Northern Devon Healthcare NHS Trust

North Devon District Hospital

Quality Report

Raleigh Park
Barnstaple
Devon
EX31 4JB
Tel: 01271 322577
Website: www.northdevon.nhs.uk

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

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	**Requires improvement**
Maternity and gynaecology	**Requires improvement**
End of life care	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected North Devon District Hospital to check if changes had been made in specific areas where we found breaches of regulations for the core services of urgent and emergency care, end of life care, and maternity and gynaecology during our comprehensive inspection in July 2014. The inspection was carried out between 5 and 7 August and on 17 August 2015.

As this was a focused follow-up inspection, we did not inspect the following core services: medical care (including care of the elderly), critical care, surgery, services for children and young people, and outpatients and diagnostic imaging.

For the core service and quality issues inspected, we rated the North Devon District Hospital as Requires Improvement. Some areas of concern found at our previous inspection had been dealt with but others required further work, such as the need to provide effective and safe care for patients at the end of their life and to provide responsive and safe care for patients using urgent care services.

Our key findings were:

- Work in the maternity and gynaecology service around working relationships between the medical and midwifery teams had progressed but more focused work was needed to ensure cohesive teamwork.
- Patient flow through the hospital due to bed capacity and delays in timely discharge of patients from wards continued to impact on the emergency department but patients were seen and treated in a timely way.
- There were delays to discharge of patients at the end of life, which led to people not being in their preferred place. While this was not always in the control of the trust, the impact on people and their families was concerning
- In response to the findings, shortly after the inspection we asked the trust to provide us with a plan of action that set out how they will ensure they are providing an effective and well led service for people at the end of their life. The trust responded with an action plan detailing the steps they are taking to address the issues raised. We will review the implementation of the action plan in due course.
- A number of actions had been taken in the emergency department to improve infection prevention and control measures. These were supported by regular audits, which showed good compliance with trust policies.

We saw some areas of outstanding practice, including:

- We heard about the recent 'open day' held by the maternity unit. This took the form of a market place and had stalls about smoking cessation, domestic violence, infant nutrition, perinatal mental health team, National Childbirth Trust, antenatal screening and the local Maternity Service Liaison Committee. All the stalls had leaflets available for people to take away. We were told it was really well attended as it had been advertised on local radio and in the local newspapers. We were told people who attended were a mix of expectant and new mothers and some people who were interested in midwifery as a career.

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

An action that a provider of a service MUST take relates to a breach of a regulation that is the subject of regulatory action by the Care Quality Commission. Actions that we say providers SHOULD take relate to improvements that should be made but where there is no breach of a regulation.

Importantly, the trust must:

- Provide a minimum of one registered children's nurse on duty in the emergency department every shift
- Store medicines and medical gases securely in the emergency department.
- Train staff adequately to ensure the safety of children attending the emergency department.
- Implement a robust recording, reporting and monitoring process for mandatory training, including paediatric life support.

Summary of findings

- Ensure that all patients who meet the criteria for consideration for a Treatment Escalation Plan (TEP) are considered and afforded the opportunity to advise of their choices and preferences for care.
- Ensure that staff throughout the trust understand how and when to make a referral to the specialist palliative care team at the appropriate time in order to meet the current and anticipated needs of patients.
- Improve the rapid discharge process to enable patients who wish to return home quickly at the end of their lives to do so.
- Ensure there is a programme of local audits in line with the national care of the dying audit which enables a review of services provided at the hospital to identify if patients preferred place of care had been achieved.
- Ensure actions resulting from audits of end of life care are monitored. Some audited standards in the National Care of the Dying Audit were not met.
- Make advance care plans available for patients in the last 12 months of life. (No advance care planning took place for patients in the last few weeks of life because there were no consistent systems in place to enable patients to make advance directives or consider the decisions needed for their future).
- Ensure NICE guidance QS103 is followed for end of life care
- Ensure there are arrangements for end of life services to be monitored and reviewed at all levels of the organisation.
- Develop a strategy to achieve a consistently high standard of end of life care.
- Continue work with the obstetrics and gynaecology and midwifery staff on team development and culture to ensure the way the teams work together does not affect patient safety.
- Change the medical rota in obstetrics and gynaecology so that all staff are working in line with the European Working Time Directive.
- Ensure that obstetric consultants undertake obstetric emergency workshops as part of their mandatory training.

In addition, the trust should:

- Ensure the emergency department's reception area provides privacy and confidentiality for patients booking in with the receptionist.
- Make the emergency department's reception suitable for the needs of wheelchair users.
- Introduce a robust, regular portable appliance testing process for the emergency department.
- Ensure appropriate and important information on patients' allergies information and pain scores are recorded by the emergency department in all cases.
- Ensure reception staff are able to recognise patients who attend the department with serious conditions that need urgent referral to the triage nurse.
- Ensure that seasonal fluctuation and it impact on the emergency departments ability to respond is considered in all planning activities.
- Ensure all agency nursing staff employed in the emergency department are appropriately prepared before working in the department and any induction processes are standardised and recorded.
- Ensure all shift handovers in the emergency department are accurate and capture all relevant information in a consistent manner.
- Review the security arrangements for the emergency department to ensure that staff and patients are supported and protected from harm or injury.
- Ensure that bed meetings include all relevant staff and that all wards and departments have a clear focus on maximising patient discharge and flow in support of the emergency department.
- Ensure that patients expected for medical and surgical care are admitted to an appropriate ward at the earliest opportunity to ensure there is no impact on the emergency department access and flow.
- Review the incident reporting process to ensure trends are identified and actions taken to minimise risk.
- Work with the ambulance service to understand and address how the emergency department can prevent medication errors following administration of medicines by the ambulance service.
- Ensure the room used to assess patients with mental health related symptoms has suitable furniture.
- Ensure all emergency department staff have completed major incident training.

Summary of findings

- Ensure the early warning score tool is fully implemented and used in the emergency department.
- Consider collation of data for non-cancer patients where support of the SPCT for symptom management is required. In order to ensure all appropriate patients can access the SPCT.
- Ensure that appropriate training for all staff, including agency staff, is made available for wards with end of life patients.
- Consider the views of people using end of life services to shape and improve the services available.
- Ensure maternity, obstetrics and gynaecology governance meetings are recorded.
- Ensure that action plans made following recommendations from the Royal College of Obstetricians and Gynaecologists (RCOG) visit and the serious incident investigation continue to be implemented.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	We judged the department to require improvement for both safety and responsiveness. Our main concerns were for children attending the department in an emergency because there were not enough registered children's nurses to have one on duty every shift and we were not assured that enough staff were trained to deal with children in an emergency. Rates of compliance with mandatory training varied. The trust's recording and reporting system was not robust enough to provide accurate information on staff members who were out of date with training. There were gaps in some care records, specifically in relation to the recording of patients' allergies and pain scores. There was, however, a positive reporting culture and sharing of lessons learned when things went wrong. Despite pressures with patient flow through the hospital affecting some of the department's performance standards, patients were triaged and had treatment started in a timely way. The trust had taken action to address areas of concern regarding infection control found at our previous inspection in July 2014. We found improved access to handwash facilities and a programme of audit that demonstrated continued compliance with infection control policies.
Maternity and gynaecology	Requires improvement 	Maternity and gynaecology services were rated as requires improvement for well led. . At our previous inspection in July 2014 we found concerns relating to inaccurate and inconsistent completion of HSA1 (grounds for carrying out an abortion) and HSA4 (abortion notification) forms, which are required to be completed under the Abortion Act 1967. During this inspection, we found that a system had been put in place to check that the records had been completed accurately. The system had been audited and found to be compliant.

Summary of findings

We also previously found that the rooms used by antenatal sonographers to carry out ultrasound scans were too small, had no curtains or screens to maintain privacy and dignity, and there was no means of calling for assistance. During this inspection, we saw two new, purpose built, rooms suitable for carrying out ultrasound scans had been developed and were in regular use.
Progress against the maternity action plan following recommendations of the Royal College of Obstetricians and Gynaecologists (RCOG) invited review visit in November 2013 was still on-going.
Since our last inspection there had been some work on strategies to improve team working, especially amongst the medical staff. For example a team development programme was in its initial stages at the time of this inspection and work was ongoing around finding a medical rota that suited all medical staff.
An investigation of 13 serious incidents found a number of different root causes, with a theme of delays in appropriate escalation of clinical concerns and failure to follow trust guidelines featured in more than one investigation.
We found that individually the medical and maternity staff were working very hard but they did not always seem to function well as a team.
Feedback from the women who had used the service continued to be good. The maternity services worked hard to engage with the local population.

End of life care **Requires improvement**

Areas of safety and well led were seen to require improvement, effective was rated as inadequate. In response to these findings shortly after the inspection we asked the trust to provide us with a plan of action that set out how they will ensure they are providing an effective and well led service for people at the end of their life. The trust responded with an action plan detailing the steps they are taking to address the issues raised. We will review the implementation of the action plan in due course.
The forms used to state patients choices and preferences for treatment and their decision about being resuscitated were better filled in. However, we saw patients who met the criteria for

Summary of findings

consideration for a TEP but one had not been completed. These patients had not been afforded the opportunity to advise of their choices and preferences for care.
Some aspects of the service provided were inadequate and were not consistently effective for patients at the end of life. The criteria for referral to the Specialist Palliative Care Team for assistance and advice with the management of symptoms were not consistently applied by all staff in all areas. Staff reported that the SPCT team responded promptly when requested.
The rapid discharge process to enable patients who wished to return home quickly at the end of their lives was not effective or well led at a trust level. The trust had recognised that the discharge of patients at the end of their lives was too slow, whilst work was being undertaken improvements in timescale for discharge were not evident
Leadership for end of life care in the hospital was not adequate. There was no formal strategy to ensure the service was provided to an agreed standard. The governance arrangements for end of life were unclear. When it was identified through national measurements that improvements were needed, these were not done. There was no end of life committee or governance group to review and discuss this aspect of the hospital service.

North Devon District Hospital

Detailed findings

Services we looked at

Urgent & emergency services; Maternity and Gynaecology; End of life care;

Detailed findings

Contents

Background to North Devon District Hospital

The Northern Devon Healthcare NHS Trust operates across 1,300 square miles and provides both acute hospital care and community services. North Devon District Hospital in Barnstaple provides a full range of district general hospital services, including accident and emergency (A&E) which we call urgent care services, critical care, coronary care, general medicine (including elderly care), general surgery, orthopaedics, anaesthetics, stroke rehabilitation, midwife-led maternity care and a breast service.

The trust has 644 beds, of which there are 341 at the district hospital in Barnstaple. The hospital has 2,111 staff.

Northern Devon has a population of 166,093, which is served by North Devon District Hospital and the Trust's community teams.

There are seasonal variations in the summer months with a large influx of holidaymakers. Over 42,000 patients (33,622 adults and 8,809 children) attended the emergency department between April 2014 and March 2015, averaging 116 attendances per day. Weekly attendance figures ranged between 642 and 965, with the biggest increases in numbers being seen during the summer months.

Our inspection team

Our inspection team was led by:

Chair: Peter Wilde, Retired Divisional Director, University Hospitals Bristol NHS Foundation Trust

Head of Hospital Inspections: Tracey Halladay, Care Quality Commission

The team included CQC inspectors and a variety of specialists: a director of nursing a consultant in palliative care, consultant obstetrician, a junior doctor for emergency care, a palliative care nurse, an emergency department nurse and an expert by experience. (An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them – for example as a carer.)

Detailed findings

How we carried out this inspection

This was an unannounced focused inspection to review the areas of concern that were found when we carried out a comprehensive inspection of the trust in July 2014.

The findings of our previous inspection in July 2014 were:

Safe:

- Rooms in which antenatal sonographers carried out their work were too small. They did not have curtains or screens to maintain privacy and dignity without the practitioner having to leave the room.
- Not all staff in all areas followed the hospital's 'bare below the elbows' policy. The availability of hand-washing facilities in the major treatment area of A&E was limited.
- Within A&E, alcohol gel was available for hand cleaning in patient bays but there was only one dispenser for the rest of the treatment area.
- There had been no comprehensive infection control audits in A&E in the last six months.
- There were no sluice facilities for non-disposable bedpans in A&E.
- There was no separate room in A&E for clinical waste, domestic waste or recycling.

Effective-

- TEPs that included do not attempt cardio-pulmonary resuscitation (DNA CPR) decisions were not consistently being completed appropriately. We saw evidence of end of life decisions having been made without documentation of, or discussion with, patients.
- Mental capacity assessments were not consistently undertaken when a patient's capacity to make decisions had been identified as an issue. Decisions about resuscitation were not consistently communicated to nursing staff.

Responsive-

- The current patient flow and escalation policies required improvement as they were not effective. Action needed to be taken to improve the flow of patients from Accident and Emergency department and across the trust.

Well led

- There was a lack of a system in place, supported by guidance, for the completion of forms for HSA 1 (grounds for carrying out an abortion) and HS A 4 (abortion notification). These records must be completed accurately and consistently and forwarded to the Department of Health as required.

At this inspection we inspected the following core services and quality issues at North Devon District Hospital:

- Urgent and emergency care – Safe and Responsive
- End of life care – Safe, Effective and Well led
- Maternity and gynaecology services – Well led

Before the inspection, we gathered information from other stakeholders, including the Clinical Commissioning Group- North East and West Devon (NEW Devon CCG), the Trust Development Authority and Healthwatch Devon. As the inspection was unannounced, we did not hold a public listening event before the inspection.

We visited North Devon District Hospital on 5, 6 and 7 August 2015. We carried out a further unannounced visit to the hospital on 17 August 2015.

We spoke with a range of staff, including doctors, nurses, healthcare assistants, student nurses, and the chief executive, medical director, director of nursing and other members of the trust board. We held a number of focus groups for staff to speak with us. We also spoke to patients and relatives.

Facts and data about North Devon District Hospital

In the 2014 A&E patient survey the trust scored about the same as other trusts for patients waiting with the ambulance crew before their care was handed over to A&E staff and for the time they waited before being examined by a doctor or nurse. The department was rated as being clean in line with other trusts and people reported they were given enough privacy when being examined or treated.

Detailed findings

Results of the 2014 NHS staff survey included some good feedback from staff, with 79 % of staff feeling satisfied with the quality of work and patient care they are able to deliver, 92% of staff agreeing that their role makes a difference to patients / service users and 73% agreeing that they would feel secure raising concerns about unsafe clinical practice.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Not rated	Not rated	Requires improvement	Not rated	Requires improvement
Maternity and gynaecology	Not rated	Not rated	Not rated	Not rated	Requires improvement	Requires improvement
End of life care	Requires improvement	Inadequate	N/A	N/A	Requires improvement	Requires improvement
Overall	Requires improvement	Inadequate	Not rated	Requires improvement	Requires improvement	Requires improvement

Notes

Urgent and emergency services

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

Information about the service

The Emergency Department (ED) at North Devon District Hospital provides a service 24 hours a day, seven days a week to the residents of, and visitors to, North Devon.

The ED has 10 treatment areas for major illness and three for minor illness. Additionally, it has a four-bed resuscitation area, with one bay equipped for paediatric emergencies.

Over 42,000 patients (33,622 adults and 8,809 children) attended the department between April 2014 and March 2015, averaging 116 attendances per day. Weekly attendance figures ranged between 642 and 965, with the biggest increases in numbers being seen during the summer months when there are large numbers of holidaymakers in the area.

On arrival at the department, patients are triaged and directed to the most appropriate area for treatment in either the major illness, minor illness or resuscitation areas.

