This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Hospital sites at the trust

Information about the hospital sites at Royal Devon and Exeter NHS Foundation Trust is below:

<table>
<thead>
<tr>
<th>Name of site</th>
<th>Address</th>
<th>Services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Devon and Exeter Hospital (Wonford)</td>
<td>Barrack Road, Exeter, EX2 5DW</td>
<td>Acute hospital</td>
<td>Exeter</td>
</tr>
<tr>
<td>Mardon Neuro-Rehabilitation Centre</td>
<td>Wonford Road, Exeter, EX2 4UD</td>
<td>Neuro-Rehabilitation Centre</td>
<td>Exeter</td>
</tr>
<tr>
<td>Royal Devon and Exeter Hospital (Heavitree)</td>
<td>Gladstone Road, Exeter, EX1 2ED</td>
<td>Community hospital</td>
<td>Exeter</td>
</tr>
<tr>
<td>Axminster Hospital</td>
<td>Chard Road, Axminster, EX13 5DU</td>
<td>Community hospital</td>
<td>East and Mid Devon</td>
</tr>
<tr>
<td>Crediton Hospital</td>
<td>Western Road, Crediton, EX17 3NH</td>
<td>Community hospital</td>
<td>Mid Devon</td>
</tr>
<tr>
<td>Exeter Hospital</td>
<td>Hospital Lane, Exeter, EX1 3RB</td>
<td>Community hospital</td>
<td>Exeter</td>
</tr>
<tr>
<td>Hospital</td>
<td>Address</td>
<td>Type</td>
<td>Region</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------------------------------------</td>
<td>-----------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Exmouth Hospital</td>
<td>Claremont Rd, Exmouth, EX8 2JN</td>
<td>Community hospital</td>
<td>Eastern Devon including Exeter, Mid and East</td>
</tr>
<tr>
<td>Honiton Hospital</td>
<td>Marlplts Road, Honiton, EX14 2DE</td>
<td>Community hospital</td>
<td>East Devon</td>
</tr>
<tr>
<td>Moretonhampstead Hospital</td>
<td>Ford Street, Moretonhampstead, TQ13 8LN</td>
<td>Community hospital</td>
<td>Mid Devon</td>
</tr>
<tr>
<td>Okehampton Hospital</td>
<td>Cavell Way, Okehampton, EX20 1DN</td>
<td>Community hospital</td>
<td>Mid Devon</td>
</tr>
<tr>
<td>Ottery St Mary Hospital</td>
<td>Keegan Close, Ottery St Mary, EX11 1DN</td>
<td>Community hospital</td>
<td>East and Mid Devon</td>
</tr>
<tr>
<td>Seaton Hospital</td>
<td>Valley View Seaton, EX12 2UU</td>
<td>Community hospital</td>
<td>East Devon</td>
</tr>
<tr>
<td>Sidmouth Hospital</td>
<td>All Saints Road, Sidmouth, EX10 8EN</td>
<td>Community hospital</td>
<td>Eastern Devon including Exeter, Mid and East</td>
</tr>
<tr>
<td>Tiverton Hospital</td>
<td>Kennedy Way, Tiverton EX16 6NT</td>
<td>Community hospital</td>
<td>Mid Devon</td>
</tr>
</tbody>
</table>

The trust also provides two satellite kidney dialysis units:

- East Devon Satellite Kidney Unit, located at Honiton Hospital
- South Devon Satellite Kidney Unit, located in Torquay.

(Source: Routine Provider Information Request (RPIR) Sites tab)

The Royal Devon and Exeter Hospital is a teaching hospital which provides specialist and acute hospital services to a population of about 460,000 people in Exeter, East and Mid Devon.

Specialist services provided by the trust include the Princess Elizabeth Orthopaedic Centre (PEOC), the Centre for Women’s Health (maternity, neonatology and gynaecology), cancer and renal services, Exeter Mobility Centre and Mardon Neuro-Rehabilitation Centre.

The main hospital sites are Wonford and Heavitree in Exeter, but increasingly the trust is providing care closer to home, including managing the day case surgery activity in East Devon community hospital theatres, community midwifery services and renal dialysis units, and the early supported discharge stroke scheme.

The trust manages over 100,000 emergency department attendances, over 600,000 outpatient attendances and over 125,000 day-case or inpatient admissions each year.

(Source: Acute Provider Information Request (RPIR) – Context acute tab)
Is this organisation well-led?

Leadership

To write this well-led report and rate the organisation, we interviewed members of the trust board, both the executive and non-executive directors, and a range of senior staff across the trust. We met and talked with a wide range of staff to ask their views on the leadership, performance and governance of the trust. We looked at a range of performance and quality reports, audits and action plans, board meeting minutes, and papers to the board. We reviewed investigations into serious incidents and deaths, and feedback from patients, local people and stakeholders.

The trust’s leadership team had the experience, capacity, capability and integrity to manage a well-led organisation. There was a board of individuals with different and complementary strengths and skills, providing collective leadership. The trust board members were a group of individuals with a wide range of NHS and commercial experience, knowledge and skills, and long service in senior management.

The executive team had a range of skills, knowledge and experience. In interviews and focus groups they demonstrated professionalism and integrity, and were passionate about, and ambitious for the trust. From our conversations with senior people, including the non-executive directors (NEDs), there was evidence of an environment of cohesive constructive challenge among the leadership team and a close working relationship where leaders felt valued, respected and listened to. We found evidence of a joined up and inclusive board, with a well-articulated and shared vision for the future.

