opportunity to review quality and safety. The first meeting was planned for August 2018 with a multi-disciplinary membership, including key roles such as the risk midwife. It was intended the maternity governance forum would receive reports from sub-speciality meetings, such as the labour ward forum. The governance forum would also assess the effectiveness of the quality management system to promote patient and staff safety. It was planned for incident reports, complaints, guidelines and audit results to be brought the meeting to evaluate if risk control measures were functioning as intended. This would be an improvement as we found risk controls had not been measured to provide assurance the service had effectively managed clinical risks.
- We found improvement in the minuting of current meetings, including attendance and actions to be taken. There was now a clear audit trail for the patient safety forum and risk management meetings. The service was able to demonstrate consistent multidisciplinary attendance to ensure the meeting was quorate. Actions were documented and assigned an owner who was accountable for completion.

- The management and oversight of risk registers was unclear. During our inspection in October 2017, we were given conflicting information regarding the risk management process. Senior staff did not appear to have direct control and management of their risks. At this inspection we found there were still areas which needed to be reviewed. We spoke with the risk midwife and group manager who showed us different risk registers. We were therefore unclear who had ownership of the risk register. There was no correlation between measures of safety, such as incidents, audits or training compliance, with the actions taken to reduce the level of risk to patient safety. For example, we were told training non-compliance did not trigger a review of the risk register to identify if further actions were needed to keep patients safe. We were also told of one example where a risk had been removed following an audit. The risk related to baby tagging, a security system to alert staff if a baby is unexpectedly moved, which was not used by the trust. The current system to prevent abduction had been successfully tested, which led to the closure of the risk. However, the actual risk was of abduction and the control measure was the system to prevent this from occurring. The validity of the current system meant the threat was controlled but the risk was not completely removed. Therefore, the entry on the register would still need to be measured and monitored.
- There was no audit framework to monitor the quality and safety of the service, although this was being developed. We previously identified there was not a robust and regular audit programme to monitor quality and safety within the maternity unit. This meant there was no proactive approach to regularly monitor against standards and guidelines. Audits were reactive following incidents or poor performance metrics. At this inspection, we found the trust had not implemented an audit programme within maternity services. We were shown a draft schedule that was in development, which captured national benchmarks, compliance with best practice guidance and local performance metrics. In the future, outcomes of audits were planned to be reviewed at the maternity governance framework, however this was not yet established.
- The maternity service had recently participated in the Clinical Negligence Scheme for Trusts (CNST) delivered by NHS Resolution. The service was required to demonstrate compliance against 10 components of maternity safety. If gaps were identified a detailed action plan had to be submitted. The risk midwife presented the CNST return, including the action plan, to the trust board on the 3 July 2018. Gaps such as ultrasound capacity had been identified alongside changes needed to improve fetal growth measurements and attendance at practical obstetric multi-professional training (PROMPT). This work was to be overseen by the new maternity governance forum. There were plans to measure the effectiveness of action as part of the new audit programme for maternity services.

Culture within the service

- The culture within the service had improved. During our previous inspection we witnessed midwifery staff were frustrated and upset. Consultants described feeling undermined and demoralised due to a lack of engagement from senior leaders in the midwifery team. All staff felt the culture of the service had improved since our last inspection. All staff we spoke with felt communication across clinical teams had improved, they felt able to raise concerns regarding patient safety and were confident these would be addressed. There was a mutual respect between professions and relationships with the new leadership team were starting to be established.
- Staff felt more positive about their working environment, which they said had improved. They described a culture which was moving to working together more, was more open and allowed staff to make suggestions. Staff told us this was having a positive impact on patient care.
- The service had undertaken a staff culture survey in June 2018, prior to the change in the senior leadership team. This type of survey is used to measure the culture of an organisation and attitudes of the staff. These measures are known to influence patient outcomes. The trust had received the initial results of the survey and were awaiting more information before providing feedback to the clinical teams. We discussed the survey results with the director of nursing who told us the trust would be continuing to work on the themes identified.
- All staff, including the management team, thought communication had improved. They told us there was a “greater sharing of information” through access to meeting minutes and other service information held on shared computer drives. Staff felt informed via emails from the leadership team and face-to-face meetings, which had been happening throughout the service. Staff

described how they had previously felt isolated but were now engaged in discussions, for example service planning. Staff told us they had access to board members, particularly the director of nursing who continued to support staff through service changes.

End of life care

Effective	
Well-led	
Overall	

Information about the service

End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, bereavement support and mortuary services.

There was a full time interim end of life care lead who had been in the role since July 2018, prior to this the previous lead was 15 hours per week.

We last inspected the service in October 2017 and rated it as requires improvement overall. Requires improvement ratings were given for safe, effective and well-led. The service was rated good in caring and responsive. Following the inspection, the trust was issued with a warning notice under Section 29A of the Health and Social Care Act 2008. Issues in end of life care relating to non-compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified under regulation 17: good governance. The warning notice required the trust to make significant improvement. This inspection was carried out to look at the improvements the trust had made in response to the warning notice.

During our inspection we spoke with two staff. This included the outreach, resuscitation and end of life manager and an interim end of life care lead. We also spoke with one patient and the relatives of a patient receiving end of life care, and reviewed three patient care records.

Summary of findings

This was a follow-up inspection of end of life services to assess whether the trust had made sufficient progress in response to the warning notice issued under Section 29A of the Health and Social Care Act 2008.

We found progress had been made in all areas of the warning notice. However, change was ongoing and some changes were not yet embedded.

We have not rated this service because of the limited focus of this inspection.

During this inspection we found:

- There was improved oversight, audit and assessment of the end of life service. There were improvements in the governance structure. Most systems were operating effectively.
- Concerns and issues could be routinely identified and improvements had been made to the service.
- The trust was participating in the National Audit of Care at End of Life.
- There were systems for maintaining accurate and completed detailed records of patients using the end of life care service.
- We reviewed three patient records, which included comprehensive advance plans of care. These individual plans of care detailed patient choices for now and at the end of their life. Patient care needs and preferences were known and met by the service.
- The end of life strategy was due to be ratified several days after our inspection on 30 July 2018. It covered the period 2018-2020.