Our inspection was unannounced and followed up on areas that required improvement following our previous inspection in July 2014, including cleanliness, infection control and hygiene, learning from incidents, triage times and patient flow. We inspected the department on three days between 5 and 7 August 2015.

During our inspection, we spoke with six patients and 32 staff, including nurses, doctors, consultants, managers, support staff and ambulance staff. We reviewed 21 care records and also reviewed performance information from and about the trust.

Summary of findings

We judged the department to require improvement for safety and responsiveness.

Our main concerns were for children attending the department in an emergency because there were not sufficient registered children's nurses to ensure the department had one on duty every shift. We were not assured that sufficient numbers of staff were trained to deal with children in an emergency situation.

Rates of compliance with mandatory training were varied. The trust's recording and reporting system was not robust enough to provide accurate information on staff members who were out of date with training courses.

There were gaps in some care records specifically in relation to the recording of patients' allergies and pain scores.

There was, however, a positive reporting culture and sharing of lessons learned when things went wrong.

Despite pressures with patient flow through the hospital affecting some of the department's performance standards, patients were triaged and had treatment started in a timely way.

The trust had taken action to address areas of concern regarding infection control found at our previous

inspection in July 2014. We found improved access to hand wash facilities and a programme of audit in place which demonstrated continued compliance with infection control policies.

Are urgent and emergency services safe?

Requires improvement

We have judged the department to require improvement in the area of safety.

Areas of concern regarding infection control found at our previous inspection in July 2014 had been addressed and there were systems in place for monitoring infection control.

The department employed only one registered children's nurse and therefore did not have the required one registered children's nurse for every shift. Additionally, we were not assured that enough staff had completed paediatric life support training, which potentially placed children at risk.

Rates of staff completing some mandatory training, including resuscitation, was low for both medical and nursing staff, and the trust was not able to produce accurate reports on training attendance.

Records were not completed fully in all cases. For example, pain scores and allergy information was missing from a number of records.

Reception staff were not trained to recognise serious illness, and the process to call for help in the event of an emergency in the waiting room was not robust.

There was a positive culture of reporting incidents of harm or risk of harm and we saw evidence of learning being shared with staff in most cases to prevent similar incidents from happening again.

There were also good processes for safeguarding patients from abuse, and we saw risk assessments being used where appropriate.

Incidents

- There were no 'never events' recorded in the department in the previous 12 months. ('Never events' are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented, so any 'never event' reported could indicate unsafe care.)
- Staff we spoke with told us the incident reporting system was accessible and simple to use. We saw

evidence that staff understood and carried out their responsibilities to report incidents and near misses, and they told us that they felt supported when they did raise incidents. When reporting incidents, staff were given the option to request feedback. We were told by incident investigators that where feedback had been requested it was not possible to finalise and close the incident until feedback had been provided and evidence of this was completed

- We reviewed the last six months' incident reports relating to the emergency department. These showed a positive reporting culture existed, including for low level and 'near miss' incidents – for example, patients arriving with pressure ulcers and a blood culture request that had the wrong name on it but was realised immediately to be wrong.
- In the previous 12 months there had been one serious incident recorded in the department, categorised as 'delayed diagnosis'. The incident related to a delayed CT scan and diagnosis of a skull fracture due to the department adhering strictly to national guidance. The investigation report concluded that the incident could have been avoided and that clinicians could have used their clinical judgement considering other information and opinions to inform decision-making. The report was shared at the department's governance meeting and included in junior doctors' training to ensure shared learning.
- Department managers told us they had seen an increase in incidents being reported by doctors after a session on risk and incident reporting had been introduced into the induction programme. We found there was a positive reporting culture when speaking to doctors in the department.
- Managers told us feedback and learning from incidents was discussed on a thematic basis during team meetings. All incidents were reviewed in the quarterly governance meeting, which was open to all staff; minutes of these meetings were circulated to staff and we saw copies displayed on a noticeboard in the rest room.
- We saw three incidents that had been reported in the last six months where the emergency department had administered a second dose of a medicine that had already been administered by the ambulance service – one in April, one in May and one in July 2015. We asked staff about these incidents and found that there had been no shared learning with the department to prevent a recurrence; however, we saw evidence that the individuals involved had been included in the investigation process and had received additional training or support.
- Mortality data was discussed in the department's clinical governance meeting, and minutes of these were placed on a noticeboard in the department's break room for all staff to view. The trust was worse than the national average for mortality rates. A new mortality review committee was established in March 2015 to review mortality information and devise an action plan to improve the trust's position. There were no concerns or actions linked specifically to the emergency department in the committee's minutes or action grids.
- Between January and July 2015, the department had a low number of reported pressure ulcers and falls with harm, and no catheter-acquired urinary tract infections.

Duty of Candour

- Staff understood their duty of candour to be open and transparent in their practice and to be honest about any errors, although they were not aware of the term 'duty of candour'. They told us that should errors be made, staff were supported to speak up and ensure the patient was informed and given an apology.

Mandatory training

- A mandatory training programme was in place for all staff. The trust's internal intranet site had a system where individuals could see what mandatory training they were required to complete. Mandatory training included topics such as information governance, customer care, equality and diversity, health and safety, fire, infection control, manual handling, and resuscitation. Completion of mandatory training in the ED varied, for example only 53% of nursing staff had completed resuscitation training this year but 97.5% had completed customer care training. Only 47% of medical staff had completed manual handling training and resuscitation training, whereas 89% had completed health and safety training. The trust's recording and reporting system made it difficult for accurate reports to be produced to show who was in date with specific levels of resuscitation training. It did not pull together information from internal and external training for resuscitation across the staff groups and show expiry dates of previously attended training for all levels of resuscitation.

- Junior doctors starting with the trust undertook a formal induction process over three days; following this a department specific induction took place over one day. The programme included avoiding and reporting risks, communication skills and x-ray interpretation. Additionally, an ongoing training programme was in place for these staff, and we saw the dates of these training days were clearly advertised on a noticeboard.
- We were told by department managers that all band six nurses had completed both paediatric life support and advanced paediatric life support training. Additionally, we were told the majority of band five nurses had also completed this training. However, figures provided by the trust showed that only 25 out of 39 nursing staff in the department (64%) had completed basic paediatric life support, emergency paediatric life support or paediatric immediate life support. We were told four staff were booked onto a training course in the next couple of months and one further was on a waiting list for training. We questioned these figures and asked for confirmation of the staff who were currently in date with these courses, but the trust was unable to produce a succinct report. The trust told us the data they held was split across different systems and was not necessarily an accurate reflection of the current position. We were told some courses were nationally attended and had either one or four year validity, while other courses were internal and recorded centrally. We were therefore not able to be assured that there were adequate numbers of staff trained to deal with children in an emergency situation.
- Only seven out of 19 medical staff (36.84%) in the department had completed basic paediatric life support, emergency paediatric life support or paediatric immediate life support through the trust.

Safeguarding

- We observed the care record for one child and saw evidence that safeguarding processes had been followed, with risk assessments completed. No safeguarding referral was made because it was not required.
- We were shown the safeguarding forms, checklists and risk assessments used in the department, for both adults and children. Staff were able to talk us through the forms and the processes they followed to assess and escalate safeguarding concerns. The trust's internal intranet system had forms for raising safeguarding concerns to the safeguarding team; these were simple to access and complete.
- Staff had access to senior paediatric and emergency medicine opinion at all times for child welfare issues, which was supported by the paediatric department. There had been no cases reported in the previous six months where this had not been available.
- All patients presenting to the department, regardless of age, had their previous attendances automatically checked and printed by the receptionists. This was clearly printed on the front page of the new care record. We observed one child attend the department who had no previous attendances. This was handed over verbally by the receptionist to the nurse. We were told a child attending more than three times with different conditions in the same year would be notified to the hospital's safeguarding team using a form on the trust's intranet site. The safeguarding team would then create an alert to the relevant safeguarding authority. Additionally, if staff had immediate concerns they could complete an urgent alert themselves to the local safeguarding authority.
- There was a process in place for all children who attended the department that ensured their GP was notified of the attendance. We were told this was an automatic process that took place at midnight every night. Additionally, if the child was of school age, a notification would be generated at the same time for the school nurse's attention.
- 95% of nursing staff (37 out of 39) in the department had completed level 3 children's safeguarding training. Trust data reported only one member of staff in the department was required to complete level 2 children's safeguarding, and this had been completed. Only 47% of the medical staffing (9 out of 19) in the department had completed level 3 children's safeguarding training. Due to limitations with the trust's recording and reporting systems, we were unable to find out if the staff who had not attended training had an existing course that was still valid.
- We were told all skull and long bone fractures in children under one year old were discussed with a senior paediatric or emergency medicine doctor. Staff told us they had good access to and support from the paediatric teams. We were told one of the emergency

department consultants reviewed a sample of x-rays of children every month and fed back any learning to the clinical governance day, at team meetings and to individuals involved. There was no formal documented audit process in place.

Cleanliness, infection control and hygiene

- Cleaners were visible in the department throughout our inspection and the department was visibly clean and tidy at all times.
- Between August 2014 and July 2015 the department had no reported cases of Methicillin-resistant Staphylococcus aureus (MRSA) and one reported case of Clostridium difficile. The reported C. difficile case was deemed not to have been acquired in the department.
- Following our inspection in July 2014 the trust received a compliance action regarding cleanliness and infection control. We found the emergency department had limited hand-washing and alcohol gel facilities. With the exception of the reception area, during this inspection we found the department was well equipped with accessible hand washing facilities, including sinks, soap and hand gel, for patients, staff and visitors. We observed staff cleaning their hands between patients. Patients also told us they saw staff washing their hands before treating them.
- Again, at our inspection in July 2014 we found staff were not always adhering to the hospital's 'bare below the elbows' policy. During this inspection we observed all staff in the department to be 'bare below the elbows' in accordance with the trust's current infection control policies.
- In July 2014 we reported that there had been no comprehensive infection control audits carried out in the emergency department for six months. During this inspection we found hand hygiene and environmental audits were being completed in the department on a monthly basis. Where issues had been identified within the environmental assessments, action plans were put in place and progress was being monitored to ensure completion of any works required. In all cases there was a named individual responsible for the action. Between July 2014 and July 2015 the department had consistently exceeded the 95% national standard for cleanliness. There was consistent achievement of the 95% hand hygiene standard between December 2014 and June 2015. A 'bare below the elbows' audit was completed in May and June 2015 and the department achieved 100% compliance on both occasions.
- Our previous inspection in July 2014 highlighted there being no sluice facilities for non-disposable bedpans in the emergency department. We found at this inspection a new sluice room had been installed in the majors department, which was clean, tidy and well organised. Staff told us this new facility was more accessible and provided them with the equipment needed to ensure cleanliness and hygiene could be maintained. We also saw the sluice room attached to the resuscitation area and found this was clean, tidy and organised. Clear systems were in place for the cleaning and disposal of equipment, including disposable bed pans and commodes.

Environment and equipment

- The entire waiting room for non ambulance patients was clearly visible from the reception desk. However, reception staff raised a concern with us that patient confidentiality was not maintained at all times because people could stand at the glass window to the side of the reception desk by the vending machines and see the computer screens. We observed this happen on one occasion and the receptionist tried to twist her body to obscure the screen.
- There was very little privacy for patients at the reception desk as conversations could be heard by others queuing or those stood next to them talking to the second receptionist. Therefore patient confidentiality could not be assured at all times.
- All equipment we looked at had in date portable appliance tests (PAT), with the exception of one eye testing machine in the minors' area and one respirator in the resuscitation area. The expiry dates of the PATs for these machines were May 2011 and January 2012, respectively. All equipment was found to be readily available and accessible.
- We saw labels on some equipment identifying that it had been serviced and/or cleaned, along with the date the label was written. However, this was not found to be the case for all items, for example one of the defibrillators out of the three we checked was not identified as being clean and one suction unit did not have a service label.

- The department was located very close to the CT and X-ray scanners.
- A designated room for the assessment of patients presenting with mental health related issues was available. This room had a call bell so that assistance could be summoned and had two doors to ensure a means of escape for staff was available if needed. We were told the furniture (three chairs and a table) were temporary solutions while replacement furniture that could be fixed to the floor was sourced. There was no timescale given for the completion of this. A risk assessment had been completed and the department was working with the psychiatric liaison team to find a suitable solution.
- We looked at the resuscitation trolleys and found the adult trolleys were kept sealed after being restocked. The paediatric resuscitation trolley was not sealed; however, all items were found to be in place and in date. The trolleys were checked daily with record sheets being completed and initialled.
- We saw waste was clearly segregated and stored appropriately. Disposal of waste occurred in a timely manner and we did not observe any waste being stored in patient areas or corridors.
- There was a clear process in place for the management of clinical specimens. If the specimens were for a patient in resuscitation, a porter took them directly to the laboratory. For all other patients the specimens were boxed and labelled in majors and a porter was called to collect them.

Medicines

- The controlled drugs used in the resuscitation department were checked and counted daily, although we did note an exception where one day had been missed. The drugs were stored appropriately, clearly labelled and documentation for prescribing and dispensing was complete.
- The medicine store in the main emergency department was tidy and medicines were clearly labelled. The department was using a paper-based prescribing system, which we observed to be accurately completed.
- Nursing staff were seen to adhere to policies on the administration of controlled drugs, and when asked were knowledgeable of the policies.
- Microbiology protocols for the administration of antibiotics were available in poster format in the department. Additionally, staff showed us a smartphone application that they were using to view guidelines.
- Of the 20 care records we observed, we found allergy information had only been recorded in 50% of cases. This presented a risk to patients being administered a medicine to which they may have an allergic reaction.
- New medical gas cylinders were kept in the majors' storeroom, along with other equipment. The door to this cupboard was not kept locked and was located immediately beside a majors' bay, which meant that unauthorised persons could access it. We were told that empty cylinders were immediately removed to the central storage facility, which was not within the department. We did not see any empty cylinders within the department.
- On one occasion we found the majors' medicine storage cupboard to be unlocked, propped open, unattended and unobserved. We noted contents included intravenous medicines including pain killers, antibiotics, glucose and fluids. The medicines were stored in unlocked trays and therefore had been accessible to anybody who walked past the cupboard. When we left the cupboard we closed and locked the door and immediately informed the senior nurse in charge.
- On reviewing the last six months' incident reports for the department, we found there were three incidents reported, one in April, one in May and one in July 2015, where medication had been administered twice in error (two were paracetamol and one was aspirin). On each occasion this was because the patient clinical record provided by the ambulance service had not been checked prior to additional medicines being prescribed and/or administered. We did not see any evidence of a department-wide response to these incidents, for example a standard operating procedure for patients receiving medicines after ambulance attendance.

Records

- The majority of care records we reviewed were accurately and legibly completed. However, of the nine records we reviewed specifically around pain scores (where these were relevant to the patient's presentation), we found only five had pain scores recorded. This meant some patients may not have been offered pain relief when they required it, or pain relief may have been offered when it was not required.

- We were told patients' previous medical records were easily accessible if required. For records held on site they could be obtained within a matter of minutes; for records held off site they would generally be available within an hour. We observed this to be the case for a number of patients in the department.
- Risk assessments were completed clearly where required. We observed one record for a patient who had received a pressure ulcer risk assessment because they were approaching six hours in the department.
- Patient records were stored in folders at the nursing station. Although the records were not locked away because they were being accessed regularly by multiple staff, there was no confidential information left visible and the area was always observed by staff.