The Chief Executive understood and could articulate the unique qualities of her team. Many of the executive board members had been in the trust a long time and some had held executive positions for some years. There was an interim director of people and the trust were looking to appoint a permanent director of people at the time of the inspection. The Chief Executive was able to clearly and insightfully articulate the qualities and skill sets of her team, and to highlight areas of strength along with targeted areas for development. They spoke highly of their complementary qualities, with an awareness of, and plan to close any gaps and deficits within the team. They described the executive team as a “well-functioning, stable, high-performing team”.

The trust’s chairman joined the trust in 2012 and was spoken of positively by the executive team, non-executive directors and governors. The chairman had a strong leadership background and the relationship between the chair and chief executive was described as supportive and respectful. The Chief Executive said the chairman was “incredibly passionate about patients and the population of Devon”. Other executives said he managed the appointment process of the chief executive officer role in 2018 well and supported the development of non-executive directors and governors.
The non-executive directors functioned well as a group. There were six non-executive directors in post, with one being appointed in the last 12 months. The non-executive team were a strong group with good oversight of the risks to the trust. The chairs of the governance and audit committees, the two sub-committees of the Board, demonstrated a strong grasp of issues and had examples of impactful challenge that had strengthened the Board decisions and impact. The governors described the non-executive directors as having a "good balance across a range of skills".

The council of governors had sufficient time to interact with the board. The governors described an open and productive relationship with the executive and non-executive teams and met regularly with them. The governors held four council meetings a year, which the non-executive directors attended. In addition to this, they were part of a wide range of committees, including the patient experience committee, audit committee, and 'my care' programme board. They were also part of various start and finish groups, such as 'patient voice to board' and work to support patients who had hearing impairments. The executives praised the input from governors and said there had been good outcomes as a result. One example given was a review of visiting times. One executive said the governors "sharpen our focus". One governor said the level of interaction with the non-executives meant they got a good insight and detail into how they performed. Following board meetings, the governors met to discuss and reflect on the performance of the non-executive directors and fed back where necessary.

Fit and proper person checks were completed. The trust had thorough processes for the recruitment and management of executives and non-executives. The process ensured, to the best of the trust’s knowledge, the directors were ‘fit and proper persons’ in accordance with the requirements placed on NHS providers. Staff were responsible under their terms of employment to inform the trust immediately if something should change the information given in their assurance report to the trust. We checked personnel files for all executive and non-executive board members. This included information on recruitment, competency-based interviewing (including focus groups with staff), disclosure and barring service (DBS) checks, qualification checks, employment checks, and occupational health checks. All personnel files had information regarding their most recent annual appraisal. This included 360-degree feedback by gathering evidence from governors and other employees of the trust for developmental purposes and analysing skills and behaviours.

Because of a joint working arrangement with another Northern Devon NHS Trust, some of the executive’s time was split between two trusts. To manage this gap in leadership, a strong support network of deputy positions was created within the Royal Devon and Exeter NHS Foundation Trust. The executive team spoke positively of this arrangement and felt this allowed the team to think strategically rather than operationally. Staff in focus groups felt this arrangement meant they had more time with the deputy staff and had more senior input than they would have had otherwise. The medical director said he felt he managed a “group of medical directors” and had good oversight of the trust.

Most staff we spoke with knew who the executive team were and felt engaged with them. We spoke with 74 staff from across the trust and it was apparent they felt the senior leadership team were visible, approachable and engaging. Staff described positive examples where they had engaged with the chief executive and other senior staff on wards and in the corridor. They felt they would be listened to. Staff spoke positively about the ways in which the chief executive engaged with staff. This included spending clinical time on a ward. One member of staff said, “she isn’t just
sat in a board room, she knows what people do”. Another said: “she is very friendly and approachable”. Another said the executive team “have their finger on the pulse” and that the chief executive “reaches out to as many people as she can”. We were given examples where the chief executive had served food in the kitchens, delivered patient meals, worked a shift as a healthcare assistant, and worked a night shift with a junior doctor. Staff were positive about the chief executive’s webinars, which were conducted through a live video link meaning staff could ask questions and get an immediate response. These videos were then available on the trust’s intranet for those that missed it.

The NHS staff survey does not specifically ask staff about the visibility of senior management but does ask about communication between senior management and staff.

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key finding 5. Recognition and value of staff by managers and the organisation</td>
<td>3.56</td>
<td>3.44</td>
</tr>
<tr>
<td>Key finding 6. Percentage of staff reporting good communication between senior management and staff</td>
<td>35%</td>
<td>33%</td>
</tr>
<tr>
<td>Key finding 10. Support from immediate managers</td>
<td>3.85</td>
<td>3.76</td>
</tr>
</tbody>
</table>

In the 2017 survey, the trust performed better than average compared to other acute and mental health trusts in England. Key finding five and key finding 10 showed improvement between the 2016 and 2017 staff survey. Key finding six was not asked in the 2016 staff survey.

The board understood its responsibilities in relation to learning from deaths. The Medical Director was the lead executive for mortality, which included the learning from deaths process. The trust had appointed a mortality lead. Thirteen members of staff, including 10 consultants and three consultant nurses, were trained and had allocated time to undertake structured judgement reviews. Regular reports were presented to the board, including monthly mortality performance metrics and quarterly learning from deaths board reports.