However:

- The trust was still addressing remaining shortfalls from the 2015 National Care of the Dying audit.

End of life care

- Actions in minutes from local working group meetings were still without timescales.
- Several audits of treatment escalation plans did not have action plans.
- Audits of advance plans of care were not available as completion of the audit was not due until September 2018.

Are end of life care services effective?

At our last inspection we were concerned there were no action plans to address the areas identified in audits where improvement was needed. Systems for maintaining accurate and completed detailed records of patients using end of life services were not operating effectively and we did not see any advance care plans.

During this inspection we found:

- Patient care needs and preferences were known in advance and could be met by staff. There were systems for maintaining accurate and complete detailed records of patients using end of life care service.
- Comprehensive advance plans of care were included in patient records. These individual plans of care detailed patient choices for this time and at the end of their life.
- The trust was participating in the National Audit of Care at End of Life.
- The trust was auditing the care plan for patients receiving care at end of life, the 'Priorities of Care Integrated Record'.

However:

- The trust had not addressed all the shortfalls in the 2015 National Care of the Dying audit.
- Audits of treatment escalation plans did not have action plans.
- Audits of advance plans of care were not available as completion of the audit was not due until September 2018.

Evidence-based care and treatment

- An action plan had been created in response to the service's performance in the 2015 National Care of the Dying audit. Following our previous inspection, we requested evidence to show the trust had addressed the shortfalls in the 2015 National Care of the Dying audit. The end of life steering group set up following our inspection did not address this as one of their actions. However, the trust had since submitted an 'Overarching End of Life Action Plan to Improve the Quality of End of Life Care Provision', which included progress and

outcomes on 51 actions to improve end of life care. This also included the outstanding actions from the National Care of the Dying audit. These outstanding actions included:

- Monthly end of life performance measures reported to the board. This action was still rated red and was due to be restarted on 11 November 2018.
- Audit of advance care plans. This was also still rated red with a deadline of December 2019.
- Introduction of the advance care plan and provision of a trust advance care planning policy. This was rated amber with a deadline of December 2018.
- Symptom management charts. This was also rated amber and due to be introduced in December 2018.
- Training for junior doctors, including communication with other organisations. This was also rated amber with a deadline of August 2019.

The action plan was informed by relevant and current evidence-based guidance, standards, best practice and legislation. For example, National Institute for Health and Care Excellence (NICE) Quality Standard 13: 'End of life care for adults', NICE Guidance 31: 'care of dying adults in the last days of life', NICE Quality Standard 144: 'National Care of the Dying Audit (NCDAH)' and 'Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020'.

- Recording of patient needs had improved. A 'Priorities of Care Integrated Record' document supported the process of advance care planning, but did not record all the required information of an advance care plan in one place. Advance care planning is generally accepted best practice and is a term used to describe a process and the conversation between people, their families, carers and those looking after them about their future wishes and priorities for care. The main goal is to clarify peoples' wishes, needs and preferences, their spirituality, and deliver care to meet these needs.
- At our previous inspection the trust had two separate care plans for patients assessed as being in the last few days of their life: one for nursing and one for medical needs. The medical care plan was not being completed and the nursing care plan was incomplete for spirituality. At this inspection we found the 'Priorities of Care Integrated Record' had been introduced, but was not being used to record medical notes alongside nursing notes. It did, however, include treatment options and patient wishes in accordance with best practice guidance.
- We sampled three sets of patient records. All three sets of records had documents in them which supported the advance care planning process. The records included fully completed treatment escalation plans, which included the resuscitation status of the patients, clear nursing and medical notes that were timed, dated, signed with names printed and, where relevant, General Medical Council doctor identification numbers. Completed records included a range of patients' needs and wishes, including spirituality.
- The patient and relatives we spoke with told us their needs had been assessed and their care planned, and this was monitored to ensure compliance. This had improved since our last inspection. During this inspection we were told the interim end of life lead had audited 10 sets of notes for the National Audit of Care at the End of Life (NACEL). This audit focused on the quality and outcomes of care experienced by those during their last admission in acute, community and mental health hospitals throughout England and Wales. The audit included advance care planning. There was no audit available for use of the 'Priorities of Care Integrated Record' because the results of the NACEL audit would not be known until September 2018. The trust had allocated a specialist palliative care officer to assist with further auditing to ensure deadlines were met.
- During this inspection we spoke with relatives of a patient receiving care at end of life. They described a 'seamless', holistic process from arrival at hospital in the emergency department to admission to a ward. Another patient we spoke with was fully informed of what was going to happen next and confirmed a conversation regarding end of life planning had occurred, including discussions regarding wishes and spirituality. This supported the information we saw in patient records for advance care planning.

Patient Outcomes

- Information about the outcomes of people's care and treatment was routinely collected and monitored. This included auditing of treatment escalation plans (TEPs). In October 2017, audits had taken place but there was no action plan to address the areas where improvement

was needed. At this inspection we found there was still a lack of action plans to address issues identified in the most recent TEP audits carried out between January and December 2017.

- The audit 'TEP forms: phase 6 – periodic monitoring (use, completion and quality)' carried out in the 12 months to December 2017 showed variable performance over the 12 months. The question about mental capacity was completed in around 80% of forms. Appropriate signatures were recorded in most cases. Signatures were recorded at their lowest number (83%) in January 2017 and their highest (98%) in May 2017. Discussions with patients and families were recorded in 65% of cases (January 2017) to 98% December 2017. Resuscitation status and reasons for the decision were recorded in 100% of cases audited. Improvements were also required for the asking and recording of questions about mental capacity, but there were not action plans to address this as a summary in the audit. There was an action to re-audit TEPs in August 2018 in the 'Overarching End of Life Action Plan to Improve the Quality of End of Life Care Provision'.
- A revised TEP form (v11) had been recently introduced. This had been audited only for the last three weeks before the inspection. Results from the audit were not available at the time of the inspection.
- The trust had summarised the themes identified from mortality reviews relating to deaths that occurred from 1 April 2017 to31 March 2018. Overall, the themes identified on completed mortality review forms were that issues could relate to any aspect of the quality of end of life care. The full set of themes were categorised. Of 309 issues, 181 comments on good practice were noted. The most common stage of care where good practice was identified was end of life care, followed by initial and consultant reviews. There were action plans with deadlines included in the review. However, it was not clear how the information was shared with staff to encourage best practice.