Assessing and responding to patient risk

- Patients self-presenting at the department's reception desk were booked in and then asked to wait in the waiting area. A nurse then called the patient through for initial triage before directing them to an appropriate treatment area. This process was underpinned by a standard operating procedure.
- Reception staff told us they did not receive any specific training for recognising serious conditions that would require immediate escalation; instead, receptionists used their own observations and common sense to call a nurse if they believed a patient required urgent attention. Two reception staff told us they would go for help if someone was suffering with obvious serious conditions such as chest pain, severe breathing difficulties or had chemicals in their eye. In order to summon help they had to leave the reception desk and get a nurse from minors, or telephone through to majors.
- Between January and July 2015 the average length of time a patient waited from arrival in the department to triage was six minutes. This was below (better than) the national average of 15 minutes.
- Patients arriving by ambulance were monitored by ambulance staff in the corridor until a handover was completed. A portable observation machine, used for taking a patient's pulse and blood pressure, was available if required to monitor a patient's condition while they waited.
- The trust had a policy in place which provided staff with guidance on monitoring and identifying any deterioration in a patient's condition using an early warning score. The department had not implemented the National Early Warning Score (NEWS) system, and were instead using a localised variation. The local variation was similar to the national tool, but some signs (for example blood pressures) had higher trigger points before a score was noted. We saw early warning score observation charts were readily accessible either on the care records we reviewed or at the foot of the patient's bed. We saw that completion of the early warning score charts varied, with some patients only having their initial observations recorded. Staff told us they only used the observation chart regularly for the more seriously unwell patients. Regular audits of compliance with early warning score processes were being completed and this information was clearly displayed on a noticeboard in the corridor where ambulance handovers took place. We reviewed the audits between December 2014 and May 2015, these showed there had been an increase in the correct completion of the early warning score tool; however, some areas (for example a correct score being applied and totalled) were consistently poor.
- The department did not have a fully implemented rapid assessment and treatment process. We were told this was being trialled one day in five, when the lead for the trial was working in the department. This was linked to a Commissioning for Quality and Innovation (CQUIN) project. We did not see this in place during our inspection but were told that when it was in use it sped up the treatment and discharge process for patients with minor illness or injury by placing senior clinical decision making at the front of patient assessment and treatment.
- We saw condition-specific pathways were in place for certain conditions, for example stroke and sepsis. If a patient arrived at the department with a suspected stroke or sepsis diagnosis, a sticker would be placed on their notes to ensure certain actions were completed. The department had an engaging reward system in place for staff who correctly identified a patients diagnosis and started the treatment plan. Pathways also existed for patients presenting with a fractured neck of femur, diabetic ketoacidosis, trauma and asthma. An additional pathway for percutaneous cardiac intervention (PCI), otherwise known as angioplasty, was also in place; this required the transportation of the patient to the Royal Devon and Exeter hospital.

Urgent and emergency services

Nursing staffing

- In April 2013 the Royal College of Nursing published an acuity tool (Baseline Emergency Staffing Tool) for use in assessing patient acuity and staffing levels and skill mix in emergency departments. The trust had not used BESTto help inform staffing levels and skill mix, but had completed other staffing audits and submitted these to the Royal College of Nursing (RCN). A response from the RCN outstanding.
- The trust board received reports on nursing staffing figures; however, these excluded the emergency department.
- The department's establishment for nursing staff was nine registered nurses on a day shift and six on a night shift. The rotas allowed for one nurse coordinator working 7am to 7.30pm, five registered nurses working 7am to 7pm, one nurse practitioner working 8am to 8pm and two registered nurses working 10am to 10pm. Overnight the rota was for six registered nurses between 7pm to 7.30am. Staff told us they felt under increased pressure overnight because the staffing levels were not sufficient during the peak summer months when the department was busier.
- We reviewed the numbers of nursing staff working in the department during the period 1 January to 30 June 2015. We saw that the vast majority of night shifts were fully staffed, with agency staff being used to fill gaps; however, on a couple of occasions there were shortages of one or two registered nurses. During the same period there were two vacant day shifts which had not been filled by agency nurses.
- We observed a shift handover at 7pm, which involved the nursing staff only. Details of every patient in the department were handed over, including their age, diagnosis, treatment and any plans for admission or discharge. Patients' early warning scores were not discussed. The handover also covered staffing numbers for the oncoming shift, taking into account any changes that may have occurred as a result of short-notice sickness.
- The trust had recently introduced a new role to provide oversight of nursing and support staffing levels and planning across both the acute and community hospitals. The clinical site manager holding this role monitored staffing rotas, planned ahead with staff moves between departments and ensured agency cover was provided where needed. They were a single point of contact for departments to go to in the event of staffing issues arising, including as a result of changes in patient acuity, and supported all departments to ensure safe staffing was maintained.
- There was a band seven nurse in charge on almost every shift. Where a band seven was not available to cover a shortfall, an experienced band 6 nurse would fulfil this function.
- Agency nurses were being used by the department to fill shortfalls. We were told by department managers that the induction process for agency staff could be improved; the existing induction was only to show them around the department. We were told that agency staff were only used in the majors area where supervision and oversight was easier. We spoke to one agency nurse who told us they had been on a comprehensive tour of the department and received a good handover of the patients in the department. However, there was no formal induction checklist to show that all necessary elements had been covered for the nurse to work safely in the department.
- The Royal College of Nursing's 'Health care service standards in caring for neonates, children and young people' states there should be at least one registered children's nurse on duty every shift, or there should be a plan in place to achieve this. The department only had one registered children's nurse employed, which meant this standard was not being met for the majority of shifts.
- The department only employed one healthcare assistant, which meant there was frequently no assistance for the nursing staff with tasks such as nutrition and hydration rounds, basic observations, assisting patients and transferring patients to other wards. When the healthcare assistant was not on duty, these tasks were completed by the nursing staff. We were told by staff that having the healthcare assistant on duty enabled them to spend more time with patients. Two department managers told us they would like to employ more support workers, to enable two on each shift.

Medical staffing

- The department employed five consultants, eight middle grade doctors and 10 senior house officers; they did not have any registrar grade doctors. The lead clinician for the department told us there was a wish to employ registrar grades for the challenge of providing

the training and expanding the workforce, but that the middle grade doctors employed were all experienced in emergency medicine and therefore the skill mix in the department was both appropriate and safe.

- Consultants were employed on annualised hours contracts; this meant they were contracted to work a set number of hours per year, rather than per week. We were told by department managers that this was working well and allowed greater flexibility to providing adequate cover.
- In addition to consultant cover, medical cover was provided in the department 24 hours a day, seven days a week, by two middle grade doctors working 10 hour shifts, and five senior house officers working 12 hour shifts starting at 8am, 11am, 1pm and 10pm; an additional senior house officer was rostered to work 4pm to 2am.
- The College of Emergency Medicine recommends emergency departments should have 16 hours of consultant presence every day; this was not being achieved by the trust. During the peak summer months consultant cover was provided 14 hours a day with one consultant between 8am and 4pm and a further consultant between 10am and 10pm; the late finish consultant then provided overnight cover on an on call basis. Outside of the summer peak, consultant cover was provided 11 hours a day between 8am and 7pm, with the out of hours' periods being covered on an on call basis. We were told there was a senior doctor on duty in the department 24 hours a day, seven days a week. On review of the staffing for the previous six months, this was the case on every shift.
- The department was using some locum cover to fill staffing gaps. The locums being used were regular and familiar with the department and hospital procedures.
- The medical handover took place at 8am and was attended by the medical staff as well as some of the nursing staff. A roll call of duty staff was completed and issues from the previous shift were discussed. Although the department had a basic structure for its medical handover, the handover we observed did not follow this.

Major incident awareness and training and security arrangements

- The trust had a major incident plan, incorporating business continuity. There were action cards for specific roles for the ED staff team at the back of the policy for use during a major incident, and a clear chain of command was identified.
- All staff we spoke with told us they had received major incident training at some time. Figures provided by the trust showed that 36% of the staff who required this training had completed it within the last 12 months.
- We observed a Chemical, Biological, Radiological, Nuclear and Explosive (CBRNE) training session taking place. This involved a number of staff being trained in the erection and use of the decontamination equipment outside the emergency department. 82% of ED staff had completed CBRNE training in the last 12 months.
- On reviewing the last six months' incident reports for the department we noted the second highest reporting category was for security-related incidents, with police having to be called in the majority of these cases. We were told by department managers that security was one of the five top risks to the department; we noted this was included on the corporate risk register, assigned to ED, and actions were ongoing to understand the issue and develop additional controls and procedures to reduce the risk. We were told a number of porters had been trained to act as a security presence out of hours, but that there was no security provided during the day and the department had to rely on a police response in the event of an incident occurring. The security provided by the trust was limited to a presence and de-escalation role; there was no training in restraint techniques for these staff. We checked the training records for the staff undertaking the security role and saw all were up to date with their training and were registered with the Security Industry Authority.
- We observed a patient being verbally abusive and aggressive to staff. The patient was detained by plain-clothed police, but had this not been the case the department would have had to call the police to attend because there was no hospital security on duty.

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

Not sufficient evidence to rate

Urgent and emergency services

Are urgent and emergency services caring?

Not sufficient evidence to rate

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

Requires improvement

We have judged the emergency department (ED) to require improvement in the area of responsiveness.

There were flow issues throughout the hospital and patients being admitted by healthcare professionals (for example general practitioners) were held in the emergency department until beds became available on an appropriate ward. This was impacting on the department's ability to achieve some of its performance standards.

We found that the department was triaging and starting treatment in a timely way, but the wider hospital system prevented timely movement of patients into other areas of the hospital.

There were clear pathways in place for a wide range of conditions and we saw these being used for appropriate patients. Additionally, staff had good access to specialist advice and translation services and guide books were available when required.

Service planning and delivery to meet the needs of local people

- The reception area was of adequate size and there was ample seating at all times during our inspection. A separate waiting room for children was available next to the main waiting area. It had a closable door, call bell and toys for younger children to play with.
- While the reception area was found to be generally patient-friendly, the reception desk was not suitable for wheelchair users. The desk was too high for a wheelchair user to see over, and we were told receptionists had to stand up and look down on wheelchair users who self-presented. Reception staff told us this had been an issue for some time but plans to lower one section of the desk had never been completed.
- Bed meetings were held throughout the day at 8.30am, 10am, 12pm and 4pm. These meetings did not include community representatives or partner agencies (for example, the ambulance service) during periods of normal activity; however, we were told that at times of severe pressure external partners would also be invited. Following the 8.30am bed meeting a bed status for the day was circulated widely across the hospital and with external partners, but this was not updated throughout the day to keep everyone regularly informed.
- Weekly attendance figures varied widely, with the summer months seeing up to 323 additional patients in a week. There was no formal plan in place to respond to these seasonal variations. However, consultants worked annualised hours so cover in the summer could be increased, and additional medical cover was made available on bank holidays.

Meeting people's individual needs

- The department had access to a telephone-based translation service. To support this, the receptionists held a folder with multiple phrases in multiple languages which could be used while an interpreter was being sourced, and also to identify a patient's language. Deaf patients were supported in the department through the use of a simple book with pictures and some basic sign language guidance. Staff could not tell us if there was a facility to access a signer if required.
- A designated room for the assessment of patients presenting with mental health related issues was available. We saw two patients with mental health conditions in the department with medical-related symptoms. While they were awaiting transfers to medical beds the hospital's psychiatric liaison team had been notified that the patients were in the department. Although they weren't required at that time, the liaison team provided some additional information to the staff involved with the patient's care and offered further support if necessary to ensure the patients were adequately supported while in the hospital. Work was ongoing to further strengthen training and access to mental health services, with the work plan progressing against target. Additionally, the department had a psychiatric triage tool in place for staff to follow.

- We were shown how the computer system could be used to place a marker against a patient with learning difficulties. This marker would be seen by staff involved in the patient's care to alert them to the fact the patient may require additional support. The marker could also be picked up by the hospital's learning disability nurse who would offer support to the department if needed. We did not see a need for this process to be used during our inspection.
- Department managers told us they were working on a dementia pathway as part of the trust's focus on dementia care this year. There were no dementia champions in the department, but we were told support was available from the dementia ward if required. We were told dementia training was being planned for all staff in the trust as part of their ongoing focus in this area.
- A separate waiting area for children was available. It was located beside the main waiting area and opposite the reception desk but had a closable door to prevent it being overlooked. Although staff did not have direct observation of the room when the door was closed, a call bell was available should help need to be summoned and the room was monitored in majors via a CCTV system.
- There was a good supply of wheelchairs available at the entrance to the department.
- We were told that when bariatric patients were arriving by ambulance the department would be pre-alerted by telephone so that appropriate equipment could be ready in the department on their arrival.
- We saw a patient admitted to the department who was very unwell and did not have relatives with them. There were no side rooms available in the medical assessment unit so the patient was moved to a side room in the emergency department for their and their family's, privacy and dignity.
- We were told that for patients who attended the department during pregnancy staff from the maternity service would attend the department if support or advice was required. If the patient was presenting with maternity-related symptoms they would be assessed by ED staff and transferred to the maternity unit if necessary.

Access and flow

- Patient flow and waiting times were cited by department managers as being one of the top five risks to the department; however, this was not recorded on the risk register attributed to ED. It was, however, recorded in the Board Assurance Framework. There was one entry on the risk register regarding the misidentification of patients as a result of increased demand because of flow issues. One action against this risk stated a total capacity plan had been written and was awaiting sign off by the executive team. The due date for completion was 30 June 2015 but this action was still outstanding because work with the Emergency Care Intensive Support Team (ECIST) and System Resilience Group was. A total capacity plan is designed to provide information and guidance on a hospital's bed numbers and how this can be managed during times of increased demand to ensure patient safety. The trust did not have a current capacity plan. We were provided with a copy of the 2014-15 capacity plan, which was still being used. We were told a new capacity plan had been written but was waiting for executive approval. The 2014-15 capacity plan included actions to be taken at certain escalation levels, in response to set criteria around performance and patient safety. Escalation levels ranged from 'green' (normal activity levels, business as usual) through 'amber', 'red' and up to 'black' (severe pressures not managed through escalation processes impacting on the local health system's ability to deliver comprehensive emergency care). Triggers and actions specific to the emergency department were included in the appendices of the plan to ensure all staff were aware of what to do at each level to maximise patient care.
- Between January and July 2015 the department had consistently failed to achieve the 95% standard for patients being seen within four hours, with performance ranging from 82.6% in January to 93.3% in July.
- On average between January and July 2015, 5% of patients waited four to 12 hours from the time a decision was made to admit the patient to the time they were actually admitted. This was below (better than) the national average of between 8%(March 2015) and 20% (January 2015). Between January and July 2015 the average length of time patients stayed in the department was two hours 23 minutes, with the longest stay being 14 hours 12 minutes.
- The number of patients leaving the department before being seen between January and July 2015 has been consistently below (better than) the national average of 5%, ranging from 1.3% to 2.4%.