In response to two mortality outlier alerts for pleurisy, pneumothorax and pulmonary collapse, and chronic renal failure, the trust had reviewed all patients in these groups using a structured judgement review methodology. The learning was themed, presented to the board, and an action plan agreed to improve care in the future. Some individual learning was also identified, which was fed back to the individuals concerned.

The trust’s policy included guidance for reviewing deaths of patients with a learning disability, mental health diagnosis, children and maternity-related deaths. Work was ongoing to introduce a medical examiner as part of a national programme.

Leadership development opportunities were being developed, including opportunities for staff below team manager level. The trust was developing a programme of talent management through a people strategy. To achieve this, the talent, learning and resourcing team were developing six pathways for staff to work through depending on their experience in leadership and their career aspirations. These were:
Developing fundamental leadership skills
Developing team leadership
Developing strategic leadership
Developing organisational leadership skills, and
Developing bespoke development plans

These pathways were due to be initiated through staff annual appraisal and personal development conversations using a well-structured template and methodology to identify leadership development needs.

Vision and strategy

The trust had a clear vision and set of values with quality and sustainability as the top priorities. Leaders and staff we spoke with across the trust could talk about the vision and values, and these were displayed on the website and around the hospital. The trust’s vision was “to provide safe, high quality care, delivered with courtesy and respect”. Through a strategic refresh in 2017 the board agreed the vision of the trust should not change but aligned with a ‘strategic intent’ to give clarity on how the vision would be achieved. This was “we will be a leader in transforming the health and care system, working in partnership to connect people, services, communities and voluntary groups to meet the needs of the communities we serve. In doing so, we will continue to provide safe, high quality, seamless services delivered with courtesy and respect”. The trust’s values were:

- Fairness
- Honesty, openness and integrity
- Respect and dignity, and
- Including and collaboration.

The trust’s objectives were aligned with the vision and values. The trust board had identified three corporate objectives to shape how the trust implemented the values in their work and developed services further. These were:

- Listen to people and continually improve what we do.
- Connect people, communities and services so that we can work together to improve health and wellbeing for everyone, and
- Innovate so we can continue to grow our world-class specialisms, working with partners and our patients to push forward the best medical research.

Staff and governors had an opportunity to influence the direction of improvements within the trust. After listening to staff and governors, a set of ‘distinctive qualities’ were developed. These were used to identify what the hospital’s mission statement was in delivering high-quality care. These distinctive qualities were:

- Kind and caring
- Teamwork, and
- Always improving.

The trust had a clear and realistic strategy for achieving the objectives and delivering good quality sustainable care. The trust had an annual strategic plan for 2018 and were developing a
five-year plan. At the time of the inspection this was being discussed by board members and was a topic for debate at trust board and sub-board committees. There was a focus in the strategy on the development and implementation of an electronic patient record and new model of care called ‘my care’. This was a clinically led transformation programme. This work was separated into two elements which included the introduction of an electronic patient record which could be accessed across the trust, and an evaluation and redesign of patient pathways throughout the hospital and in the community. The trust had a strategy for continuous improvement in infection, prevention and control, including accountable leadership, multi-agency working and use of surveillance systems. This underpinned and linked with the trust’s overall strategy and was in line with the National Institute of Health and Care Excellence (NICE) quality standard 61 statement two.

The trust had a strategy for meeting the needs of patients with a mental health, learning disability, autism or dementia diagnosis. The service had a mental health strategy appropriate for patients with mental illness approved by the Board and reviewed annually. This strategy was being overseen by the medical director, who spoke passionately about mental health and had an ambition for the trust to have mental health built in to all strategies. There was a service level agreement with the local mental health trust to provide mental health liaison, which included adult mental health provision 24 hours a day, seven days a week and learning disability liaison Monday to Friday. The medical director told us the trust was working ever more closely with the local mental health trust. The two organisations had been engaged in a three-year flow coaching academy project between the acute and mental health trusts. The two trusts were also working together to establish a joint vision for psychological input into acute care.

Culture

The trust’s strategy, vision and values placed people who used services at the centre. The key qualities identified by staff and the governors at the trust identified ‘kind and caring’ as most important. This had characteristics under it including “always providing a human touch”, “creating a warm atmosphere”, and “listening, demonstrating empathy, understanding and friendliness”. This influenced a patient centred culture, which we saw when speaking with staff and observing care. Staff we spoke with during the inspection clearly demonstrated the patient always came first, and they valued the positive feedback received from patients. One member of staff said, “I am proud to work for an organisation that cares for patients in a way I would like to be cared for myself”. Another said, “I would recommend care here to family and friends and I am proud to deliver individualised care to patients”.

Staff we spoke with recognised that since the appointment of the chief executive, there had been a change in direction for how services were managed. Some staff described a more clinical leadership focus within services.