Are end of life care services well-led?

At our last inspection we were concerned systems did not operate effectively. There was a lack of audit and assessment of the end of life care services, and a poor governance structure. Shortfalls to audits had not been addressed and there were no timescales for actions.

During this inspection we found:

- Most systems were operating effectively. For example, there was improved oversight, audit and assessment of the end of life service. There were improvements in the governance structure.
- There was an executive and a non-executive board member with responsibility for end of life care.
- There had been a full time interim end of life care lead since January 2017.
- End of life care had been discussed and actions taken in local working groups as part of the 'living well strategy'.
- Concerns and issues were able to be routinely identified and improvements had been made to the service.
- There was an 'Overarching End of Life Action Plan to Improve the Quality of End of Life Care Provision', which included actions and timescales.
- There was an end of life strategy, which included actions and realistic deadlines. This was due to be approved several days after our inspection. The period for implementation of the strategy was 2018-20.

However:

- Actions in minutes from local working group meetings were still without timescales.

Leadership of service

- Leadership of the end of life service had improved since our last inspection. There was now an executive and a non-executive board member with responsibility for end of life care. The executive end of life lead was the director of nursing. The non-executive lead had experience in governance and was a member of the risk management committee. There was now a full time interim clinical end of life care lead who had been in post since January 2017. Interviews had started in July to appoint a permanent, full-time lead. The personnel attending the various meetings where end of life care issues were discussed were appropriate to make decisions about end of life care. For example, they included the lead chaplain, senior nurses, quality improvement facilitators and specialist palliative care team nurses.
- The end of life steering group had not met formally since December 2017 but was planned to restart on 30

July 2018. The membership requested for the steering group was appropriate for leadership and oversight of end of life issues and included the trust chair, the clinical director and the chaplain.

Vision and strategy for this service

- There was a clear vision for achieving priorities for end of life care through the draft 'End of Life Care Strategy 2018 – 2020', with realistic action plans and timescales. This was an improvement upon the end of life strategy which had been devised following our inspection in 2015. The draft strategy now included clear and achievable timescales, such as assessment of end of life care training for staff (November 2018), national bereaved person audit (31 October 2018) and promotion of advance care planning throughout the trust (31 December 2018). The draft strategy was an agenda item to be ratified at the first end of life steering group due to restart on 30 July 2018. The strategy stated "end of life care was everyone's business" and confirmed end of life care delivery was the responsibility of the director of nursing and the board chairman, who was the end of life care champion.
- The strategy was designed to encourage a culture change across the organisation; being open to, and not fearful of, discussion of death and dying. It was designed to encourage and enable patients and families to have these difficult conversations. This would improve the chance of delivering the best possible care and, as far as possible, to fulfil patient and family choices in the process.
- There was a clear vision to provide high quality end of life and palliative care. For example, the outreach, resuscitation and end of life manager and interim end of life lead spoke of the potential for improved joint working between the trust and the local hospice. They told us of plans to work closer with the local hospice to further develop specialist palliative care in the hospital. Senior nursing staff from the hospice met with the trust's end of life care leads during our inspection to discuss how this might work.

Governance, risk management and quality measurement

- The governance framework and management systems were being reviewed and improved. Following our previous inspection, we said systems did not operate effectively. There was a lack of oversight, audit and assessment of the end of life care service provided and a poor governance structure. This meant concerns or issues were not routinely identified for improvements to be made. Governance had improved overall since our last inspection, but there was still work needed. Some audits still needed to include action plans and advance care plans needed to be embedded in practice. Additionally, some meetings for end of life had not taken place.
- Oversight of end of life care was expected to improve with the new end of life steering group meetings starting in July 2018. An 'overarching action plan' had been updated on 30 July 2018 and included owners for actions, with deadlines set. The trust was also able to summarise some of the themes identified from mortality reviews relating to deaths that occurred in 2017/18. However, it was not clear where or how this information was shared so others could reinforce good practice. Some deadlines in the action plan, such as the plan to audit advance care plans by December 2019 required review to ensure they monitored progress effectively.
- At our last inspection we found the end of life steering group had a list of actions at the end of each set of minutes, but no timescales for when these would be addressed. This was still the case.
- End of life matters were not adequately covered by the mortality review group. Staff told us the mortality review group had not worked effectively to cover all relevant end of life matters in enough depth. This was because end of life issues had not featured highly enough in discussions. End of life care issues had not been discussed in the meeting since December 2017. Instead, end of life care was discussed and actions taken at the mortality review committee, which was chaired by the interim medical director. Members included the specialist palliative care team staff. These meetings had taken place in January, February and March 2018 and included discussion about support for bereaved families and carers, and the end of life strategy. The mortality review committee meetings had action logs attached and actions had due dates. However, there had been no mortality review committee meetings since April 2018. Local working groups to support the 'living well to the very end quality improvement project' had ensured some monitoring of end of life care still occurred and some actions were taken. The minutes of these meetings included relevant agenda items. For example,

meal provision for relatives of dying patients and information provision for bereaved relatives. Actions to be taken against the agenda items were recorded, but were still without deadlines to be completed.

- The National Assessment of End of life Care audit had been started. This auditwould enable oversight of the quality and outcomes of care experienced by those in their last admission in acute, community and mental health hospitals throughout England and Wales. The results were not available at the time of the inspection.