- Between January and July 2015 the department had consistently achieved the 60 minute standard for the time taken for treatment to start from arrival, with average times ranging from 33 minutes to 40 minutes.
- The hospital had a patient flow working group established and a recently appointed lead manager to identify difficulties within the wider hospital and community systems which were having an impact on flow through the department. One of their key roles was to improve patient flow to support the safety performance measures in the emergency department.
- The television screen in the waiting area displayed a scrolling message along the bottom, which included the expected waiting time. During our inspection we saw the waiting time range between one and three hours. Reception staff told us they manually updated this information on a regular basis based on their observations of demand in the department and time data available from computer records. We were told there was a plan to display waiting time information on a separate dedicated display with an automatic process in place to update the current waiting time. One patient who was in a majors bay told us they would have liked some information or communication about waiting times once they had been triaged.
- We attended the 8.30am bed meeting, which was attended by the bed manager and duty manager. We were told the purpose of this meeting was a handover of bed and patient numbers to ensure the morning bed figures could be calculated to predict how the hospital would likely cope with the day's expected admissions. The bed and patient figures discussed had been taken from the trust's computer system, and at that time discussions with wards had not taken place. It was not a full overview of the number of empty beds or how many discharges were expected for the day. There were no plans or actions resulting from this meeting.
- We also attended the 10am 'tactical' bed meeting, which was attended by representatives from all departments in the hospital, with the exception of the emergency department. At this meeting bed figures and expected discharges were collated. Some wards, however, had not completed ward rounds, and there was very little challenge from the person leading the meeting for those departments who had low or no morning discharges. Numbers of patients, expected discharges and admissions were collated and predicted using historical data but there were no plans or actions put in place as a result of this meeting.
- We attended the 4pm bed meeting, which was attended by the bed manager and duty manager. Bed numbers, discharges and expected admissions were discussed but again there were no plans or actions resulting from this meeting. Overall, we found the bed meetings did not provide a robust overview of the bed state and actions required to maintain effective flow from the emergency department.
- A bed coordinator worked directly in the department every afternoon. Their role was to liaise with other areas of the hospital, monitor the time patients were staying in the department and liaise with the nurse in charge and the bed management team. However, we did not see them in attendance at any of the bed meetings.
- We were told by nursing staff that the bed and site management team were accessible and approachable. They felt communication was constructive and felt well supported as a department. We saw the bed manager in the department several times throughout the day talking to the nurse in charge and coordinating patient transfers when beds did become available.
- Patients arriving by ambulance were taken to the corridor outside majors where the senior nurse on duty would take a verbal handover. We observed several verbal patient handovers taking place in this corridor and noted a lack of privacy for patient confidentiality. Other patients waiting in the ambulance queue and staff members walking through the corridor were able to overhear what was being said. There was no private area being used for this handover process. Once the initial handover and triage process was completed the ambulance crews were directed to the most appropriate area (resuscitation, majors or minors) for the patient. Ambulance staff we spoke with felt hospital staff actively listened to the verbal handovers they gave.
- We observed two patients on separate occasions being brought in by ambulance following a pre-alert telephone call to the hospital. On both occasions a full team was assembled and briefed in the resuscitation department prior to the ambulance arriving. Good teamwork was displayed on both occasions allowing a robust handover process between the paramedic and hospital team and a good response to the patient's requirements.

Urgent and emergency services

- During the period January to July 2015 over 30% of ambulance handovers were outside the 15 minute national handover standard. This standard is measured from the time the ambulance arrives outside the department to the time the patient is transferred to a hospital bed. Between two and six percent of the handovers over 15 minutes took place after 30 minutes. In January 2015 there were 10 handovers that were over one hour, and in April 2015 there were seven. Additionally, in both February and April 2015 there was one handover over two hours.
- The department had an ambulance handover plan, with clear expectations and escalation procedures. This plan worked alongside the ambulance service's delayed handover standard operating procedure.
- The trust's process for patients being admitted by a healthcare professional (for example, their general practitioner) to either a medical or surgical ward was for that patient to first attend the emergency department. Medical and surgical patients arriving in the emergency department had their observations recorded and remained in the department until a bed became available on the appropriate ward. During our inspection we saw a number of breaches of the four hour ED standard and a large proportion of these were for patients awaiting admittance to medical beds.
- We were told that when the department was full, patients would 'queue' in the ambulance handover corridor with nursing staff regularly observing the area. We were told this was infrequent and we did not observe the department being full during our inspection. The senior nurses we spoke with told us the escalation procedures were simple and that the duty manager and bed manager would attend the department to assist where necessary. However, we were told there was little response throughout the hospital to further support patient flow when the emergency department was full because it was generally as a result of the other departments in the hospital also having no available beds.
- The interim deputy general manager for emergency services told us they had taken on the day time function of the duty manager to provide consistency throughout the week. Working in the same office as the site management team and attending the bed meetings, they had close working relationships and oversight of bed numbers for the day.
- The trust had recently worked with the Emergency Care Intensive Support Team (ECIST) to conduct a 'perfect week exercise'. This was a period of a week where there was an increased focus on flow and early discharges, which in turn supported the emergency department's performance. The trust told us they had seen an increase in discharge performance as a result of this exercise, and a further exercise was being planned to look at some other areas where improvements to patient flow could potentially be achieved.
- We were told the trust had a target to achieve 35% of their daily discharges before 12pm. While they were only achieving 19% before 12pm at the time of our inspection, we were told this had been an improvement on previous performance. The interim deputy general manager for medicine told us there was still some way to go to change the culture around discharge and to reinforce that patient flow is about patient safety, and that every discharge supports the emergency department's ability to manage access and flow.

Learning from complaints and concerns

- In the 10 months between August 2014 and June 2015 there were 18 complaints received relating to the emergency department, averaging just under two per month. 'Clinical care and treatment' was the most complained about area receiving 11 complaints, with 'attitude of staff' being the second area and receiving three complaints.
- Of the staff we spoke with, none had knowingly been subject to a complaint. All staff said they felt supported by the department managers and believed if there was a complaint that they would be actively involved in its investigation, and department managers echoed this belief.
- One nurse told us that if somebody wished to make a complaint they would be directed to the main reception; however, they would try to resolve the issue in the department first. They were not aware of any leaflets being available in the department to provide to someone who wished to make a complaint.
- Learning from complaints was discussed at team meetings and departmental governance meetings, with minutes being available on the noticeboard in the rest room for staff who were unable to attend.

Urgent and emergency services

- We saw one Patient Advice and Liaison Service (PALS) poster and a good stock of PALS leaflets in the waiting area. Staff knew how to direct patients to make a complaint if needed, and the trust's website also had a section on making complaints.

Are urgent and emergency services well-led?

Not sufficient evidence to rate

Maternity and gynaecology

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

Information about the service

Northern Devon Healthcare NHS Trust provides maternity care at North Devon District Hospital. Community midwifery services are provided throughout north, east and west Devon and north Cornwall.

Facilities within the hospital (Ladywell Unit) include:

- Bassett ward, providing antenatal and postnatal care. The ward has 18 beds, made up of three bedded, one side room and an overnight room for women and their partners if required. A two-bed day assessment unit runs from Bassett ward between 9am and 5pm five days a week.
- The labour ward , comprising six rooms, two of which include a birthing pool. There is one dedicated obstetric theatre and recovery area.
- An antenatal clinic
- Community Midwifery services
- Ultrasound services within the antenatal clinic, staffed by sonographers provided by the radiology department.

Triage (process of determining if a woman is in labour) occurs via the labour ward.

The Clinical Negligence Scheme for Trusts; provides a means for NHS Trusts to fund the cost of clinical negligence litigation and to encourage and support effective management of claims and risk. The scheme covers claims arising from incidents on or after 1 April 1995. The trust achieved CNST level 2 status in October 2013.The trust achieved level 2 UNICEF Baby Friendly Initiative status in 2014 and is aiming to achieve level 3. Level 2 accreditation is achieved when a service demonstrates that all staff have been educated according to their role and that this training has prepared staff to care for mothers and families effectively. Level 3 accreditation is achieved when the care mothers and babies have received will be assessed with the following standards:

- Support pregnant women to recognise the importance of breastfeeding and early relationships for the health and well-being of their baby.
- Support all mothers and babies to initiate a close relationship and feeding soon after birth.
- Enable mothers to get breastfeeding off to a good start.
- Support mothers to make informed decisions regarding the introduction of food or fluids other than breastmilk.
- Support parents to have a close and loving relationship with their baby

Between 1 June 2014 and 31 March 2015 there were 1,422 births across the whole of the service, which included 61 home births and eight births described as being before arrival at the hospital. The average number of deliveries per day was four.

Maternity and gynaecology

Summary of findings

Maternity and gynaecology services were judged to require improvement for well led.

At our previous inspection in July 2014 we found concerns relating to inaccurate and inconsistent completion of HSA1 (grounds for carrying out an abortion) and HSA4 (abortion notification) forms which are required to be completed under the Abortion Act 1967. During this inspection, we found that a system had been put in place to check that the records had been completed accurately and the system had been audited and found to be compliant.

We also previously found that the rooms used by antenatal sonographers to carry out ultrasound scans were too small, had no curtains or screens to maintain privacy and dignity, and there was no means of calling for assistance. During this inspection, we saw two new, purpose built, rooms suitable for carrying out ultrasound scans had been developed and were in regular use.

Since our last inspection there had been some work on strategies to improve team working, especially amongst the medical staff. A team development programme was in its initial stages at the time of this inspection and work was ongoing around finding a medical rota that suited all medical staff.

An investigation of 13 serious incidents found a number of different root causes. With a theme of delays in appropriate escalation of clinical concerns and failure to follow trust guidelines featured in more than one investigation.

Progress against the maternity action plan following recommendations of the Royal College of Obstetricians and Gynaecologists (RCOG) invited review visit in November 2013 was still in on-going. A number of recommendations had been achieved for example, stopping amniocentesis procedures. However a number of other actions that involved improving communication between teams, a review of the consultants on call rota and developing a more inclusive and positive culture around risk management were still outstanding. This was despite a time frame to achieve by July and October 2014. We found individually the medical and maternity staff were working very hard but they did not always seem to function well as a team.

Feedback from the women who had used the service continued to be good. The maternity services worked hard to engage with the local population.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Not sufficient evidence to rate

Are maternity and gynaecology services effective?

Not sufficient evidence to rate

Are maternity and gynaecology services caring?

Not sufficient evidence to rate

Are maternity and gynaecology services responsive?

Not sufficient evidence to rate

Are maternity and gynaecology services well-led?

Requires improvement

Maternity services were rated as requires improvement as leadership needs to improve.

Since the last inspection we found systems for the completion and audit of HSA1 and HSA 4 forms had been reviewed and new processes put in place to ensure compliance with requirements.

We found the rooms used for ultrasound scanning had been renewed to maintain privacy and dignity, and means of calling for assistance were now in place.

Progress against the maternity action plan following recommendations of the Royal College of Obstetricians and Gynaecologists (RCOG) invited review visit in November 2013 was still in progress. We found individually the medical and maternity staff were working very hard but they did not always seem to function well as a team. There had been some work on strategies to improve team working, especially amongst the medical staff. A team development programme had started in August 2015. This programme was in the initial stages and as such we are unable to comment on the effectiveness and impact on team working and culture. Work was ongoing around finding a medical rota that suited all medical staff.

An investigation of 13 serious incidents found a number of different root causes and an action plan to address these was in place.

Feedback from the women who had used the service continued to be good.

Vision and strategy for this service

- Staff had an awareness of the trust strategy for maternity services, which included developing the service (low risk midwife-led service) to encourage normal birth and as a result reduce the elective caesarean section (CS) rate and the induction of labour (IOL) rate, which were higher than the national average.
- Staff were aware of plans to upgrade the antenatal clinic area and Bassett Ward but there were no firm dates for the work to begin.
- The trust had a Commissioning for Quality and Innovation (CQUIN) improvement goal around promoting normal birth through evidence-based practice and learning. CQUIN is a payments framework that encourages care providers to share and continually improve how care is delivered to achieve transparency and overall improvement in healthcare. Staff we spoke with were aware of the CQUIN and the four parts of it. These were around providing written policies and procedures that evidenced caesarean section guidance was in line with the National Institute for Health and Care Excellence (NICE) guidance. Particularly that there was a documented discussion to show that all pregnant women who requested a caesarean section as opposed to a normal vaginal birth had the risks and benefits explained and discussed with them. Another element was to develop ways to review all emergency caesarean sections as a multidisciplinary team to increase team learning. Midwives and managers expected this would help to reduce the caesarean section and induction of labour rates to within parameters expected by the trust.
- When we visited the unit in July 2014, there was no consistent midwife presence in the antenatal clinic.

Since June 2015, a midwife had been working in the antenatal clinic on a six-month secondment. Staff told us the role had proved very useful in terms of co-ordinating with the screening midwife and with the day assessment unit, and in continuing to work with women who abuse drugs and alcohol. Staff felt it provided a more consistent service and signposted women to appropriate services more effectively. A business case for the secondment post to continue had been rejected three times and staff told us this felt frustrating.

Governance, risk management and quality measurement

- At our previous inspection we found inaccurate and inconsistent completion of HSA1 (grounds for carrying out an abortion) and HSA4 (abortion notification) forms required to be completed under the Abortion Act 1967. There was no system in place to ensure the records were completed and forwarded to the Department of Health as required. During this inspection we saw a robust system had been introduced that meant all forms were checked for completeness and that they had been sent to the relevant authority. The system had been audited and was achieving 100% compliance.
- There had been 13 serious incidents (SI) in the maternity service reported in between July 2014 and March 2015. A 'deep dive' investigation had been carried out and a subsequent draft report had been completed (March 2015). The report found that although there were no root causes identified in eight of the 13 incidents there were a number of key safety and practice issues identified throughout the course of the investigations. Root causes identified in five of the serious incidents that required investigation (SI) reports included:
  - Failure of staff to recognise the seriousness of the presenting clinical situation and a delay in appropriate escalation.
  - Communication issues that contributed to a delay in appropriate escalation of clinical concerns and obstetric consultant review.
  - Incorrect interpretation of cardiotocography (CTG) leading to a delay in patient review and appropriate timely treatment.
  - Non adherence to trust guidelines for fetal monitoring.
  - Static fetal growth was documented but not reported on and failure to follow trust guidelines.
- The incident investigation report had been presented to the quality assurance committee and the trust board. An action plan had been produced which had been shared with the commissioners of the service and the NHS Trust Development Authority (TDA who provide support, oversight and governance for all non-Foundation Trust NHS Trusts). We saw that the issue with the number of reported incidents in the last year was on the trust's risk register. The lead clinician and head of midwifery were responsible to ensure the action plan was completed and initiatives in place to drive improvement.
- The action plan included the need to:
  - Urgently review the middle grade doctors (ST4) rota and ensure it was compliant with European working time directives. Currently all the middle grade doctors were working 24 hour shifts. Whilst there would be some shifts that were not very busy there were times when the doctor was very busy and got very little sleep or rest during their 24 hour shift. The issue of the 24 hours on call shifts and the desire to change the medical staff rota had been ongoing for some time. Trust executives were well versed in the detail of the issues. They told us progress had been made in agreeing the way forward with a plan to implement a new rota in the autumn of 2015. However some medical staff in maternity and obstetrics told us they felt their concerns with the proposed new rota were still not resolved. They were not able to tell us when the new rota was to be introduced. The trust told us they were pushing ahead with the revised rotas despite objections from some medical staff.
  - To ensure all staff engagement in the 'normal birth' programme to address the higher than desired caesarean section and induction of labour rates (this would also address the issue of staff not always following trust guidelines).
  - Monthly training reports were already in place to ensure strict monitoring of attendance at training sessions and to ensure lead clinicians managed poor performance effectively
- There was a maternity action plan in place, following recommendations made as a result of the Royal College of Obstetricians and Gynaecologists (RCOG) invited review visit in November 2013 which was still in progress. A number of recommendations had been achieved for example, stopping amniocentesis procedures at North Devon District Hospital as there

were too few carried out for staff to maintain their competency. Other issues that involved meetings to improve communication between teams, a review of the consultants on call rota and developing a more inclusive and positive culture around risk management were still outstanding despite a time frame to achieve by July and October 2014. We saw, however, that work was ongoing to complete the action plan.