At board level, a mission statement had been created to identify behaviours and values which would be shared and expressed by all executive members. Executive staff we spoke with used these as a reference when they were discussing how they challenged and supported each other. These were known as ‘I statements’:

- I will not put trust ahead of standards, and I will expect others to do the same
- I will assume best intent first and foremost
- I won’t back away from challenging my exec colleagues (on a 1:1 and team level)
- I will welcome challenge
- I care for, and will be compassionate to, my exec colleagues
- I will contribute and deliver the agreed exec plan
- I won’t stew (hold onto things)
- I will forgive
- I will have fun at work

Staff felt respected, supported and valued and as a result felt positive and proud to work for the organisation. We spoke with 107 staff in focus groups across the trust in both the community and the acute settings during the inspection and spoke with many more staff during the core services inspection. Staff consistently told us they were proud to work for the organisation. One member of staff said their wellbeing was “prioritised by the trust” making them feel supported and valued. Another said they felt “welcomed everywhere they go in the hospital” and felt as a result they had “a better understanding of each other’s roles”. Another said: “it is nice to walk into a new place of work where everyone is so nice”. Staff in the community felt engaged

We spoke with many allied healthcare professionals during the inspection who appreciated the support from the trust to celebrate ‘allied healthcare professional day’ and ‘occupational therapy day’. One member of staff said: “we had a fuss made of us”. Another said: “it was great to tell other staff about what we do”.

The trust recognised staff success through staff awards and feedback. There was an ‘extraordinary people awards’ scheme to recognise the contribution made by staff who had gone above and beyond what was expected of them. These were held three times a year and recognised contributions made by individuals and teams under various categories, including excellent care, exceeding, extra mile, exceptional leaders, and excellence in values and behaviours. Some staff recognised the trust executive team and leaders were becoming more active on social media as a way of recognising staff and celebrating success within teams and for individuals.

We spoke with staff in the community who felt they were not as valued as their acute counterparts. Some described an example where acute staff were recognised for their hard work getting to the site during heavy snow, but no recognition was given to the community teams “wading through the snow in wellies to get to people’s homes”.

The trust worked appropriately with trade unions. There had been recent and positive improvements in the culture, as evidenced by the trust’s investment in and engagement with staff side. This had been improved by an injection of talent and enthusiasm when community services were acquired by the trust. The staff side met monthly in a ‘staff side committee’, which allowed union representatives to bring issues and problems to discuss and resolve together. Staff side commented this was a positive forum. The effectiveness of arrangements had also been improved since the appointment of the interim Director of People. This included the support of a bi-monthly partnership forum with the director of people, which gave staff side the opportunity to engage with the executive team. Although there was more to do, there was a shared dedication to making the trust a great place to work. There were arrangements to allow unions time to engage with the executive team.

The trust had appointed a Freedom to Speak Up Guardian and provided them with sufficient resources and support to help staff to raise concerns. The trust had appointed six Freedom to
Speak Up Guardians who were managed by the trust’s head of governance. The arrangements reflected national best practice, except for presenting an annual report to Board and appraisal in the role. The guardians had good visibility with the board members as individuals and attended the governance committee on a quarterly basis. A guardian had been recruited specifically to cover the community services and two guardians had additionally been trained as mental health first aiders. There was good publicity throughout the trust and the team picked up on a good awareness of the role. Some trends had been identified, for example with some new managers and this had resulted in improved training for managers.

**Staff knew how to use the whistle-blowing process, knew about the role of the Freedom to Speak Up Guardian and felt able to raise concerns without fear of retribution.** We asked questions about the guardians in focus groups and found all staff knew who they were and thought they were approachable. Staff we spoke with also felt managers within their service were approachable and they felt confident to escalate concerns beyond their direct line manager if they needed to.

**There was a consideration for the safety and wellbeing of medical staff at a local level.** The role of Guardian of Safe Working Hours was introduced to provide a representative for junior doctors. This was a pastoral role, with the guardian attending junior doctor induction to explain their remit and demonstrate accessibility. The guardian met with other guardians from other trusts to ensure a continuity and support for the role. Some issues had been raised with the guardian. For example, exception reporting was an extended process and further support was needed to ensure the process was as easy as it should be for junior doctors to report incidents. Rotas could also be problematic, with delays in their availability. Junior doctors told us they felt supported and well represented by the guardian.

**Workforce Race Equality Standard**

In the 2017 NHS staff survey, there were relatively good results for the experience of black and minority ethnic (BME) staff when compared with the national average. However, we were unable to identify if there had been improvements since last year due to low numbers of responses. The scores presented below are questions relating to bullying and harassment from the NHS staff survey. These are question 17b and key findings 25, 26 and 21, split between white and black and minority ethnic (BME) staff, as required for the Workforce Race Equality Standard.

**Notes:**

- These scores are un-weighted, or not adjusted.
- For question 17b, the percentage featured is that of ‘Yes’ responses to the question.
- Key finding and question numbers have changed since 2014.
- To preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.
With regards to KF25, the percentage of BME staff experiencing harassment, bullying or abuse from patients or relatives was comparable to that of white staff within the trust. This was 4% less (better) than the England average.

With regards to KF26, the percentage of BME staff experiencing harassment, bullying or abuse from staff was 6% higher (worse) than that of white staff within the trust, but was 2% lower (better) than the England average.

With regards to KF21, the percentage of BME staff believing the organisation provided equal opportunities for career progression and promotion was 6% lower (worse) than the England average by 2%. This was also 23% lower than for white staff.

With regards to Q17b, the percentage of BME staff experiencing discrimination at work was 3% lower (better) than the England average, but 5% higher (worse) than for white staff.

(Source: NHS Staff Survey 2017)

The trust did not fully comply with NHS England’s requirements to complete and publish a Workforce Race Equality Standard (WRES) survey and action plan. The most recent report of the required data (July 2018) was published and available on the trust website. However, we were unable to find the associated action plan, which is a requirement set out by NHS England. Additionally, we could not find any data relating to previous WRES submissions so were unable to review data between 2015 and 2017.