Outpatients and diagnostic imaging

Safe	
Effective	
Responsive	
Well-led	
Overall	

Information about the service

The main outpatient department at North Devon District Hospital provides new and follow-up outpatient appointments Monday to Saturday across the north Devon region. There were 429,185 trust outpatient attendances from March 2017 to February 2018, across all outpatient locations in the trust, with 307,585 at North Devon District Hospital. Trust outpatient attendances included:

- Ophthalmology – 36,056 attendances
- Dermatology – 11,552 attendances
- Medical specialities – 208,341 attendances
- Oncology – 7,342 attendances
- Other – 69,194 attendances

The main outpatient department at North Devon District Hospital is divided into three main outpatient areas (A, B and C), near the hospital main entrance. Additional speciality clinics such as ophthalmology, oncology and fracture were located throughout the hospital. There were several different waiting areas. Individual clinics were run with their own reception desks, with some locations running clinics simultaneously. The administrative staff were located throughout the individual clinics.

The Seamoor chemotherapy and day treatment unit consists of an outpatient clinic area and an outpatient treatment area. The unit was open Monday to Friday 8am to 6pm, with additional clinics running on Saturdays as required. The clinics are consultant led. There are seven consultant rooms and two quiet rooms. The treatment area is nurse-led and consists of an open plan treatment area containing 14 patient chairs. There are three private side rooms available for procedures requiring privacy.

We last inspected the service in October 2017 and rated the service as inadequate overall. Inadequate ratings were given for safe and responsive. Well-led was rated as requires improvement and caring was rated as good. Effective was not rated. Following the inspection, the trust was issued with a warning notice under Section 29A of the Health and Social Care Act 2008. Issues in outpatients related to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 under regulations 12: safe care and treatment, and 17: good governance. This warning notice required the trust to make significant improvement to their outpatient service. This inspection was carried out to look at the improvements the trust had made in response to the warning notice.

During this inspection we spoke with 22 staff. This included: directors, managers, administrative staff, consultants, matron, ward manager, nurses, healthcare assistants and receptionists.

Outpatients and diagnostic imaging

Summary of findings

This was a follow-up inspection of outpatient services to assess whether the trust had made sufficient progress in response to the warning notice issued under Section 29A of the Health and Social Care Act 2008.

Some progress had been made in outpatients, however processes were still not embedded and in some areas we did not find a significant amount of change.

We have not rated this service because of the limited focus of this inspection.

During this inspection we found:

- Trust managers were better sighted on waiting lists and those patients who were waiting a long time to be seen. Weekly referral to treatment time meetings reviewed patients in detail.
- The trust was formalising their harm review process, with retired clinicians identified to complete this exercise.
- Specialities found it easier to gain approval for additional clinics, however this was dependent on capacity.
- The ophthalmology task and finish group were reviewing how they could improve the efficiency of the ophthalmology service through different project workstreams. However, there were still actions remaining and work required to move things forward.
- There was weekly monitoring of data quality issues. Management were fully aware of any limitations with the electronic health record which incorporates the booking system.
- Governance processes were being improved. However, they were not yet embedded for us to judge the impact across the service.
- There was an improved system to manage and record risks at a local outpatient level.
- The ophthalmology action plan had a person responsible for each action.

However:

- The culture for incident reporting in the Seamoor chemotherapy and day treatment unit had not improved. There was a back-log of incidents which had not been signed off by management, delaying the learning for staff.
- Mandatory training compliance for medical staff had improved but was still below trust target for some modules. Compliance with resuscitation training was poor and safeguarding training needed improvement.
- There was not capacity for regular clinician reviews in some specialities. When requested we were not provided with evidence to show the processes had improved in cardiology.
- The in-house competency assessments on the Seamoor chemotherapy and day treatment unit were not completed in a timely way. There was still a misunderstanding between staff and the unit management about what training was required to ensure competency. Some staff would soon be signed-off as competent, however they were not always confident in their role.
- The trust was still underperforming against referral to treatment times and patients were waiting for long periods of time.
- Trauma and orthopaedics had a high number of patients who had been waiting over 52 weeks. However, all patients waiting over 40 weeks were being formally reviewed.
- There were concerns about the culture and morale of staff on the Seamoor chemotherapy and day treatment unit. Staff told us they had not been engaged since the issue of the warning with regards to the concerns raised about the unit.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

At our last inspection we were concerned about incidents not being reported for the Seamoor chemotherapy and day treatment unit, mandatory training compliance for medical staff, processes for clinicians reviewing patients who were waiting a long time to be seen, overdue follow-ups to assess risk and patient harm incidents in ophthalmology.

During this inspection we found:

- Managers and leaders was better sighted on waiting lists and those patients who were waiting a long time to be seen. The weekly referral to treatment time meetings reviewed patients in detail.
- The trust was formalising their harm review process, with retired clinicians lined up to complete this exercise.

However:

- The incident reporting culture in the Seamoor chemotherapy and day treatment unit had not improved. There was a back-log of incidents which had not been signed off by the ward manager, delaying the learning for staff.
- Mandatory training compliance for medical staff had improved but was still below the trust target for some modules. Compliance with resuscitation training was poor and safeguarding training needed improvement.
- There was not capacity for regular clinician reviews in some specialities. Processes had not improved in cardiology.

Incidents

- We were not assured incidents were always reported on the Seamoor chemotherapy and day treatment unit, or that learning was shared in a timely way. This had not improved since our last inspection. At our previous inspection staff told us there were no incidents of patient harm and staff were not reporting near misses and other incidents. During this inspection staff told us they were aware of what constituted an incident and said they were confident to report these. However, they did not receive feedback when incidents were reported and sometimes found it difficult to find time to complete an incident report. Staff said they were now reporting incidents of near misses, although there were few occurrences. They also said they reported treatment starting late and when staff finished late. We reviewed a report for the unit covering incidents over a six-month period from 23 November 2017 to 10 July 2018. Only 20 incidents had been reported over this time and we saw no examples of near misses or staff reporting treatment delays, which did not correlate with what staff told us. The incident numbers did not match a report provided on the unit's position statement, which stated from 9 April to 19 July 2018 there had been 38 incidents reported. On review of this report we found one incident had been captured 18 times and a second incident had been captured 10 times, therefore there had only been 12 incidents in this time period. The clinical matron confirmed each incident was discussed at their governance forum. However, when reviewing incidents with the ward manager there was a backlog of incidents dating over a year to March 2017, which had not been signed off by the ward manager. This meant learning from these incidents and feedback to staff had not happened or had been delayed. The ward manager regularly worked clinically so had little time to review incidents, a number which had been inherited since they started in their post.
- The number of incidents reported and levels of patient harm for ophthalmology had reduced since our last inspection. At our previous inspection 20 patients in ophthalmology were identified where they had gone past their follow up dates, with evidence of patient harm suffering partial or total vision loss. Since our last inspection the trust have continued to identify and review any patient harm for patients with delayed follow-ups in ophthalmology.