- Uptake of obstetric emergency (PROMPT) workshops was 88.7% for midwives and 43.8% for obstetric medical staff. Medical staff attendance for neonatal resuscitation and CTG training was also low. We did not see any plans in place to improve the attendance rates.
- There had been one Never Event reported in the maternity unit the last 12 months, in May 2015, (Never Events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented). The relevant authorities had been informed. A full investigation had taken place and as a result all midwives had to complete specific e-learning, although there was no specified timescale for this to be achieved on the action plan. Some specific training had also been added to the mandatory training programme that staff had to undertake. Staff told us as a result of the Never Event a gap in knowledge had been identified and a standard operating procedure was being developed for staff to follow should a similar situation ever arise.
- The midwife to birth ratio was 1:30 in May 2015 compared to the England average of 1:27. The Royal College of Obstetricians and Gynaecologists guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, October 2007) recommends that there should be an average midwife to birth ratio of 1:28. The unit were actively recruiting midwives and hoped to increase the ratio of midwives to births, although there was no timescale set. The investigation into the 13 serious incidents had not cited the midwife to birth ratio as a contributory factor in any of the investigations.
- As a low risk unit the trust had a target to reduce caesarean sections (CS) to 24% as a percentage of all births. The current monthly average according to the trust maternity dashboard (April 2014 to March 2015) was 25.2% for all CS, which was split between 12.4% for elective CS and 12.8% for emergency CS. The target was to achieve 12% for elective and 12 % for emergency CS. The trust had a target of 15% for induction of labour (IOL) rates. The trust maternity dashboard (April 2014 to March 2015) showed the monthly average was 23.7%.The unit was expecting the action plan developed as part of the serious incident "deep dive" would help to reduce these rates. Actions to reduce the IOL rates included all staff engagement with the 'normal birth programme', maintenance of the IOL pathway and human factors training.
- Some of the middle grade doctors we spoke with told us they had completed incident reports about the difficulties of being on 24 hour call and how this impacted on them with tiredness. The doctors and some senior midwives we spoke with told us the long shift did affect their ability to concentrate and make safe decisions sometimes.
- We were told a bi-weekly maternity operational risk meeting was held. Membership comprised of the Head of Midwifery, the lead obstetrician for risk, two lead midwives, a supervisor of midwives, maternity services risk manager and the practice development midwife. Members of the neonatal team joined the meeting near the end. At each meeting all of the incident reports, required actions and timelines were reviewed. We saw minutes of previous meetings that confirmed this.
- The risk management midwife told us the unit had recently introduced a system that provided automatic feedback for staff who submitted an incident report via the electronic reporting system.
- A newsletter called 'risky business' was circulated to all staff every other month. The newsletter included information about the incidents that had been reported and if there were any themes identified. It also pointed staff to existing or new guidance and systems in place that helped to ensure patient safety. An extra news sheet was circulated in between the newsletter dates, if necessary, in response to incidents which occurred to ensure learning was disseminated in a timely way. Staff told us there had been a more multidisciplinary approach to risk management since the new consultant had been appointed as they had a special interest in risk management.
- We were told that discussion about all emergency caesarean sections (CS) and abnormal cardiotocography (CTG) readings (technical means of recording a fetal heartbeat and uterine contractions) took place each day. This had been a recent

introduction following the morning handover. We were not able to hear one of these discussions as no CS or abnormal CTG readings had occurred the previous night.

- A governance afternoon took place every two months for the obstetrics, maternity and gynaecology staff. Staff said there was reasonable attendance from all staff groups although some consultant obstetricians never attended. The meetings were scheduled for Wednesday afternoons as it coincided with the medical training day and allowed consultants and staff grade doctors to attend. Some of the staff grade doctors had been asked to produce some guidelines for the governance meetings. We did not see any minutes or notes made during the governance sessions during our inspection.

Leadership of service

- We met with the Head of Midwifery (HoM) who said the last year had been challenging. They were pleased a new band eight matron had started in post three weeks ago. The post had been vacant for a number of months and the responsibilities had been shared amongst the other senior midwives in post. Amongst their responsibilities was to encourage normal birth ensuring all staff on labour suite knew about and implemented the most up to date guidance around normal birth.
- The ratio of SoM to midwives was 1:12. This exceeded the Nursing and Midwifery Council (rules and standards – rule 12, 2004) of 1:15. This meant midwives had access to SoM when they need to discuss aspects of their practice or personal development. Midwives told us they had good support from their supervisor of midwives (SoM) and were able to access them whenever necessary. They said they could discuss any situation with their SoM especially when they needed assurances about how they had managed particular situations or when personal development opportunities had arisen and as a result learning had taken place.
- We met with the new lead consultant for labour ward who was very interested in risk management. They told us that some of the middle grade doctors were interested in ensuring the unit provided the most up to date and safest procedures available to them.
- The lead clinician and divisional lead, in discussion with medical director had recently asked consultant obstetricians, middle grade doctors and senior midwives to be involved in a team development programme. This was rolling out from August 2015 and therefore the impact of such a programme could not yet be assessed.
- None of the consultant obstetricians were trained as appraisers which meant the middle grade doctors were being appraised by consultants from another speciality. The trust told us as speciality teams were small so to ensure appraisals remained meaningful medical staff had appraisals with trained appraisers from other specialities.

Culture within the service

- During our previous inspection in July 2014 we found the trust had been asked to consider actions they should take as a result of feedback provided through external reviews, such as the Royal College of Obstetricians and Gynaecologist (RCOG) report following their visit in November 2013. The report recommended medical teams engaged in processes designed to reduce the caesarean section rate and induction of labour rate for example through engagement with the guidelines group. Additionally the RCOG review found medical staff were also finding it difficult to agree on a rota that provided equity of working hours. During this inspection we found that progress had been slow in this area and most of the medical staff could still not agree a rota that suited all their requirements, although trust executives told us an agreement was close and they planned to implement new rotas in the autumn. There remained a lack of medical staff engagement with the guidelines and policy group to ensure best practice was introduced and monitored. Additionally there was still work to do on ensuring medical staff had adequate job plans.
- We found individually the medical and maternity staff were working very hard but they did not always seem to function well as a team. For example midwives were sometimes having to ask doctors to document their conversations so they could explain to women what had been said in ante natal consultations, as the medical staff did not always write down what had been discussed.
- There continued to be some issues with some obstetricians' willingness to engage with the most up to date and recommended best practice. There were times when consultants and middle grade doctors did not agree on the management of, for example, breech

deliveries and choices around preferred forms of delivery for women. These issues had been recognised and work to engage all consultants, middle grade doctors, midwifery managers and senior midwives had begun with an initial completion of a survey in August 2015. A cohort of those who completed the survey would be chosen to join a development programme designed to provide a way to align organisational objectives to team purpose and individual values. This would then lead to further development work to ensure a cohesive and supportive team. We are unable to comment further as this programme of work was in the early stages.

- Staff were aware of the whistleblowing policy and told us they would be happy to raise concerns with the appropriate person even if that person was outside of the maternity unit.

Public engagement

- The maternity support liaison committee (MSLC) was continuing to meet at regular intervals and were continuing to recruit new members. The group included a lay member as the chair and a National Childbirth Trust breast feeding counsellor. We were told the geography of the area sometimes made it difficult for women to travel the long distances to the hospital to meet. The last meeting was cancelled as a result of not many women being able to attend and prior to this the previous meeting had seen eight women attend. The Department of Health says each trust providing maternity services should have an MSLC that includes the provider, the commissioning body and local people who have used the service. In order to try to improve attendance midwives sourced alternative bases such as children's centres, where they sometimes held ante natal clinics, to hold MSLC meetings. This may mean the meetings are closer to women's homes and therefore easier to access.
- The ante natal clinic manager told us they were continuing to try to recruit women who could provide peer support to other women in the immediate post-natal period when they were still on the ward; this could take the form of help with breastfeeding or listening to worries.
- We heard about the recent 'open day' held by the maternity unit. This took the form of a market place and had stalls about smoking cessation, domestic violence, infant nutrition, perinatal mental health team, National Childbirth Trust, ante natal screening and MSLC. All the stalls had leaflets available for people to take away. We were told it was really well attended as it had been advertised on local radio and in the local newspapers. We were told people who attended were a mix of ante natal, post-natal and some people who were interested in midwifery as a career.
- The Friends and Family Test (March 2014 – February 2015) results were very positive. The number of responses from post-natal women remained low but staff told us they always tried to encourage women to complete the survey forms before leaving the hospital.

Staff engagement

- We met with the new recently appointed matron. Staff we spoke with were very pleased with the appointment as they had been without a band eight midwife to cover labour suite and the ante/post-natal ward for a number of months. Staff thought they would take the pressure off the other band eight midwife who managed ante natal, community and public health services and the Head of Midwifery who had been helping out on the labour suite as required.
- During the inspection there was a band seven midwives away day – although in the hospital it was away from the maternity unit. Staff who were able to attend, felt very positive about it. The new matron was involved in the whole day and was asking band seven midwives for their ideas of how to continue to improve the maternity services offered to women locally.

Innovation, improvement and sustainability

- Following our last inspection we found issues related to rooms used by the antenatal sonographers to carry out ultrasound scans. They were too small, had no curtains or screens to maintain privacy and dignity and had no means of calling for assistance if a women fell ill or a sonographer felt threatened. During this inspection we saw two new purpose built rooms suitable for carrying out ultrasound scans had been developed and were in regular use. They were much bigger, had privacy curtains and an emergency call bell system. A sonographer we briefly spoke with told us they were "so much better now".
- During our last inspection we were told of plans to re-develop Bassett ward to improve the environment for women and staff and create more useable space. During this visit staff were not able to tell us when the proposed

re-development of the ward (ante and post-natal mix) was to take place and felt it was still "being put off". The trust told us the full business case for the final phase of development of the maternity unit was held up at divisional level and had yet to be presented to the executive team.

- There was a continued feeling amongst the staff that innovation and improvements were still not happening due to the attitude of some of the medical staff, who it was felt were not engaged in or interested in developing the service.
- The trust told us they were working with "partners across Devon to develop a Devon wide maternity strategy". This would help to assure consistency of service provision across Devon.
- The trust told us they were also working with partners to develop a networked (shared) maternity dashboard.

End of life care

Safe	Requires improvement
Effective	Inadequate
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Provision for the delivery of End of life care is provided by staff on wards and in departments throughout the hospital. The Specialist Palliative Care Team provides support and advice for those patients who have complex care needs, complex symptoms or both. Support is also provided to some relatives of end of life patients. The Specialist Palliative Care Team offers advice on all aspects of symptom management, including holistic assessment, psychological support and education in palliative care. The trust uses the Devon wide treatment escalation plan (TEP) which is a tool to support treatment options and any discussions with the patient and family regarding these choices.

The Specialist Palliative Care Team (SPCT) consists of one part-time palliative care consultant (16 hours a week), one full-time Clinical Nurse Specialist (37 hours a week) and one part-time Clinical Nurse Specialist (22 hours a week). There is also 22 hours of administrative support. The service is provided Monday to Friday, with advice outside normal working hours provided by telephone from the local hospice.

During 2014-2015 the Specialist Palliative Care Team carried out 446 first visits and 245 follow up visits to end of life patients and relatives in the hospital.

The Specialist Palliative Care team tries to make contact within two working days of receiving a referral. Referrals to the service can be made by health care professionals within the trust with agreement from the consultant team directly responsibility for the patient.

We visited16 wards and department areas. We met three patients, spoke with four relatives and reviewed 34 care records. We talked with more than 30 staff about end of life care. These included the Specialist Palliative Care Team, ward nurses and doctors, allied health professionals, porters, the chaplaincy team, and bereavement and mortuary staff. We observed care being provided to patients and relatives. During our inspection, we reviewed the trust's performance information

End of life care

Summary of findings

Areas of safety and well led were seen to require improvement, effectiveness of the services was rated as inadequate

The forms used to state patients' choices and preferences for treatment and their decision about being resuscitated were better filled in. However, we saw patients who met the criteria for consideration for a hospital completed treatment escalation plan TEP but one had not been completed. These patients had not been afforded the opportunity to advise of their choices and preferences for care.

Some aspects of the service provided were inadequate and were not consistently effective for patients at the end of life. The criteria for referral to the Specialist Palliative Care Team for assistance and advice with the management of symptoms were not consistently applied by all staff in all areas. Staff reported that the SPCT team responded promptly when requested.

The rapid discharge process to enable patients who wished to return home quickly at the end of their lives was not effective or well led at a trust level. The trust had recognised that the discharge of patients at the end of their lives was too slow, whilst work was being undertaken with key stakeholders, improvements in timescale for discharge were not evident.

Leadership for end of life care in the hospital requires improvement. There was no formal strategy to ensure the service was provided to an agreed standard. The governance arrangements for end of life were unclear. When it was identified through national measurements that improvements were needed, these were not done. There was no end of life committee or governance group to review and discuss this aspect of the hospital service. The service has not made the progress we were told was planned the last time we visited and some aspects would appear to have deteriorated.

In response to the findings, shortly after the inspection we asked the trust to provide us with a plan of action that set out how they will ensure they are providing an effective and well led service for people at the end of their life. The trust responded with an action plan detailing the steps they are taking to address the issues raised. We will review the implementation of the action plan in due course.

End of life care

Are end of life care services safe?

Requires improvement

Systems in place were not always used by staff to keep patients safe. The forms used to state patients' choices and preferences for treatment and their decision about being resuscitated were better filled in. However, we saw patients who met the criteria for consideration for a hospital completed TEP but one was not completed. These patients had not been afforded the opportunity to advise of their choices and preferences for care.

Safety issues were identified and reported by staff. Mortality reviews took place but data available was not considered by the trust accurate and more work was being undertaken to identify themes.

The approach to assessing and managing day-to-day risks for patients did not consistently take a holistic view of patient's needs. The Specialist Palliative Care Team advised that, although at full establishment, they did not have capacity to visit the wards regularly to assess patients and to ensure that their needs were being identified and met.

We saw that medicines were provided in line with guidelines for end of life care.

Incidents

- Staff were all able to explain clearly the process used for reporting incidents of harm or risk of harm. They told us the trust had an open reporting culture that encouraged them to alert managers to any concerns they had. This included reporting when outcomes for patients were not satisfactory. Staff explained that this included delayed discharges. Staff advised that they learned from incidents in other areas of the hospital and trust through team briefings and staff handovers.
- We looked at 18 incidents relating to end of life care in the previous year. They included staffing issues, when last day of life had not been clearly identified, transport home, pressure skin damage and poor discharge.
- The Overarching Action Plan for End of Life (2015) provided by the trust identified an action to 'Investigate possibilities for audit: incident reports' This area had a time frame for achievement of October 2014 but was not yet done
- The Medical Director said the Mortality Review Committee met monthly. It's role was robust review and reflection on all deaths of patients in the care of the trust to promote learning and corrective action. This committee monitored end of life care. The trust had recognised that there had been a gap in the overarching review of mortality within the trust so these meetings now included a structured case review of all deaths and would include discussion about the timeliness of completion of the Treatment Escalation Plans.
- The trust board had discussed the mortality rate and had identified an issue with figures being skewed by palliative care patients in the community and were working to review coding to ensure the figures were accurate.

Duty of Candour

- The trust had a policy for Duty of Candour which identified promoting a culture of openness, transparency, and truthfulness as a prerequisite to improving the safety of patients. Staff understood their duty of candour to be open and transparent in their practice and to be honest about any errors. They told us that should errors be made, staff were supported to speak up and ensure the patient was informed and an apology given.

Medicines

- We saw that when patients reached the last weeks of life, anticipatory medicines were prescribed. Anticipatory prescribing is designed to enable prompt symptom relief.
- One relative who had insight into the patients pain management told us that they were confident staff provided appropriate pain relief.
- We observed two patients who complained of pain, in one incident the staff were aware but continued talking and did not respond.