There was a gender pay gap in the organisation which the trust was acting on. From 2017, any organisation that has 250 or more employees must publish and report specific figures about their gender pay gap. The gender pay gap is the difference between the average earnings of men and women, expressed relative to men’s earnings. Senior staff within the trust described the pay gap between male and female consultants a “clear difference” with the consultant workforce being predominately male. They described how they felt female staff were “put off” applying because of what they saw as a “traditional tribe and speciality firm” culture within the consultant body. There
were actions around this including introducing mentoring for female consultants and championing the next female consultants.

**The trust was actively engaging with staff from a range of equality groups.** The Trust engaged staff who have identified as having protected characteristics through focus groups (BAME staff; transgender etc). In addition, the Trust has engaged externally with different communities of interest to ensure that they have equal access to services (including the hearing impaired community and learning disabled groups).

We recognised there was a zero tolerance to poor attitudes and behaviours around equality and were given some clear examples of how specific incidents have been investigated and acted upon. However, senior staff were unable to articulate how they were using information collected to drive change and improve the experiences for staff working at the trust. We were given an example where it became apparent there was a need for middle managers to have unconscious bias training but found there were no plans to act upon this. We were given examples where a learning need had been identified around unconscious bias for middle managers but were not told of any plans to implement this training to staff. We were also given an example around concerns with the gender pay gap but found that there were limited actions to address this.

At the time of the inspection we found that the board had taken the inclusion agenda seriously was beginning to develop this area of the trust. They had set ambitious objectives around this work and have committed resources into this area. At the time of the inspection, the trust had employed an inclusion lead who’s role was to work with the board to review the evidence around this agenda and drive improvements.

**The trust applied duty of candour appropriately, but the recording processes did not evidence all aspects of the requirement had been met.** The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (and other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. We reviewed 10 examples of duty of candour requested prior to the inspection, which demonstrated candour was considered and actioned but was not clearly demonstrated in all documents reviewed. For example, we saw nine records which referred to telephone call discussions and apologies to the patient or family, but there was no record of the discussion or conversation content to enable a clear record and audit trail. We saw dates were recorded when the final information was given to the family or patient, but the content of that information was not stored with the record to ensure a clear audit trail and evidence of compliance with the regulation.

**Sickness absence figures were an outlier.** Sickness rates were discussed as part of the health and wellbeing section of the trust’s integrated performance report. This identified the reasons for sickness and how the health and wellbeing strategy was impacting on absence rates.

The trust’s sickness absence levels from September 2017 to August 2018 were consistently higher than the England average. However, the trust’s sickness rate followed a similar trend to that seen nationally with higher levels in the winter months.
This trend of higher sickness rates over winter continued into 2018/19. The trust’s integrated performance report presented at board on 30 January 2019 stated sickness had remained stabled at 4.5% over the last 12 months but in December 2018 had increased (worsened) from 4.74% to 4.87% compared to the previous month.

The trust had a good understanding of the impact of sickness in the hospital. Sickness, combined with vacancies, were identified in the integrated performance reports presented to board as the highest contributors to the use of bank and agency staff, particularly in information technology, radiology, porter services, laundry, and catering.
The percentage of days attributable to anxiety/stress/depression/other mental illnesses decreased (got better) from 26.9% in November 2018 to 25.6% in December 2018. The trust assessed the cause of workplace related stress against the Health and Safety Executive Management Standard. This showed that workload/demand accounted for 28% of work-related stress and work conditions related to 13% of work-related stress. The Health and Safety Executive have set management standards for stress that if followed demonstrate a good approach to stress risk management and to produce data in a standardised way.

As part of a national health and wellbeing indicator there was a focus on flu vaccinations for frontline staff. The trust met the 75% target for flu vaccination uptake required to meet the NHS Commissioning for Quality and Innovation scheme target.

**Staff had access to support for their own physical and emotional health needs through an innovative programme of support called ‘Health and Wellbeing for RD&E Staff’.** Due to a high number of stress-related sickness absences, the trust developed a strategy for health and wellbeing in 2017. This focused on three themes: prevention, intervention and protection. These were developed into a range of campaigns to raise awareness and support staff. They included mental ill-health, musculoskeletal injuries, fitness or inactivity, smoking cessation, alcohol consumption and drug abuse, support for obesity, and support for menopause. This was linked and aligned to the trust strategy.

In addition to services provided by occupational health, a variety of courses had been set up. These included mental health first aid, stress management workshops, specific training courses for managers, stress management, resilience building, and mindfulness. The trust offered walk-in services for staff for physiotherapy for musculoskeletal injuries and cervical screening.

There were classes held regularly to support staff with menopause at work. There were fitness classes such as yoga, Pilates, circuits and running sessions. There were cycling proficiency classes. In one focus group a member of staff told inspectors about an ‘away day programme’ where they were able to have a massage and a rest away from work and from their busy home life. The staff member said: “I was able to sit down and sleep for three hours during the day and it was lovely”.

The trust had a team of staff trained to support staff with physical and mental health needs. At the time of the inspection, 64 health and wellbeing champions and 60 mental health champions had been trained to signpost and support staff to access services and classes. The trust employed a full-time health and wellbeing practitioner to work with wards and departments to provide bespoke support and deliver training. The trust’s practitioner attended over 40 ‘Comms Cell’ meetings in 2018 and had supported these areas in training around supporting staff with mental health needs. The trust had also employed a dietitian for one day a week to support staff with healthy eating through team discussions and one to one consultations if required.