Mandatory training

- Training compliance for medical staff had improved, but was still below the trust target for some modules. The trust had improved the oversight of medical staff training and were reviewing ways to improve the timeliness of uptake of training courses to ensure staff remained in date. The management team had requested executive support for the completion of statutory and mandatory training. Since our last inspection the trust had focussed on improving training

compliance across the trust, particularly for medical staff. A monthly report was sent to the board and managers. This was broken down by staff group, and clearly showed medical staff compliance.

- Trust-wide data for 30 June 2018 showed medical and dental staff were 74.4% compliant, which was below the 85% trust target. Compliance with NHS conflict resolution (30%), resuscitation (59.1%), and emergency preparedness, resilience and response (48.1%) training programmes were particularly poor. We spoke with the assistant director of workforce about resuscitation compliance and were told there had been difficulties booking staff in to training dates around clinics. This had been escalated to the resuscitation team who were working to provide additional dates to provide the training. Safeguarding level two (69.4%) and safeguarding level three (80.3%) were also below target. Reviewing the data for planned care division specialities (including most outpatient specialities), this showed a similar picture for medical staff with poor compliance for resuscitation and safeguarding level two training. There were still gaps where medical staff had no date recorded for completion of training.
- A flowchart had been developed to trigger what training was required for staff members, and was aligned to the core skills framework. This was made available to all staff.
- Human resource team processes had been formalised to escalate and follow-up any non-compliant staff. Individuals were written to if training had expired and would be performance managed.
- A lead consultant for training had been identified. They were responsible for monitoring training compliance and reminding medical staff of training requirements. Training was raised at meetings as a further reminder. Appraisals were used to review training compliance, and a new appraisals lead ensured this happened.

Assessing and responding to patient risk

- Managers were better sighted on waiting lists and those patients who had been waiting for long periods of time. However, there was not enough capacity for clinicians to complete reviews and processes still needed to be finalised and embedded to clearly and consistently review patients who were waiting a long time to be seen or overdue their follow-up appointments. At our previous inspection we found clinicians were not reviewing long-waiters to risk assess each patient across outpatient specialities. Although they ran a report for outpatient long waiters, a face-to-face review with the clinician was not being completed. At this inspection we found there were improved processes within outpatients for reviewing patients who had been waiting a long time to be seen. This ensured patients were risk-assessed and patients were seen as soon as possible, dependent on risk. Patients waiting over 40 weeks were reviewed individually at weekly referral to treatment time (RTT) meetings. We reviewed the last four RTT meeting minutes, which covered all specialities. The meetings reviewed the current RTT position and talked about patients in detail. A 52-week breach review meeting was also held to review those patients who had been waiting longer than 52 weeks, or were approaching this time.
- Some specialities had processes to review and risk-assess patients. We observed a consultant in ophthalmology reviewing the 'overdue for follow-ups' list. They read each patient's clinic letter and medical records, identified the risk level, and determined the most appropriate clinic and time for them to be seen. This was completed every four to six weeks with each consultant. This was not a new process and had been occurring monthly between the patient access co-ordinator and consultants since December 2016. We also saw a review process completed for trauma and orthopaedic patients who were waiting for 40 weeks or over. Clinicians reviewed all X-rays and clinic letters to risk assess and prioritise the patients.
- There was limited evidence patients on the cardiology waiting list were being reviewed. At our previous inspection we found there were ineffective processes for monitoring patients on the cardiology waiting list. Patients at risk of deteriorating while waiting were not always identified. At this inspection we were told there were improved processes for the monitoring patients on the cardiology waiting list. However, we requested evidence of this but were not provided with anything that demonstrated formalised processes for clinician reviews. We were told the patients who had been waiting the longest were reviewed monthly and risk was assessed. Any overdue follow-ups or procedure waits were discussed at the quarterly cardiac operational group. However, we reviewed the minutes from the February and May 2018 meetings and although patient numbers were discussed there was no evidence individual patients were discussed. We were also told

cardiology used email to discuss all patients reviewed and they were planning to align processes with other specialities. We requested evidence of this and were provided with email trails. However, these did not show a clinician review to monitor individual patients.

- The backlog of cardiology patients who were overdue their follow-up appointment had been cleared since our last inspection. On review of data for at the time of our July 2018 inspection we found no overdue follow-ups for the previous year. There were two overdue patients from January 2018, four from February 2018, 19 from March 2018, 13 from April 2018, 84 from May 2018 and 94 from June 2018. This had improved since our last inspection in October 2017 where we had found 214 patients from 2016 still showing in the follow-up list for 2017.
- The trust was formalising its harm review process to ensure it was consistently applied. This included over 40-week waits, cancer waits over 62 days, overdue follow-ups pending, and emergency department trolley waits. A draft document for the process had been written but had not been finalised. Retired clinicians were taking on the role of reviewing and completing harm reviews. This process would replace the current process of completing significant event audits.
- Staff on the Seamoor chemotherapy and day treatment unit were concerned about the delays in calling for medical support as there was no doctor for the unit. When treatment was continued after 5pm staff were required to bleep the on-call doctor, which added further delays to medical staff support being available on the unit. We were told there had been incidents where patients had reacted to their treatment and doctors did not get to the unit quickly, staff said there was no harm caused to the patient but there was the potential form harm. On review of incidents we did not see any incidents to record these issues. We were told an oncology staff grade was due to start in post in Autumn 2018, which would provide more regular medical support.