Records

- Staff told us that there was very good access to patient records at all times. They told us that for patients admitted for end of life and who had ongoing treatment this was invaluable to ensure a continuity of care.
- Last Days of Life care plans had been implemented and were seen to be used for a few patients at the end of

their lives. These were used in conjunction with existing nursing documentation. If the Last Days of Life care plan was not used, routine nursing documentation was used and was not specific to end of life care.

- Patient records were seen to be accurate, complete and legible, there were stored securely. To ensure that decisions around Treatment Escalation Plans were easily accessible these were secured at the beginning of each person's records to enable staff quick reference. These TEP decisions were also included in staff handover sheets. We identified that because of the use of agency staff the staff safety briefing was essential to inform all staff.
- The trust used Treatment Escalation Plans (TEP) to ensure clinicians who did not know the patient were aware of appropriate treatment options and any discussions they had with the patient and family regarding these choices. The most recent version had been implemented (Version 10). The completion of the Treatment Escalation Plans (TEP) was seen to have improved, with completion of most aspects of the forms. We looked at 20 forms across eight wards and departments and saw that in the most part they were fully completed. A monthly audit of TEP form completion had been ongoing with results showing some areas of consistent practice around completion.
- However, we saw that there were patients for whom a TEP should be considered because they were in the last year of life. We saw that for those patients they had not been advised or considered for a TEP form. The trust decision making criteria for patients for whom a TEP should be considered included those patients who are likely to be in their last year of life. For seven out of ten notes seen for patients who were receiving chemotherapy, this form had not been used to identify the patient's choices and preferences when a prognosis of less than a year of life was identified. We discussed this with staff who agreed that the forms should be considered but had not been.
- Out of 10 case notes reviewed on the wards Glossop and Victoria, four were identified as meeting the criteria for consideration of a TEP but had not been considered.
- The trust have told us that patients can be considered for a TEP who were within a year of the end of their life, this needed to be balanced by the current situation that they were in. The Trust therefore prioritised the patients who were in imminent risk of dying to ensure that a TEP is in place. However, the trust decision making criteria for patients for whom a TEP should be considered, included those patients who are likely to be in their last year of life.

Safeguarding

- Staff told us that safeguarding training was provided annually. We saw several wards that had agency staff on duty. The trust told us that it was their responsibility to ensure agency staff supplied were fit for practice and as part of engagement with agency staff minimum training included safeguarding.
- We saw evidence in patient's records of when staff had identified that a patient was vulnerable and needed further assessment to ensure their safety.

Mandatory training

- End of life training was provided as part of staff induction with some opportunity for staff to spend time with the SPCT. We saw that student nurses were given the opportunity to spend shifts with the SPCT and that some end of life training was also provided to junior doctors, this included top tips and FAQ for new doctors starting with the trust. Mandatory training covered other areas including safeguarding, equality and diversity, infection control, health and safety, moving and handling and fire safety

Assessing and responding to patient risk

- The Emergency Department had an alerting system for patients already receiving chemotherapy. The system would flag an alert to the oncology and cancer services that the patient had been admitted. This would enable staff to have a continuity of care. This alert did not include the SPCT.
- We saw that Early Warning Scores (EWS) were used for all patients. We observed patient records, which evidenced that when a patient's condition suddenly deteriorated prompt action was taken. For example we saw that when a patients deteriorating condition required an increase in pain medication via a syringe driver, this was monitored and reviewed to ensure its effectiveness and adjusted to meet the patient's needs.
- Risk assessments were in place with risk management plans in place to support patients and ensure their safety. We saw that patients at the end of their lives were, in some cases assessed as no longer needing routine observations to monitor their health and so had

been discontinued to ensure the least disturbance. Staff told us that they still made the same routine comfort round visits without undertaking any pulse or blood pressure monitoring.

Nursing staffing

- The Specialist Palliative Care Team consisted of one full time Clinical Nurse Specialist (37 hours per week) and one part time Clinical Nurse Specialist (22 hours per week). The service was Monday to Friday with out of hour's advice via telephone from the local hospice. This is a formal arrangement and the Trust employs the palliative care Consultant who works at the hospice site. The team told us they were at current full establishment.
- Between December 2014 and April 2015 there was only one full time SPCT team member available for the hospital. This was because one staff member was off long term sick and another post was vacant. The vacant post had been filled in April 2015.
- In the week of our inspection the SPCT saw eight patients and the following week they saw 11 patients. We saw that on Glossop and Victoria ward patients with complex symptoms were not referred to the SPCT. Ward staff told us that they didn't like to overload the SPCT with too many referrals. They explained that they were a small SPCT and that if they referred to them all of the time they would have too much workload. The SPCT appreciated that staff did not always refer to them and that this was an ongoing risk that patients may not be appropriately referred.
- Each ward noticeboard had the nursing establishment calculation and the nursing level of staff on duty for each shift. We saw that the staffing level on most wards was met or exceeded.
- There was an end of life link nurse on each ward. They met every three months with the SPCT to consider updates and discuss actions to cascade to the ward staff. Ward staff told us that they were considered a good source on information and support.

Medical staffing

- There was one part time palliative care consultant providing 16 hours per week split over four sessions, each session lasting four hours. Should the SPCT need consultant support outside of this time, there was a formal arrangement for access to consultant advice from the hospice. This meant that there was a gap of time of a consultant being available at the hospital between the SPCT consultant finishing for the week and returning the following week. This limitation may also affect the ability for the input into Multi-Disciplinary meetings. These meetings were held weekly and should the SPCT attend they would not be available to attend referrals for that period.
- Out of hours and at the weekends ward staff needing medical support for palliative and end of life patients would use the medical team on duty and access any specialist information from the local hospice.
- All referrals to the SPCT consultant were dependant on the agreement of the patients lead consultant. Some consultants confirmed they did not refer to the SPCT and always undertook the palliative and end of life care without their support. This was because they felt confident to assess and treat and meet the patient's needs.

Major incident awareness and training

- The staff in the mortuary were aware of the trusts major incident plan to ensure that the dignity and respect for the deceased would be maintained.
- A policy was in place for mortuary staff which set out the procedures for dealing with capacity problems (caused by increased activity or major incident), refrigeration breakdowns and water/power supply failures that impact on the delivery of the service.

Are end of life care services effective?

Inadequate

Some aspects of the service provided were not effective for patients at the end of life.

Not all patients who would benefit for review by the Specialist Palliative Care Team were referred. Staff on a number of wards throughout the hospital did not consistently understand how and when to make a referral to the specialist team at the appropriate time in order to meet the current and anticipated needs of patients. We saw five out of ten incidences when referral for patient's symptom management could have been considered but was not, which may have had an impact on the patient in terms of pain and other symptom management being delayed or not being sufficient to meet their needs.

End of life care

There was very limited monitoring of patients' outcomes of care and treatment and audit results did not effect changes in practice. Some standards in the National Care of the Dying Audit were seen to not be met. Areas for development previously identified had not yet been implemented.

End of life care on wards was not monitored by the Specialist Palliative Care Team to ensure that any deterioration in practice was identified, managed and improved. We saw two instances when patients told us they were in pain. Staff training in end of life care varied from ward to ward with some wards not achieving 50% of staff having received some training in end of life care.

The last days of life care plans identified advance care planning as an option but unless that documentation was used, no evidence was seen it was considered. No other systems were in place to enable patients to make advance directives or consider the decisions needed for their future.

The rapid discharge process to enable patients who wished to return home quickly at the end of their lives was not effective. The trust had recognised that the discharge of patients at the end of their lives was too slow, whilst work was being undertaken with key stakeholders improvements in timescale for discharge were not evident.

Consent to care and treatment and the Mental Capacity Act 2005 were used to support patient's best interests. The management of Deprivation of Liberty Safeguards was in the one case we saw, not well monitored and actioned.

In response to the findings, shortly after the inspection we asked the trust to provide us with a plan of action that set out how they will ensure they are providing an effective service for people at the end of their life. The trust responded with an action plan detailing the steps they are taking to address the issues raised. We will review the implementation of the action plan in due course.

Evidence-based care and treatment

- An overarching action plan was produced to improve the quality of end of life provision. This document was last updated on 11/05/2015.This was linked to NICE Quality Standard 13 (1604): QS and the National Care of the Dying Audit and a local audit of inpatient deaths.
- The Specialist Palliative Care team produced guidelines for staff to follow around the five quality markers as identified in the Department of Health document End of Life Care Strategy 2009. There were Last Days of Life care plans for medical and nursing staff and we also saw posters relating to end of life care on some wards.
- We saw that some NICE guidance was not being followed, for example NICE guidance QS103 in that people approaching the end of life were not all identified in a timely way. We saw the overarching action plan had identified that to meet this expectation the trust had 'to produce a toolkit for identifying patients in the last hours of life", this was marked as having an achievement date of October 2014. However, we did not see this had been implemented in practice, as while we saw the last days of life care plan gave prompts for identification this was not seen to be widely used in the hospital.
- The trust told us they had developed a proactive approach with the resuscitation team to review all people with high early warning scores. For those that had EWS above 11, the resuscitation team identified them and supported the ward teams to complete TEPs and move to end of life care.
- The National care of the Dying Audit (NCDAH) was undertaken every two years. The most recent outcomes in May 2014 identified that the hospital did not meet five out of the seven organisational key performance indicators. Areas not met included:

- Access to information relating to death and dying

- Access to specialist support in the last days / hours of life

- Care of the dying, continuing training education and audit

- Trust board representation and planning for care of the dying

- Clinical provision / protocols promoting patient privacy, dignity and respect up to and including death.

- Two areas had been achieved during our inspection, these were clinical protocols for the prescription of medications for the five key symptoms at the end of life and formal feedback processes regarding bereaved relatives/friends views of care delivery.
- In June 2014 actions needed as a result of the audit were identified and presented to the hospital board. This action plan included actions but no timescales for implementation and no reviews or updates. The presentation noted that recognition that the patient was dying before death only occurred in 25% of cases and

that communicating a plan of care did not score highly. Also there was recognition that spiritual care was crucial and further work was needed to improve the spiritual care provided. In the area of nutrition and hydration the presentation noted that this was rarely reviewed and rarely discussed with their relatives and families. Furthermore, any review of documentation after death did not take place.

- In the NCDAH the trust performed worse than the England average for 7 out of 10 of the clinical KPIs with low scores for assessing the patient's hydration and nutritional requirements and their spiritual needs.
- The SPCT undertook an audit comparison to the National Care of the Dying Audit in 2015 with a sample of 52 patients and 48 sets of notes reviewed over the whole trust including some community services. The results were largely reflective of the 2014 National Care of the Dying Audit results as follows:
  - The SPCT were largely only involved in the patients last two weeks of life.
  - Very few patients were using the Last Days of Life paperwork for those patients identified in the last few days of life, and there were symptoms evident that would have enabled this recognition.
  - 36% of patients were only identified as in the last days of life within the last 24 hours of life.
  - 48% of patients did not have their plan of care discussed with them.
  - 50% of those surveyed were referred to the SPCT and all were seen within 2 days of referral
  - 96% were not seen by a spiritual advisor
- An Overarching Action Plan was in place by the SPCT which was linked to the National Care of the Dying Audit 2013 which identified goals and timescale for completion. There was a further less detailed action plan produced by the SPCT which did not make it clear what had been achieved and what was still ongoing. For example, the date of completion for the implementation of the Amber Care Bundle (a tool for patients who may be in the last months of life) was September 2014 but was currently not in place.
- There were no clear end of life care plans in use in a consistent manner throughout the hospital. We requested further information about care plans used. The trust confirmed that a policy has not yet been written to replace the Liverpool Care Pathway. The National Gold Standards Framework was not in use; this is a tool to train staff to provide coordinated care to meet patient's specific needs. The trust told us they ran an awareness campaign in June 2015 called RADAR to raise the profile of the expectations of care, and provide focus on information.
- The SPCT data was submitted through the cancer services network however, no data had been submitted for the previous two years. The cancer networks enables NHS organisations to work together to deliver high quality, integrated cancer services. There had also not been any peer review for the last two years of the SPCT as part of the National Cancer peer review Programme. Staff did not offer any explanation as to why these two processes had not been undertaken.
- In the year 2014 to 2015 the SPCT saw 446 patients as a first visit and did 245 follow up visits. The reasons for follow up visits included assessment and support for patients, symptom control, support for medical staff, liaising and psychological support.
- The SPCT also provided input for patients who required end of life care but did not have a diagnosis of cancer. There was no current recording of non-cancer referrals to the SPCT to enable the service to identify any challenges or demand.
- The SPCT did not have capacity to visit the wards regularly to assess how increased needs of patients towards the end of life were being identified and met. No audits were undertaken to establish if patients at the end of their lives had appropriate mouth care or that food and fluid management was effective to ensure patient comfort and safety. This meant that should extra training be needed it was not identified, assessed and responded to with extra staff training.

Pain relief

- The management of pain varied from ward to ward. We saw some good examples of care provided around pain management and the management of agitation, but we also saw wards were pain was not well managed and we spoke to two patients who were in pain. On one occasion which was not a patient at the end of life, we observed an urgent request for pain relief was made to the trained nurses from an HCA on behalf of the patient. The two trained nurses carried on talking for approximately five minutes before responding. On another occasion, a patient was experiencing discomfort in their position in bed. They had been told that staff couldn't find a pressure relieving cushion for the patient to sit out of bed. We discovered that the

chairs in use had an inbuilt pressure relieving cushion, but staff did not explain this to the patient or endeavour to find a suitable alternative. On each of those occasions, we informed staff members.

- Tools were in place to identify pain levels between 1-10. There were also tools in place to identify any evidence of pain from facial expressions and non-verbal communication. We saw that for some patients these were completed. Comfort rounds took place on the wards regularly throughout the day. Pain was assessed at these rounds.
- The palliative care team produced an information leaflet for staff in October 2014 on 'as required' medication. This included information about how patients with a palliative diagnosis have increased risk of certain symptoms including pain and when consideration of appropriate prescription of medication on an as required basis was appropriate.
- We saw in some instances anticipatory medicines were requested and put in place to enable quick access to pain relief medication should the patient's pain levels change.

Nutrition and hydration

- Nutrition and hydration needs were seen to be met in all areas. We saw patients had access to food and drinks and saw staff supporting those patients who could not manage food and drink independently. Equipment to assist patients to remain independent whilst eating was in place where the need was identified.
- We saw that care plans in place identified patients nutritional and hydration needs and when these changed. We saw for one patient at the very end of their life, nutrition and hydration was re assessed each time care was provided.

Patient outcomes

- We visited the Chemotherapy unit and saw that learning from practice had resulted in the redesign of documentation for administration of chemotherapy. Further developments included chemotherapy drug ordering to ensure availability both in the hospital and the patient's home. Further auditing was ongoing to analyse the success of telephone triage on the unit.
- There was significant staff confusion about how to make a referral to the SPCT and the route this should come from. Staff told us that referrals could only be made by a consultant to consultant, whilst other staff told us that nurse to nurse referrals could be made.
- The referral criteria to the Specialist Palliative Care Team for assistance with the management of symptoms was not consistent by all staff in all areas. From ward to ward, nursing and medical staff understanding of the Core Referral Criteria (Reviewed June 2015) to refer to the SPCT for support and advice for symptom management varied. We saw five incidences when referral could be considered under the criteria, but was not. The SPCT were aware that this was a shortfall in the service they provided but offered no active solution.
- The referral form stated that 'Referrals for the provision of specialist palliative care services should be in relation to patients with advanced progressive incurable disease'. We spoke with staff about when referral would be considered and it was evident from the response that in some instances a consideration for referral was deferred until active treatment for disease was discontinued or a definitive diagnosis confirmed. Nursing and medical staff also told us they did not refer because they did not wish to overload the team. This meant that patient symptom management was delayed.
- We spoke with medical and nursing staff who told us they would not make a referral to the SPCT unless a MDT decision had been made that the patient was for palliative treatment even when the patient had symptoms which may benefit from SPCT input.
- A poster was seen on some wards 'Principles of Care for the Dying. The poster stated that as part of the clinical review process, an opinion was needed from the Specialist Palliative Care Team. The SPCT were also noted to be contacted at the review stage. This was not seen to consistently be the case.
- We looked at ten patients' notes between Glossop and Victoria Wards. Of those ten sets of notes five of the patients on Glossop ward may have benefited from referral to the SPCT for review of symptom management and two already had been referred. There was no documented reason why the five we identified had not been considered for referral.