The trust had a ‘staff lottery’ fund specific to support health and wellbeing projects. This had included team social events, massage sessions, pedometers, fruit boxes and improving estates for wellbeing, such as gardens.

Staff we spoke with were consistently positive about the support available to them in relation to health and wellbeing. Staff were aware of the health and wellbeing and mental health champions and could give examples where there had received quick and effective support from them. Some examples from staff included: one member of staff said, “if you tell people you are struggling, you
get the help and support you need”, and another said, “the trust is prepared to look after us, and its great”. A third said: “the trust is protective and supportive of its staff”.

In 2018, the trust conducted a health and wellbeing survey, which 2,037 staff from all divisions and staffing groups in the hospital participated in. This identified key areas of focus for 2019 and beyond including the development of more focused workshops and training sessions, and the need for greater support to change lifestyle.

NHS Staff Survey 2017 – results better than average of acute trusts

The trust had 21 key findings that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equality and diversity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key finding 20. Percentage of staff experiencing discrimination at work in the last 12 months</td>
<td>9%</td>
<td>10%</td>
</tr>
<tr>
<td>Key finding 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>89%</td>
<td>85%</td>
</tr>
<tr>
<td><strong>Errors and incidents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key finding 28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>27%</td>
<td>29%</td>
</tr>
<tr>
<td>Key finding 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.77</td>
<td>3.73</td>
</tr>
<tr>
<td>Key finding 31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.76</td>
<td>3.67</td>
</tr>
<tr>
<td><strong>Health and wellbeing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key finding 17. Percentage of staff feeling unwell due to work related stress in the last 12 months</td>
<td>32%</td>
<td>38%</td>
</tr>
<tr>
<td>Key finding 18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves</td>
<td>49%</td>
<td>53%</td>
</tr>
<tr>
<td>Key finding 19. Organisation and management interest in and action on health and wellbeing</td>
<td>3.73</td>
<td>3.63</td>
</tr>
<tr>
<td><strong>Job satisfaction</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key finding 1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.97</td>
<td>3.75</td>
</tr>
<tr>
<td>Key finding 4. Staff motivation at work</td>
<td>3.96</td>
<td>3.91</td>
</tr>
<tr>
<td>Key finding 7. Percentage of staff able to contribute towards improvements at work</td>
<td>74%</td>
<td>70%</td>
</tr>
</tbody>
</table>
### Key finding 8. Staff satisfaction with level of responsibility and involvement

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td></td>
<td>3.93</td>
<td>3.89</td>
</tr>
</tbody>
</table>

### Key finding 9. Effective team working

<p>| | | |</p>
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<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>3.83</td>
<td>3.74</td>
</tr>
</tbody>
</table>

### Key finding 14. Staff satisfaction with resourcing and support

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>3.40</td>
<td>3.27</td>
</tr>
</tbody>
</table>

### Violence, harassment & bullying

| Key finding | Percentage of staff experiencing physical violence from staff in last 12 months | | Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months | | Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months | | Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse |
|---|---|---|---|---|---|---|
| | 1% | 2% | 22% | 27% | 21% | 24% | 49% | 47% |

---

### NHS Staff Survey 2017 – results worse than average of acute trusts

The trust had no key findings that were worse than the average for similar trusts in the 2017 NHS Staff Survey.

(Source: NHS Staff Survey 2017)

### Friends and Family test

The NHS Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

The trust scored consistently above the England average for recommending the trust as a place to receive care from November 2017 to March 2018. However, the percentage fell to a similar level as the England average in the subsequent six months, April to September 2018.
General Medical Council – National Training Scheme Survey

In the 2018 General Medical Council Survey the trust performed the same as expected for all 13 indicators. Every year the GMC survey all doctors in training and trainers for their views. This is to ensure that doctors in training receive high quality training in a safe and effective clinical environment, and that trainers are supported in their role.

<table>
<thead>
<tr>
<th>Survey area</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall satisfaction</td>
<td>○</td>
</tr>
<tr>
<td>Clinical Supervision</td>
<td>○</td>
</tr>
<tr>
<td>Clinical Supervision out of hours</td>
<td>○</td>
</tr>
<tr>
<td>Handover</td>
<td>○</td>
</tr>
<tr>
<td>Induction</td>
<td>○</td>
</tr>
<tr>
<td>Adequate Experience</td>
<td>○</td>
</tr>
<tr>
<td>Supportive environment</td>
<td>○</td>
</tr>
<tr>
<td>Work Load</td>
<td>○</td>
</tr>
<tr>
<td>Educational Supervision</td>
<td>○</td>
</tr>
<tr>
<td>Feedback</td>
<td>○</td>
</tr>
<tr>
<td>Local Teaching</td>
<td>○</td>
</tr>
<tr>
<td>Regional Teaching</td>
<td>○</td>
</tr>
<tr>
<td>Study Leave</td>
<td>○</td>
</tr>
</tbody>
</table>

(Source: General Medical Council National Training Scheme Survey)
All indicators were rated as ‘same as expected’.

**Governance**

The trust had structures, systems and processes to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior manager meetings. There was a clear governance, operations and performance system to support the delivery of the trust strategy. Individual service lines reported to divisional business and governance meetings. There was then divisional representation at various committees. These included:

- The integrated safeguarding committee,
- The clinical effectiveness committee,
- The workforce governance committee,
- The safety and risk committee,
- The patient experience committee.