Are outpatient and diagnostic imaging services effective?

At our last inspection we were concerned about the competency of staff to administer chemotherapy in the Seamoor chemotherapy and day treatment unit.

During this inspection we found:

- The in-house competency assessments on the Seamoor chemotherapy and day treatment unit were not completed in a timely way. There was still a misunderstanding between staff and the management team as to what training enabled them to be competent. Although some staff would soon be signed off as competent, they were not always confident in their role.

Competent staff

- The timeliness of completing in house competency assessments to administer chemotherapy was poor. There were two nurses who started in the department approximately 14 months and 18 months before our inspection, but neither had fully completed the competency assessment. In our previous inspection staff raised concerns that they were verbally signed off to administer chemotherapy with no formal assessment of the competency. This had improved since our last inspection. We spoke to a nurse completing their in-house competency assessment and they confirmed the ward manager observed their practice and had provided feedback and support each time a competency was complete. We reviewed one competency assessment document, which had been ticked and signed off by the ward manager, but there were no comments recorded to evidence the feedback. We were told the difficulties lay with co-ordinating time to sign off competencies. We were told the process for in-house competency assessment was due to be improved imminently, with the department introducing a nationally recognised document, this would be trialled for new staff starting their assessment. All staff completed annual chemotherapy revalidation. This was last completed in June 2017 and the next revalidation was due in October 2018.
- Confusion around the competency of staff to administer chemotherapy remained. At our previous inspection staff told us they were not trained to administer chemotherapy and there were long waits to access the accredited course. At this inspection we confirmed staff were not required to obtain the accredited chemotherapy course, although this was advantageous. We were told communication had taken place to explain to nurses they did not need the external accredited

chemotherapy course to be deemed as competent. However, during our inspection we found staff still did not think they were competent because they had not all received the accredited training.

- The number of experienced staff who had completed an accredited chemotherapy course was going to reduce and these posts had not yet been filled. Four of the eight staff had completed the accredited course, including the ward manager, a sister (nurse in charge), a nurse and an agency nurse. The remaining two nursing staff were due to undertake the accredited course in September 2018 and two new staff members would be enrolled the following year. The course had been delayed from May to September 2018 as there had not been enough delegates to run the course. The ward manager and nurse, who were both accredited, were leaving their posts, recruitment processes had been commenced. This would reduce the number of experienced staff, and impact on the ability to run rotas to include one accredited chemotherapy nurse on each shift. Following our inspection a Seamoor Unit position statement was completed to give assurance to the executive team that the Seamoor unit was delivering safe and effective care by a team that were competent and skilled to do so. The executive team were reviewing this information in line with the concerns we raised about the service.
- Not all staff felt confident in their role. Some staff who had been assessed as competent following the in-house and external accredited training did not necessarily feel confident. There was a lack of experienced staff members and a high turnover of staff, reducing the number of staff who were available to support the less experienced and less confident staff members.

Are outpatient and diagnostic imaging services responsive?

At our last inspection we were concerned patients were not being seen in a timely manner in ophthalmology, and data was not accurate for the trust to be aware of patients waiting across outpatient specialities.

During this inspection we found:

- Specialities found it easier to gain approval for additional clinics, however this was dependent on capacity.
- The ophthalmology task and finish group were reviewing how they could improve the efficiency of the ophthalmology service through different project workstreams. However, there were still actions remaining and work required to move things forward.
- There was weekly monitoring of data quality issues. Management were fully aware of any limitations with the electronic health record which incorporates the booking system.

However:

- The trust was still underperforming against referral to treatment times and patients were waiting for long periods of time.
- Trauma and orthopaedics had a high number of patients waiting over 52 weeks. However, all patients who had been waiting for over 40 weeks were being formally reviewed.

Service planning and delivery to meet the needs of local people

- Increased numbers of clinics had helped improve the delivery of the ophthalmology service. The trust had allowed outpatient specialities to run additional clinics without requiring an approval for each request. Our previous inspection identified patients were not being seen in a timely manner in ophthalmology due to limited capacity within outpatient clinics. At this inspection, managers told us it was easier to put on additional clinics as they did not need to go through a lengthy approval process. However, this was dependent on capacity to deliver additional clinics. There had been 89 extra clinics in ophthalmology since October 2017, and approval to set up clinics for the next six months. This had helped reduce the waiting time for patients to see consultants in ophthalmology.
- There was now a clear route for the ophthalmology service to be reviewed through the ophthalmology task and finish group. This group looked at improving how the ophthalmology service could be delivered. At our previous inspection we found the trust had failed to act in a timely manner to actions identified from previous investigations about improving the ophthalmology service. The task and finish group was a multidisciplinary team set up to review how the efficiency of the ophthalmology service could be improved. The group had been running for 12 weeks

and had agreed to stay together for another 12 weeks to enable them to accelerate some work and to meet the set timescales. Projects included: demand modelling, capacity planning, administrative processes, multi-skilled healthcare professionals, administration staff, nursing support, long term workforce planning and recruitment, clinic efficiency, space and equipment, accident and emergency pathway, what to stop doing/ demand management, and clinical harm review and mitigation. The demand and capacity project remained red when assessed against targets and the progress made. It was still a challenge to ensure data was accurate, long-term staffing was in place and clinic space available, this was being reviewed by the group. We reviewed and discussed with the group the update on their progress they had presented to the trust's quality oversight and assurance committee. Although progress had been made within the group there were still several projects with actions remaining. For example, a model had been put together for glaucoma but still required validation. They had improved standard operating procedures for administrative processes, but these required approval and dissemination. Competency documents had been developed and agreed for healthcare professionals, but training was required.