End of life care

- We saw in two cases that symptoms were not identified and considered. For example one patient told us about physical symptoms being experienced which were not recorded in the patient's notes. We passed this information on to ward staff.
- Once referred to the SPCT we saw that symptom management for patients was ongoing with regular support and advice provided. Staff told us that they found the SPCT helpful and available when requested.
- Some ward staff were clear that referral would be made but that this would only be when they could no longer successfully manage the patient's symptoms. The successful management of patients' symptoms would depend on the skills and knowledge base of staff. We saw that some wards managed this well. They confirmed that should the patient's condition become more complex, assistance from the SPCT would be sought. We saw that a patient on the acute stroke unit was receiving end of life care managed by the unit staff. The care was clearly provided and recorded, monitored and adjusted when needed. The patient appeared comfortable and their best interests were being considered and served.
- No advance care planning for patients in the last 12 months or last few weeks of life took place. The last days of life care plans identified advance care planning as a patient option but was not seen to be consistently used. No other systems were in place to enable patients to make advance directives or consider the decisions needed for their future.
- There were no accommodation facilities available for relatives to stay with the patient during their admission to hospital. The relatives could use the day room if the ward had one and it was free for use. Alternatively a recliner chair could be provided at the patient's bedside. We saw that on Tarka ward side rooms were sometimes used for patients identified as dying and this level of privacy enabled patient's relatives or carers to stay with them.
- No dedicated room was available in the Emergency Department for relatives to view their deceased patients. However, the department had plans in place, which we saw actioned, to use a specific side room or cubicle, should the need arise. The mortuary had in place a viewing room available for relatives by appointment to view their deceased.
- There was no audit of care of the dying services provided at the hospital to identify if patients preferred place of care had been achieved. and no other local audits took place to identify any trends or areas for development. Patient discharge to their preferred place of care for the last days of their lives was not consistently achieved. This aspect of end of life care was not audited to monitor its success or failure.

Competent staff

- Some aspects of end of life training were supplied by the SPCT and others such as the setting up and supporting of syringe drivers for ongoing pain relief was provided by the Workforce Department and the local hospice. Ten end of life teaching sessions had been provided in the last 12 months and sessions had included a total of 82 staff.
- Staff training for end of life varied from ward to ward. Up to November 2014, 74% of trained nurses on Glossop ward had received end of life training, 33% on Staples ward and 30% on Fortiscue ward.
- Each ward had an End of Life Link nurse who attended training and updates and cascaded information to the ward. There was also literature available on each ward relating to the end of life care.
- We saw that on occasion band 5 registered nurses were the most senior staff member responsible for patient care at ward level. Data provided to us up to November 2014 showed, some of these staff had not undertaken specific end of life training and so may not yet have the experience to identify when the symptom management of end of life patients was in need of the specialist advice of the SPCT. On Glossop ward of the 19 Band 5 nurses employed, six had not completed end of life training. On Alex ward of the ten Band 5 nurses, four had not yet received the training and on Staples ward of the 13 Band 5 nurses employed, 11 had not yet received the training.
- The Overarching Action Plan for End of Life Care identified that training arrangements to include assessment of competencies and communication training had not been addressed and were recorded on 19/03/2015 as 'No plans currently'.
- Agency staff were employed on wards. Staff told us that they were not made aware of the competency and skills levels for agency staff around end of life and so staff on the wards had to assess if the agency staff were competent to manage end of life care at the start of each shift. They told us "we get who we get".

End of life care

- We saw that a palliative 'Focus' document had been produced monthly by the SPCT. Each month an aspect of palliative care was addressed with advice and support for staff. These included individualised care planning, discharge planning, mouth care and referral criteria.
- Ward staff told us that they had regular supervision and appraisal to ensure their support and ongoing personal development and practice. The Specialist Palliative Care Team records indicated that two out of the three staff had not received updated appraisals for the last year.
- Some training was available for junior doctors by the SPCT and information was provided to them from the SPCT about the criteria for referral and referral responsibilities.
- The SPCT told us no training was provided by them at consultant level on the criteria for referral to the SPCT. The trust told us training was provided and available to all staff including the medical workforce, training would and has been provided both in terms of formal training but also work based and through governance days which would include referral to SPCT.

Multidisciplinary working

- We followed the pathway of end of life patients through the emergency department. If the patient was known to the oncology team an alert would be made and an oncology specialist would attend. However as this is a 9-5 service, out of hours was done by the medical doctor on call. Should the patient be identified as being in the last day of life a side room would be sought in the hospital .If death was imminent then a side room and a bay in the Emergency department were allocated for use. These spaces may be busy and so staff would need to seek alternative provision. We saw that when a patient needed these spaces at end of life they were provided and the system appeared to be effective. Staff in the ED told us that whilst they could contact the SPCT they didn't do this routinely and the SPCT did not visit the department.
- The hospital Pathfinder service is a seven day service assisting rapid discharge of patients to their home. End of life patients were always fast tracked on this service as they met the criteria 'rapid deteriorating condition' but we found the rapid discharge process did not enable effective transfer of patients from hospital to home or community services quickly at the end of their lives.
- If a patient has been assessed for rapid discharge and paperwork completed and their case submitted for validation on a Friday, it would not be returned until the earliest the following Monday. This validated assessment would then go to a brokerage system lasting a minimum of three days. If a care home was identified to have a suitable place, the home must then attend the hospital to assess the patient for suitability. The fastest track discharge without any complications, to a care home would be a minimum of five days to a week. For patients requiring a package of care to return to their own home the fastest discharge without complications and assuming a package of care was available would be four days.
- The pathfinder team said that if the hospice could assist with a rapid discharge they would but this was dependant on their capacity. On the day of our inspection there were four patients in the hospital at the end of their lives waiting for discharge. One patient had been waiting eight days and had been submitted twice to the tender process to confirm care home accommodation. Another patient had been waiting four days and another five days. Staff explained that the impact on the extended delays of process meant that patients were not able to be discharged home to die and died in hospital or they went home with less care package than they were assessed for. Staff told us of an instance the week before our inspection when a patient referred to the Pathfinder service had died within the hospital which had not been their preference. The Pathfinder team told us this happened every one to two weeks as an estimate.
- Data received from the trust for rapid discharge for the 16 days between 27 July 2015 and 11 August 2015 showed five patients had experienced delays. One patient waited 15 days and was at that time too unwell to discharge and died in hospital. Another patient waited eight days before discharge home.
- We were advised that as part of the SPCT responsibility the SPCT nurse attended the lung and Upper Gastro Intestinal MDT meeting weekly. An assessment report for these meetings noted that by June 2015 the SPCT had not met their targets for attendance that these MDT meetings. As of July 2015 the SPCT had only been able to attend 60% of the lung MDT meetings due to lack of capacity. The self-assessment for the upper GI MDT

identified that the SPCT attendance was not met due to staff sickness and staff vacancy. There were no formalised links or pathways with the oncology services to identify the services worked together.

- There were no formal links to the Chaplaincy service to inform the Chaplaincy when end of life patients had been identified. The Chaplaincy was dependant on the referral of ward staff and this was not consistent. We saw that the documentation used by wards varied and so unless the right documentation was used there was no prompt for staff to raise this issue. The Chaplain provided staff training to raise the awareness for staff to identify and enable spiritual support to be made available. The Overarching Action Plan provided by the SPCT stated that 'Develop strategy for improving provision for spiritual needs of patients as identified in the National Care of the Dying Audit' had recoded no progress since March 2015.
- There were some links between the SPCT and the bereavement service. The SPCT would visit and support relatives post death as required.

Seven-day services

- End of life care was provided on all wards and areas 24 hours a day. This included access to imaging, pharmacy and some therapists on an on call basis. The SPCT were available Monday to Friday and were not available out of hours. Weekend and out-of-hours support was provided in a formal arrangement with the local hospice. Staff told us they used the support link to the hospice out of hours and that it was effective for their needs.
- As the SPCT were a team of three staff, one consultant, one full time trained nurse and one part time nurse, access varied dependant on who was on duty. On the week of inspection the level of SPCT some of the team were on leave and as a result most days the consultant was the only person available for the hospital. The SPCT did not undertake the training or initial starting of syringe drivers for patient pain relief. Should no ward staff with sufficient competency be available, the on call clinical site team was contacted to undertake this procedure. We spoke with the site manager who confirmed this took place. The clinical site manager also undertook out of hours the triage of patients on chemotherapy to ensure a continuity of service.

Access to information

- We saw that the use of documentation varied. Some patients at end of life had the last Days of Life Care plans and some had the trust standard admission and recording documentation. We noted that the documentation used varied in its level of identification of patients spiritual needs. The general admission documentation did not identify of the patient had any specific spiritual needs. This meant that unless the patient was identified as needing the last days of life care plan this area of need may not be identified or explored for the patient.
- At the point of discharge for patients back into the community, the documentation for the discharge process was seen to be extensive, particularly for those patients transferring to a residential care setting or in need of a package of care support at home. Staff told us the information gathering was detailed and time consuming and impacted on the discharge process. Staff told us that should the documentation not be seen as adequate by the external validation team it was returned for further work which delayed the discharge process.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at 20 Treatment Escalation Plans for patients at the end of life and those with ongoing treatment. We saw they were mostly completed to a good standard and clarified patients choices, preferences and included a rationale for decisions made. Where patients lacked capacity to be involved or make those decisions, the Mental Capacity Act 2005 was in the majority of cases followed and the process recorded how decisions were made in the patient's best interest.
- We saw patient notes which identified a Deprivation of Liberty Safeguard had been put in place. The circumstances of the decision had been recorded with a timescale for expiry. However, we noted that the duration of the safeguard was pending imminent expiry at the weekend. By Friday no action had been taken, we alerted staff to this issue to ensure the staff and patient safety.
- We saw evidence that when needed a patient with no capacity had a best interest meeting which concluded with an implementation of an independent advocate to ensure the patient's best interests were met.

End of life care

Are end of life care services well-led?

Requires improvement

There was no clear and realistic strategy for end of life care with no plans available to see how the service was to be assessed, developed and moved forward to meet patient's needs. The Medical Director and Director of Nursing , who lead on the end of life provision at the trust confirmed that there was no formal strategy to ensure the service was provided to an agreed standard. The executive lead did not demonstrate an insight into the issues around variable referral to the SPCT.

The governance arrangements for end of life were unclear. There was no end of life committee or governance group in place to review and discuss this aspect of the hospital service. Information available to monitor performance had not created change to the service being provided. The service has not made the progress we were told were planned the last time we visited and some aspects would appear to have deteriorated.

Recognition of the poor service for end of life patients for rapid discharge had been identified when the trust had a whole service focus on patient flow but since then while data was being collected no action had been implemented by the trust to meet those patients' needs at the end of their lives to facilitate a timely discharge.

There was minimal evidence of engagement with people who use the service, staff and public to develop the end of life service. There was minimal evidence of learning and reflective practice leading to changes in the end of life service.

In response to the findings, shortly after the inspection we asked the trust to provide us with a plan of action that set out how they will ensure services for people at the end of life service are well led. The trust responded with an action plan detailing the steps they are taking to address the issues raised. We will review the implementation of the action plan in due course.

Vision and strategy for this service

- The Specialist Palliative Care Team sits within the medicine division. There was in place an operational policy for the SPCT which had been last reviewed in July 2013. This operational policy had been written to ensure that all members of the palliative care service and other members of medical and nursing staff were aware of the purpose and organisation of the Specialist Palliative Care Team, its structure, meetings and scope of services. This document had been written in accordance with national guidelines including the National Manual of Cancer Services and Peninsula Cancer Network guidelines.
- There was no clear and realistic strategy for developing and achieving a consistent standard of end of life care for the hospital. The medical director and director of nursing were the executive leads on the end of life provision at the trust and confirmed that there was no formal strategy to ensure the service was provided to an agreed standard.
- The Chief Executive advised that there was no immediate plan to develop a strategy and the staff had access to a suite of information developed by the Consultant in Specialist Palliative Care.
- A briefing paper had been provided to CQC from the SPCT for the development of the end of life service. (Date unknown).This paper identified shortcomings in the current service provision and proposals to develop the service. We were told this paper had been submitted and that no feedback or response had been received. The trust board told us they had never received this paper. We were advised that the CQC Action Plan was presented to the Executive Directors on a fortnightly basis and the Trust Board on a Bi-Monthly basis. Any exceptions were escalated to Directors who took up the action to ensure it was completed.
- There was no evidence that end of life service was reviewed or discussed at any strategic committees or was presented on a regular basis to the hospital board as a core area for discussion.
- The trust had in place a Non-Executive board which have the responsibility to ensure that the board sets challenging objectives for improving its performance across the range of its functions. The trust had a non-executive director lead for end of life but there was no evidence of them providing challenge to the board for this service.

Governance, risk management and quality measurement

- There was limited governance in place for end of life provision. There was no end of life committee or

governance group in place to review and discuss this aspect of the hospital service. The trust provided us with presentations of governance issues around TEP and the National Care of the Dying Audit. These did not include any discussion, minutes or action plans from the meeting the presentation was delivered. A TEP audit of documentation was available.

- There were limited quality measurement tools in place for end of life for the trust to measure itself both locally and nationally. There was little evidence that outcomes seen from the National Care of the Dying Audit had led to a change in outcomes for patients.
- A Mortality Review Group was implemented instead of an end of life strategy or group in place to review end of life provision. This group was chaired by the medical director with the purpose of ensure all case notes were reviewed by two clinicians. We looked at minutes of the last three meetings for March, April and June 2015 and saw end of life representation at one of the meetings. Discussion related to the Treatment Escalation Plans was seen. The Mortality Review Group were not monitoring end of life strategy and ensuring that staff understood their role and were achieving it.
- The trust risk register included an entry as follows: There is a risk of Non-compliance with CQC standards and an inability to deliver the End of Life Strategy due to the Trust not having an End of Life Lead or Team'. The timescale for update was 31/07/2015 and had identified the medical director as taking the lead role.
- There was however, clear evidence that quality measurement had implemented changes on the Chemotherapy unit, where ongoing monitoring continued to create changes in the documentation used for patients.
- The Operational Policy for the Specialist Palliative Care team was last reviewed in 2013 and made reference to the Liverpool Care Pathway that is now obsolete. The document did not include any record of plans of care to be used for end of life care in replacement for the Liverpool Care Pathway. We requested further information and the trust confirmed that a policy had not yet been written to replace the Liverpool Care Pathway. They advised that the effect of the removal of the Liverpool Care Pathway was discussed at length prior to its removal.
- The trust had recognised that the discharge of patients at the end of their lives was too slow, whilst work was being undertaken with key stakeholders improvements in timescale for discharge were not evident. This led to instances where patients were dying in hospital rather than being discharged to their preferred place.