These committees reported to the trust’s sub-board governance committee and the sub-board audit committee which reported to board. The trust’s service delivery team reported directly to the performance assurance framework committee and operations board which reported to the trust board. The trust held public board meetings every month and published the minutes and papers for each public board on its website. Part of the board meeting was held in private session, which is normal practice in NHS trust boards and for matters considered confidential.

Alongside the strategy the trust had developed a two-year operation plan to incorporate how the trust intended to deliver the strategy and objectives separated into a set of workstreams. There was a plan with delivery metric, issues and risk logs for each workstream with an executive director. Monthly reports were delivered to the trust’s senior leadership team and progress on delivery was shared. Actions from this were then cascaded to services using ‘Comms Cells’ (the daily gathering of staff in an area to discuss what went well, what could be better, and to share information) to facilitate individuals understanding and monitoring of their role in the delivery of the operational plan.

Some papers that should be presented to board, and then be publicly available on the trust website was not which would be considered best practice. The guardian of safe working hours report was not presented to the trust board. The terms and conditions of service of the junior doctor contract require the guardian of safe working hours to submit a quarterly report to the board, together with an aggregated annual report. However, we found that the last report which went to the board was in January 2017. We found that instead, monthly updates were presented by each clinical division regarding rota’s and gaps in rota’s which was then presented to the governance committee which did not satisfy the requirement of the contract.

The freedom to speak up guardian reports were not presented to the trust board. The NHS Improvement guidance states that the board should receive a report on freedom to speak up every six months, from the freedom to speak up guardian. We could not find any occasion where this had been presented to the board in the last 12 months. We found instead that this was presented to the governance committee which did not meet the guidance. Additionally, the guidance suggests that the board should invite staff who speak up to present their experience in person to board which
did not happen.

Non-executive directors, executive directors, and non-voting board members were clear about their roles and understood what they were accountable for. The wide range of staff we met had clear remits if they had managerial or oversight responsibilities. Evidence from staff suggested they had reasonable levels of expectation of their roles but were also given the flexibility and trusted to act professionally and to any clinical or other standards they worked to.

During the inspection we were not provided with a clear audit trail to show the trust was doing everything it should with regards to serious incidents. However, following the inspection we were provided with additional information which highlighted that records were complete. We reviewed ten serious incident records which we requested prior to the inspection. The systems and processes used to document investigations and outcomes were not consistent. Only one investigation explicitly included family or patient involvement with the investigation terms of reference. A further two reference contact and the remaining seven made no reference to terms of reference discussion and agreement. When undertaking an investigation into a serious incident clear terms of reference must be stated to ensure that the process is correctly and completely followed.

There was no overall clear audit document used to reference completion of the process and enable an auditable overview. We saw documents missing including no final letter including copy of the investigation/report to the patient/family and logs of names, dates and times were incomplete. As a result, it was not always possible to identify a completed process and there was no evidence of review, learning or challenge.

Not all areas of the complaints were addressed in completion. As such there were missed opportunity for learning and did not ensure reliable governance to lead change. We looked at ten complaints and found that not all areas of the complaints had been reviewed and addressed. We saw that in three complaints, when two issues were raised, only one area was evidenced as being investigated and responded to. The responses to the complainant were not in full and lacked sufficient assurance that follow up would happen to prevent reoccurrence. For example, when patients complained about missed or delayed appointments, the responses lack assurance that the issue would be addressed and prevented in future. There were missed opportunity for learning for staff and for shared learning outside of the trust, for example GP’s and community services.

There was a clear policy for learning from deaths, and the trust understood their responsibility, but the trust was not always adhering to this. The trust’s policy required all deaths where poor or very poor care was identified to be subject to a second review, however the trust was unable to provide evidence of this process. Additionally, the trust’s policy required bereaved families and carers to be informed when a second review was required, but again no evidence of this was provided. However, where harm was identified that met the required thresholds for formal investigation the trust complied with the duty of candour regulation by notifying and involving relevant persons.
There was a flow diagram included in the policy to help staff understand when a review was required. However, the formatting in the policy made this difficult to read and follow, which risked staff not adequately understanding the process.

**Actions taken following a structured judgement review relating to learning from deaths were not recorded in the record.** None of the structured judgement reviews provided to us included any actions. There was a section on the template for actions to be recorded, but in every case, there were no actions recorded. We were told by the mortality lead this was because the individual structured judgement reviews did not bring about specific actions, but rather learning was themed alongside other reviews. Where formal investigations were subsequently required, this was not recorded in the actions taken section of the structured judgement review. However, the trust held structured judgement review forum meetings where cases which were attracting either a ‘poor’ or ‘very poor’ rating were reviewed by a team of structured judgement review reviewers, the mortality team and Trust Risk Manager. The structured judgement review records were then individually discussed.

**There was a governance framework for ensuring that peoples’ mental health needs are being met.** The application of the mental health act was via the site management team who were accessible 24 hours a day, seven days a week. The site management team were able to demonstrate a clear understanding of the act and how it applied in an acute setting. The acute medical unit had twenty-four hours a day, seven days a week access to mental health liaison support. All other wards had access throughout the week, but not at weekends. Wards also had access to an on-call psychiatrist and junior doctor cover.