Access and flow

- The trust was still underperforming against referral to treatment times and patients were waiting for long periods of time. There were a high number of patients waiting for over 52 weeks for trauma and orthopaedics. The trust was not meeting the 92% standard referral to treatment (RTT), but this was similar nationally and within the Sustainability and Transformation Partnership (STP). At the time of our inspection the current position of RTT reported by the trust was:
- Ophthalmology – 80.1%
- Cardiology – 69.3%
- Trauma and orthopaedics – 60.2%
- General surgery – 67.8%
- Neurology – 40.7%
- Rheumatology – 82.7%
- The trust was now reporting RTT data and had been reporting for over one month. At the time of our previous inspection the trust did not have accurate monitoring data for patients accessing services. Referral to treatment (RTT) reporting had been suspended since May 2017, in agreement with NHS England, while the trust implemented a new bookings system. Due to unexpected issues following implementation, the trust continued its 'reporting holiday'. There was a large delay before the trust was able to return to reporting.
- The trust's action plan to reduce overdue follow-ups was delivering mixed results. Between December 2017 and June 2018, cardiology, ophthalmology, general surgery and respiratory medicine were improving and performing better than plan. However, some months showed an increase in overdue follow-ups from the previous month's figures. Colorectal surgery, gastroenterology, rheumatology, neurology and orthoptics were not meeting the plan. Patients on the follow-up pending list with an overdue date included 14 patients in neurology from 2016 and 386 from 2017; one patient in cardiology; 36 in ophthalmology and 166 in orthoptics.
- Cancellations and non-attendances were better managed. Training and processes had been improved to support staff with this. Outcome forms were completed if no appointment was available in the requested time-period, and a time critical wait list was being monitored.
- There were a number of patients waiting for over 52 weeks, and we were told the position was likely to worsen before getting better. A report dated 16 July 2018 showed there were 94 patients waiting for over 52 weeks. Most of these patients were for trauma and orthopaedics. We discussed the position with the trauma and orthopaedics management team who felt this was likely to get worse before it got any better. There was a recovery action plan. All patients who were waiting for over 40 weeks were being reviewed. Some of the delays were due to patient choice, for example declining an appointment at an earlier time.
- Consultant-led ophthalmology had seen a reduction in their follow-up pending list, despite increased referrals. However, orthoptic-led glaucoma monitoring capacity was still an issue due to vacancies and patients being moved from consultant lists to orthoptic lists. The recruitment of orthoptists had failed. Short-term solutions were being reviewed and were awaiting approval from the executive team. There was one vacant medical post and two vacant orthoptist posts.
- The cardiology trajectory was on plan and there was an action plan to reduce waits further. Two additional

sessions had been planned each month and were being achieved. There was an overlap of one consultant leaving and another consultant starting, which had also temporarily increased capacity. However, cardiology had difficulties filling vacant appointments at short notice as there was no reporting function to identify these slots.

- Issues with the electronic health record, which incorporates the booking system, had been reviewed and managers told us they were more assured of the reliability of the waiting list. At our last inspection the new electronic health record had been implemented, but this had not gone smoothly. Information about outcomes and follow-ups was missing from the booking system and some patients were incorrectly placed on pending lists. At this inspection we found the trust were fully aware of the limitations with the booking system and data was being regularly reviewed to ensure outcomes were recorded and follow-ups weren't missing. An upgrade was due to the system, but following testing the trust did not go ahead with the upgrade because further issues were identified. They would not go ahead with the upgrade until the problems were resolved with the system provider.
- Weekly monitoring of data quality issues was being completed. This reviewed unrecorded outcomes and missing recall date. In July 2018 the number of patients without a recall date was less than 10. These patients were reviewed and discussed with medical staff to complete any missing details. Unrecorded outcomes from clinics were monitored. This had peaked at 1,681 in December 2017 and had since reduced to 322.
- The numbers of patients 'lost to follow-up' had reduced. Our previous inspection found there was an increase in the number of patients who were lost to follow-up across all outpatient specialities because of lost contact or IT failure, impacted by the introduction of the new electronic health record, which incorporates the booking system. During this inspection the lost to follow-up patients were reviewed on a weekly basis so this could be addressed immediately. The trust was aware of one problem where there were blank recall dates, all blank recall dates were reviewed to ensure a date was added. A weekly report was also received by the administrative team listing any unrecorded outcomes to make sure this information could be obtained and recorded.

Are outpatient and diagnostic imaging services well-led?

At our last inspection we were concerned the governance system did not support the delivery of good quality care, there was not an effective system to manage risks, and there had been an historical failure to act on issues identified.

During this inspection we found:

- Governance processes were being improved. However, they were not yet embedded for us to see the impact across the service.
- There was an improved system to manage and record risks at a local outpatient level.
- The ophthalmology action plan had a person responsible for each action, to ensure ownership.

However:

- We were concerned about the culture and morale issues on the Seamoor chemotherapy and day treatment unit. Leaders had not engaged with staff since the issue of the warning notice.

Governance, risk management and quality measurement

- The changes to governance appeared positive and had been well received by leaders. However, this was early in the change process and required time to embed.
- At our previous inspection we found the governance system did not support the delivery of good quality care and we could not identify who had overall responsibility for all outpatient areas at both clinic and board level. There was no identifiable manager in charge of the clinical aspects of the ophthalmology department and clinics. Not all managers were aware of the programme of audit being carried out. Managers did not receive feedback about themes and trends from incident data, and multiple managers investigated incidents in the same speciality but were not aware of the outcomes.
- At this inspection we found there was a clearer operational structure for outpatients, which identified

the responsible individuals and reporting lines. This was in the process of being finalised before being shared with staff. Board level responsibility lay with the director of nursing and quality.