Leadership of service

- Currently the end of life lead for the hospital was the medical director with the support of the interim director of nursing, with the SPCT part time consultant taking the clinical lead. There was little evidence that the executive and clinical leads had met to formally discuss governance and development of the service.
- We highlighted the concerns we found with the inconsistency in timely referral by ward staff to the SPCT to the medical director and director of nursing. They did not demonstrate an insight into the issues or awareness that patient experience may be variable dependant on which ward they were receiving care on in the hospital.
- We were advised that as of the date of the inspection, development plans were being considered and an End of Life lead role was being considered to report to the trust board.

Culture within the service

- Staff on the wards told us that they felt able to raise issues with senior staff and felt their views were valued and respected. Ward staff were clear that they put the patient at the centre of the service they provided.
- Ward staff told us that they worked well with the SPCT and valued their support and advice. Once referred, they worked alongside each other to ensure the patient received the care needed.

Public engagement

- There was no evidence that patients' and relatives' views shaped and improved the services available. No hospital based bereavement survey was undertaken for the trust to identify if the service provided to end of life patients was of a good standard.
- End of Life Care was not discussed at Patient Experience Group, the trust told us this was something they would be looking to introduce.

Staff engagement

- At our previous inspection in July 2014 we saw plans in place to develop an end of life group and to nominate

individuals at board-level to be designated with specific responsibility for end of life care. We saw that the medical director had undertaken and end of life role but no end of life group was evident.

- At our previous inspection we saw an action plan from the results of the NCDAH with a timescale to achieve by October 2014 that included a task of nominating a lay member with specific responsibility for end of life care by October 2014. We did not see any evidence that this had taken place.

Innovation, improvement and sustainability

- The SPCT had been identified by some ward staff as not being visible in some areas of the hospital. The members of the SPCT told us they were unable to provide a proactive service to wards, this was because they did not have the capacity to attend wards and departments in a routine way and that predominantly they only attended to provide advice for patients who had been referred for symptom control.
- The SPCT were aware of the difficulties in referral systems for complex symptom management but systems had not been improved to ensure all patients had the same access to the SPCT.
- Developments to end of life services were not evident. Consideration was being given to a new end of life lead role to promote and facilitate end of life care.
- At our previous inspection in 2014, implementation of the amber care bundle was scheduled to be implemented. This is an alert system to identify patients who were not responding to current treatment in order to support patients that were assessed as deteriorating in health or where recovery was uncertain. This remains unfulfilled.

Outstanding practice and areas for improvement

Outstanding practice

Vision and strategy for this service

- The Specialist Palliative Care Team sits within the medicine division. There was in place an operational policy for the SPCT which had been last reviewed in July 2013. This operational policy had been written to ensure that all members of the palliative care service and other members of medical and nursing staff were aware of the purpose and organisation of the Specialist Palliative Care Team, its structure, meetings and scope of services. This document had been written in accordance with national guidelines including the National Manual of Cancer Services and Peninsula Cancer Network guidelines.
- There was no clear and realistic strategy for developing and achieving a consistent standard of end of life care for the hospital. The medical director and director of nursing were the executive leads on the end of life provision at the trust and confirmed that there was no formal strategy to ensure the service was provided to an agreed standard.
- The Chief Executive advised that there was no immediate plan to develop a strategy and that staff had access to 'A suite of information' on how to deliver effective end of life care.
- A briefing paper had been submitted to the board for the development of the end of life service. (Date unknown).This paper identified shortcomings in the current service provision and proposals to develop the service. We were told that no feedback or response had been received. We requested the trust provided us with assurance that these areas were being addressed. We were advised that the CQC Action Plan was presented to the Executive Directors on a fortnightly basis and the Trust Board on a Bi-Monthly basis. Any exceptions were escalated to Directors who took up the action to ensure it was completed. We are still waiting for a copy of the Executive Directors meetings to confirm any actions completed.
- There was no evidence that end of life service was reviewed or discussed at any strategic committees or was presented on a regular basis to the hospital board as a core area for discussion.
- The trust had in place a Non-Executive board which have the responsibility to ensure that the board sets challenging objectives for improving its performance across the range of its functions. The trust had a non-executive director lead for end of life but there was no evidence of them providing challenge to the board for this service.

Governance, risk management and quality measurement

- There was limited governance in place for end of life provision. There was no end of life committee or governance group in place to review and discuss this aspect of the hospital service. The trust provided us with presentations of governance issues around TEP and the National Care of the Dying Audit. These did not include any discussion, minutes or action plans from the meeting the presentation was delivered.
- There were limited quality measurement tools in place for end of life for the trust to measure itself both locally and nationally. There was little evidence that outcomes seen from the National Care of the Dying Audit had led to a change in outcomes for patients.
- A Mortality Review Group was implemented instead of an end of life strategy or group in place to review end of life provision. This group was chaired by the medical director with the purpose of ensure all case notes were reviewed by two clinicians. We looked at minutes of the last three meetings for March, April and June 2015 and saw end of life representation at one of the meetings. Discussion related to the Treatment Escalation Plans was seen. The Mortality Review Group were not monitoring end of life strategy and ensuring that staff understood their role and were achieving it.
- The trust risk register included an entry as follows: There is a risk of Non-compliance with CQC standards and an inability to deliver the End of Life Strategy due to the Trust not having an End of Life Lead or Team'. The timescale for update was 31/07/2015 and had identified the medical director as taking the lead role.

Outstanding practice and areas for improvement

- There was however, clear evidence that quality measurement had implemented changes on the Chemotherapy unit, where ongoing monitoring continued to create changes in the documentation used for patients.
- The Operational Policy for the Specialist Palliative Care team was last reviewed in 2013 and made reference to the Liverpool care Pathway that is now obsolete. The document did not include any record of plans of care to be used for end of life care in replacement for the Liverpool care Pathway. We requested further information and the trust confirmed that a policy had not yet been written to replace the Liverpool Care Pathway.
- Whilst recognition of the poor service for end of life patients for rapid discharge had been identified within the trust, no action in the short term had been implemented by the trust to meet those patients at the end of their lives to facilitate a timely discharge. This lead to instances where patients were dying in hospital rather than being discharged to their preferred place.

Leadership of service

- Currently the end of life lead for the hospital was the medical director with the support of the interim director of nursing, with the SPCT part time consultant taking the clinical lead. There was little evidence that the executive and clinical leads had met to formally discuss governance and development of the service.
- We highlighted the concerns we found with the inconsistency in timely referral by ward staff to the SPCT to the medical director and director of nursing. They did not demonstrate an insight into the issues or awareness that patient experience may be variable dependant on which ward they were receiving care on in the hospital.
- We were advised that as of the date of the inspection, development plans were being considered and an End of Life lead role was being considered to report to the trust board.

Culture within the service

- Staff on the wards told us that they felt able to raise issues with senior staff and felt their views were valued and respected. Ward staff were clear that they put the patient at the centre of the service they provided.
- Ward staff told us that they worked well with the SPCT and valued their support and advice. Once referred, they worked alongside each other to ensure the patient received the care needed.

Public engagement

- There was no evidence that patients' and relatives' views shaped and improved the services available. No hospital based bereavement survey was undertaken for the trust to identify if the service provided to end of life patients was of a good standard.
- End of Life Care was not discussed at Patient Experience Group, the trust told us this was something they would be looking to introduce.

Staff engagement

- At our previous inspection in July 2014 we saw plans in place to develop an end of life group and to nominate individuals at board-level to be designated with specific responsibility for end of life care. We saw that the medical director had undertaken and end of life role but no end of life group was evident.
- At our previous inspection we saw an action plan from the results of the NCDAH with a timescale to achieve by October 2014 that included a task of nominating a lay member with specific responsibility for end of life care by October 2014. We did not see any evidence that this had taken place.

Innovation, improvement and sustainability

- The SPCT had been identified by some ward staff as not being visible in some areas of the hospital. The members of the SPCT told us they were unable to provide a proactive service to wards, this was because they did not have the capacity to attend wards and departments in a routine way and that predominantly they only attended to provide advice for patients who had been referred for symptom control.
- The SPCT were aware of the difficulties in referral systems for complex symptom management but systems had not been improved to ensure all patients had the same access to the SPCT.
- Developments to end of life services were not evident. Consideration was being given to a new end of life lead role to promote and facilitate end of life care.
- At our previous inspection in 2014, implementation of the amber care bundle was scheduled to be implemented. This is an alert system to identify

patients who were not responding to current treatment in order to support patients that were assessed as deteriorating in health or where recovery was uncertain. This remains unfulfilled.

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- Provide a minimum of one registered children's nurse on duty in the emergency department every shift.
- Store medicines and medical gases securely in the emergency department.
- Train staff adequately to ensure the safety of children attending the emergency department.
- Implement a robust recording, reporting and monitoring process for mandatory training, including paediatric life support.
- Ensure that all patients who meet the criteria for consideration for a TEP are considered and afforded the opportunity to advise of their choices and preferences for care.
- Ensure that staff throughout the trust understand how and when to make a referral to the specialist palliative care team at the appropriate time in order to meet the current and anticipated needs of patients.
- Improve the rapid discharge process to enable patients who wish to return home quickly at the end of their lives to do so.
- Ensure there is a programme of local audits in line with the national care of the dying audit which enables a review of services provided at the hospital to identify if patients preferred place of care had been achieved.
- Ensure actions resulting from audits of end of life care are monitored. Some audited standards in the National Care of the Dying Audit were not met.
- Make advance care plans available for patients in the last 12 months of life. (No advance care planning took place for patients in the last few weeks of life because there were no consistent systems in place to enable patients to make advance directives or consider the decisions needed for their future).
- Ensure NICE guidance QS103 is followed for end of life care
- Ensure there are arrangements for end of life services to be monitored and reviewed at all levels of the organisation.
- Develop a strategy to achieve a consistently high standard of end of life care.
- Continue work with the obstetrics and gynaecology and midwifery staff on team development and culture to ensure the way the teams work together does not affect patient safety.
- Change the medical rota in obstetrics and gynaecology so that no staff are working in line with the European Working Time Directive.
- Ensure that consultants undertake obstetric emergency workshops as part of their mandatory training.

Action the hospital SHOULD take to improve

- Ensure the emergency department's reception area provides privacy and confidentiality for patients booking in with the receptionist.
- Make the emergency department's reception suitable for the needs of wheelchair users.
- Introduce a robust, regular portable appliance testing process for the emergency department.
- Ensure appropriate and important information on patients' allergies information and pain scores are recorded by the emergency department in all cases.
- Ensure reception staff are able to recognise patients who attend the department with serious conditions that need urgent referral to the triage nurse.
- Ensure that seasonal fluctuation and its impact on the emergency departments ability to respond is considered in all planning activities.
- Ensure all agency nursing staff employed in the emergency department are appropriately prepared before working in the department and any induction processes are standardised and recorded.
- Ensure all shift handovers in the emergency department are accurate and capture all relevant information in a consistent manner.

Outstanding practice and areas for improvement

- Review the security arrangements for the emergency department to ensure that staff and patients are supported and protected from harm or injury.
- Ensure that bed meetings include all relevant staff and that all wards and departments have a clear focus on maximising patient discharge and flow in support of the emergency department.
- Ensure that patients expected for medical and surgical care are admitted to an appropriate ward at the earliest opportunity to ensure there is no impact on the emergency department access and flow.
- Review the incident reporting process to ensure trends are identified and actions taken to minimise risk.
- Ensure a there is a robust process in place to prevent medication errors following administration of medicines by the ambulance service.
- Ensure the room used to assess patients with mental health related symptoms has suitable furniture.
- Ensure all emergency department staff have completed major incident training.
- Ensure the early warning score tool is fully implemented and used in the emergency department.
- Consider collation of data for non-cancer patients where support of the SPCT for symptom management is required. In order to ensure all appropriate patients can access the SPCT.
- Ensure that appropriate training for all staff, including agency staff, is made available for wards with end of life patients.
- Consider the views of people using end of life services to shape and improve the services available.
- Ensure maternity, obstetrics and gynaecology governance meetings are recorded.
- Ensure that action plans made following recommendations following the Royal College of Obstetricians and Gynaecologists (RCOG) visit and the serious incident investigation continue to be implemented.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 HSCA (RA) Regulations 2014 Person centred care 9(1) The care and treatment of service users must –(a) be appropriate.(b) meet their needs and (c) reflect their preferences Not all patients who met the criteria for consideration or a Treatment Escalation Plan had been considered and the patients afforded the opportunity to advise of their choices and preferences for care. 9(3) (a) carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user. There was no provision for advance care planning for patients in the last 12 months of life to take place. No advance care planning took place for patients in the last few weeks of life. No consistent systems were in place to enable patients to make advance directives or consider the decisions needed for their future. Staff did not consistently refer patients to the palliative care team at the appropriate time to meet the current and anticipated needs. Not all patients who could have been considered for a TEP were considered and therefore afforded the opportunity to advise their preferences. 9 (3)(b) designing care or treatment with a view to achieving service users preferences and ensuring their needs are met There were significant delays to discharge which impact on patient's end of life choices. The rapid discharge process in place to enable patients who wished to return

Requirement notices

home quickly at the end of their lives was not effective or well led. Whilst recognition of the poor service for end of life patients for rapid discharge had been identified within the trust, no action in the short term had been implemented by the trust to meet those patients at the end of their lives to facilitate a timely discharge.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(2) (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. Obstetric consultants attendance at obstetric emergency workshops, neonatal resuscitation and cardiotocography was low. Not all staff in the emergency department had received appropriate training in respect of children's resuscitation. 12(2)(g) the proper and safe management of medicines The medicines storage cupboard in the emergency department was not always kept secure.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Requirement notices

15 (1) All premises and equipment used by the services provider must be

(b) secure

Medical gases in the emergency department were not stored securely at all times.

New medical gas cylinders were kept in the majors store room, along with other equipment. The door to this cupboard was not kept locked and was located immediately beside a majors' bay, which meant that unauthorised persons could access it.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good governance 17.-(2)(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services) There was limited governance in place for end of life provision. There was no end of life committee or governance group in place to review and discuss this aspect of the hospital service. Developments to end of life services were not evident. There was no clear strategy for developing and achieving a consistent standard of end of life care. By having no strategy the trust did not assess, monitor and improve the service For end of life care there was very limited monitoring of patients outcomes of care and treatment and audit results did not effect changes in practice. Some audited standards in the National Care of the Dying Audit were seen to not be met. Necessary action was not taken to address the shortfalls. Areas for development previously identified had not yet been implemented.

This section is primarily information for the provider

Requirement notices

There was no local audit of care of the dying services provided at the hospital to identify if patients preferred place of care had been achieved and no other local audits took place to identify any trends or areas for development.

On this inspection our findings were that the culture in obstetrics and midwifery had not yet improved significantly. There was a lack of a system to take steps to review and improve the leadership of the service and enable effective multi- disciplinary working.

17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

NICE guidance for end of life care was not followed, for example NICE guidance QS103 in that people approaching the end of life were not all identified in a timely way.

The trust had yet to resolve the issues of introducing a medical staff rota designed so that no medical staff are working 24 hour shifts (more hours than the European Working Time Directive states).

during. Due to long shift patterns doctors sometimes found their ability to concentrate and make safe decisions was compromised.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA (RA) Regulations 2014 Staffing 18 (1) sufficient numbers of suitably qualified, competent, skilled and experienced person must be deployed in order to meet the requirements of this part. In the emergency department there were insufficient registered sick children's nurses to ensure one was available on each shift in the emergency department.

This section is primarily information for the provider

Requirement notices