- New governance meetings had been introduced and improved the oversight of risk and quality. The outpatient service held their first governance meeting a couple of weeks before our inspection. The plan was for these meetings to be held monthly and a review process to take place after three months. This governance meeting enabled the discussion of finance, performance and clinical governance. It then fed in to the divisional governance meeting, which was the route up to board level. From 1 July 2018 a decision was made for ophthalmology and the fracture clinic to be standalone services, although the administration staff still sat within the outpatient management structure. They were in the process of forming their own governance structures, which mirrored outpatients.
- Weekly morning safety huddles were taking place. These were led by an executive and attended by the group manager for planned care. Issues and concerns about risk and quality were raised at these meetings to ensure the executive team were aware and actions could be taken to address concerns.
- Divisional co-ordinators had been recruited but were yet to start in their post. The role of these co-ordinators was to support managers with risk and governance.
- There was an improved system to manage risks at a local level. Leaders we spoke with were able to access the risk register and had the understanding and knowledge of their own risks. Risks were reviewed at speciality and divisional governance meetings. At our previous inspection we found there was not an effective system to manage risks and the local outpatient risk register did not have any risks recorded. Once escalated to the trust-wide corporate risk register the risks were closed on the local risk register. This meant local managers did not have oversight of the risks and updates on risks were not being fed back down to service leads and clinical managers. Risks were not being regularly updated or reviewed. Actions remained open had no lead identified. At this inspection we saw improvements had been made to the risk reporting system. Risks could be identified using dashboards for the outpatient service or specialities. We tracked risks and could see risks escalated to the corporate risk register remained on the local risk register and managers had an improved oversight.
- All risks and actions were now assigned to an individual as the responsible lead. Every day from three days before an action was due to be complete, the risk owners were sent a reminder to prompt them to review and update the risk. The risk management committee was responsible for reviewing any overdue actions and there was a formal process to follow-up if risks had not been completed. Staff had access to a new link on the intranet to submit a risk. This helped encourage staff to record and escalate risks.
- We reviewed the outpatient risks. There were nine outpatient risks, with the majority relating to the electronic health record which incorporates the booking system. There were two risks in ophthalmology, which included one overarching risk capturing the actions from the deep dive reviews and incidents of patient harm for example waiting times, staffing, and clinic space. There were seven risks for cardiology, which included delays to follow-ups and scanning times. A risk had also been added for monitoring of the cardiology waiting list.
- There was improved oversight of actions required following investigations. At our last inspection we identified there had been an historical failure to act on issues identified through a deep dive review in ophthalmology which identified numerous similar incidents of patient harm. Between January 2011 and December 2016 there had been 51 incidents which were escalated to significant event audits. A total of 164 actions had been identified. Many actions remained open with no ownership by an individual. The deep dive report also identified that following a national patient safety alert a required clinical audit was not undertaken and actions remained open. At this inspection we reviewed the actions for the ophthalmology action plan, which included actions identified in two deep dives and an NHS Getting It Right First Time visit report. Each action had a person who was responsible for taking ownership of the action and actions were progressing.

Outpatients and diagnostic imaging

- Actions from the national patient safety alert clinical audit had now been completed. The glaucoma monitoring clinic referral guidelines had been reviewed and standard operating procedures updated.
- We raised concerns about the Seamoor chemotherapy and day treatment unit with regards to culture and morale, patient safety, staffing skill mix, patients being sent to other hospitals, training, competencies, and turnover. Following our inspection, a position statement was written to provide assurance to the executive team the unit was delivering safe and effective care by a team that were competent and skilled to do so.

Culture

- The culture and morale in the Seamoor chemotherapy and day treatment unit was concerning and staff appeared disengaged. Staff were concerned how the staffing levels, skill mix, and lack of support impacted on patient safety. This had been raised with management and at the time of our inspection was being reviewed.
- The management team had not engaged with staff to identify and attempt to resolve issues since the warning notice had been served. We saw little improvement or positive change in the department as a result. There was no evidence to show information had been shared with staff via team meetings, staff were not aware of any change and managers could not tell us about the change they had made to processes.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure the emergency department is cleaned to a high standard and there is not a build-up of dust.
- Meet trust targets for mandatory and practical obstetric multi-professional training in maternity. It should be ensured the training data produced centrally is accurate.
- Develop and undertake audits to measure the effectiveness of the maternity service against patient outcomes, policies and risks.
- Ensure the skill mix is appropriate in the Seamoor chemotherapy and day treatment unit.
- Ensure staff in the Seamoor chemotherapy and day treatment unit are competent and confident to deliver a safe and effective service. Competency assessments must be completed in a timely way to ensure a competent workforce.
- Improve mandatory training compliance for medical staff across the trust, particularly for resuscitation and safeguarding training.
- Formalise clinician review processes to risk-assess patients waiting a long time to be seen or overdue follow-ups across outpatient specialities.

Action the hospital SHOULD take to improve

- Review the accuracy and validity of the cleaning audits completed in the emergency department.
- Complete actions and shared learning from serious incidents in maternity in a timely way.
- Consider how adverse events in maternity may impact identified risks to patient safety.
- Make the responsibility for maintaining the maternity risk register clear and ensure risks are regularly identified and recorded.
- Consider auditing advance care plans sooner than currently planned.
- Add timescales for action plans for the end of life service.
- Complete action plans for audits in the end of life service to identify learning and improvement, for example audits of treatment escalation plans.
- Engage with staff on the Seamoor chemotherapy and day treatment unit to support and improve the culture and morale. Gain assurance incidents are being reported and learning is shared with staff in a timely manner.

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
Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA 2008 (RA) 2014: Safe care and treatment** **12(1) Care and treatment must be provided in a safe way for service users.** **The emergency department was not cleaned to a high standard, with a significant build-up of dust. This increases the risk of infection to patient.** **Mandatory and practical obstetric multi-professional training in maternity did not meet trust targets. The data held centrally was not accurate.** **Mandatory training compliance for medical staff across the trust was not meeting trust targets. There was poor performance with training for resuscitation and safeguarding.** **The Seamoor chemotherapy and day treatment unit had a high turnover of staff, which impacted on the skill mix. Staff were not completing in-house competency assessments in a timely way and not all staff were confident in their role.** **Clinician review processes to risk-assess patients waiting a long time to be seen or overdue follow-ups for outpatient specialities were not formalised.**

Regulated activity	Regulation
Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA 2008 (RA) 2014: Good governance**

This section is primarily information for the provider

Requirement notices

17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

Audits in the maternity department were not being completed to measure the effectiveness of the service against patient outcomes, policies and risks.