There were governance arrangements with the local mental health trust to provide health psychology. We interviewed the principle psychologist who described the provision as ‘patchy’ across the Trust but that work was underway to increase the amount of psychology input across departments. This includes introducing practitioners from the Improved access to psychological therapies (IAPT) service into areas such as the gastro-intestinal department.

Psychosocial assessments and risk assessments for patients thought to be at risk of self-harm / suicide were carried out by the psychiatric liaison team or the on-call psychiatric senior house officer on the main hospital site. However, arrangements for the community hospitals was less clear. Psychiatric liaison were able to advise the community hospitals and could advise on onward referral routes.

**Management of risk, issues and performance**

The trust had systems for the management of risk both operationally through the corporate risk register and strategically through the board assurance framework.

The board assurance framework (BAF) complemented the trusts approach to risk management. The board assurance framework is a method of setting out the most important strategic risks facing the organisation. It sets out the control framework used to manage them, any gaps in control and how the organisation satisfies itself that the controls are working as intended.

The BAF comprehensively described the same set of risks as was facing the organisation and the strategy in dealing with them. The BAF was regularly reviewed at trust board and was used to
assure the board of progress with the trusts strategy and risks in achieving it. Gaps in controls and assurance were presented to the board and were openly discussed to make decisions. Risks to the strategy had lead directors assigned to them to oversee the mitigation of risks.

The trust provided their Board Assurance Framework, which details three strategic objectives within each and accompanying risks. A summary of these is below.

- Listen to people to build on and continually improve what we do.
- Connecting people, communities and services, to work together to improve health and wellbeing.
- Innovate and grow our world-class specialisms and research with our partners.

(Source: Trust Corporate Strategy – May 2018)

The trust had systems for the management of risks. The management of the risk register was through the safety and risk committee meeting which met monthly. The function of this group was to validate new significant risks and remove mitigated risks from the register. This process was replicated at governance meetings throughout the trust at departmental and divisional level, to ensure that current risks and their controls / actions were on risk registers and managed dynamically as the risk environment changed.

The trust provided a document detailing their 25 highest profile risks. A summary of the five risks scoring 16 or above is below.

The trust’s risk register provided to us during the inspection did not include the date each risk was opened or the date each was last reviewed. We received a further, more detailed, version following the inspection which included this information.

<table>
<thead>
<tr>
<th>ID</th>
<th>Short description</th>
<th>Risk score (current)</th>
<th>Risk level (target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>45</td>
<td>IT Legacy Information Systems</td>
<td>20</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Our IT core legacy information systems eg PAS, Maternity, Theatre, ED and Pharmacy are between 15-30 years old and as such are increasingly difficult to maintain and meet service requirements. Risks - service interruption, financial, breach of statutory requirements, failure to meet business objectives. Total irrecoverable loss of the Trust’s PAS is unlikely due to the numerous measures to ensure recovery of the system to a point in time but should this happen the business impact would be catastrophic causing major problems in all areas.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3027</td>
<td>Reducing risk of health care associated infection (HCAI) including infection caused by antimicrobial resistant</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Organisms</td>
<td>Capacity Management</td>
<td>Achieving cancer waiting times (CWT) targets</td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------</td>
<td>--------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>This risk describes the future/potential risk associated with antimicrobial stewardship:</td>
<td>Inability to maintain full elective activity and provide safe, high quality care for patients due to increased non-elective demand or an increase in the number of patients waiting for onward care. This could result in non-compliance with targets, risk to quality of care, reputational and confidence loss in the Trust.</td>
<td>Requirement to comply with national operational standards for cancer waiting times targets.</td>
<td></td>
</tr>
<tr>
<td>1) Increased patient susceptibility to infection, including antimicrobial resistant infections, due to hospitalisation, use of antimicrobial agents, invasive healthcare procedures and immuno-suppressive treatments. Acquisition of healthcare associated infection which increases use of antimicrobial agents (which in turn increases risk of antimicrobial resistance), increases length of hospital stay, increases morbidity and mortality and/or may impact on large numbers of patients (e.g. infection outbreak).</td>
<td></td>
<td>Risk of negative impact on quality of patient experience with subsequent increase in complaints, concerns and negative response to national patient experience survey. With risk of potential loss of public confidence in service and potential</td>
<td></td>
</tr>
<tr>
<td>2) Suboptimal antimicrobial stewardship</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergence within the local population of multi-drug resistant (including carbapenemase-producing organisms) strains of bacteria, viruses and fungi. This will lead to use of more expensive, more toxic and less effective antimicrobials in clinical use with an effect on patient morbidity and mortality.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to achieve national and local infection and antimicrobial prescribing objectives resulting in financial penalty, negative publicity, loss of public confidence and formal complaints.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
damage to organisational reputation.

Financial risk due to expenditure above income to deliver target and breach of contractual agreement to comply with targets leading to contractual penalty

Risk of failure to meet CWT targets resulting in NHS Improvement imposition of regulatory measures. Subsequent damage to organisational reputation and media coverage due to critical reports

Nursing establishment - Medical and Surgical Services Divisions.

In both Medical and Surgical Services vacancy levels have increased gradually over recent months and the nursing workforce is currently well under the desired establishment. Nationally there is an acknowledgment of the multiple causative factors of falling number of nurses in the NHS; the impact of these factors is being felt keenly within Trust.

(Source: Trust Corporate Risk Register)

Outside of the governance framework executives met weekly to take part in a ‘safety huddle’ to share and quickly act upon what was described as “soft intelligence”. This was attended by the director of nursing, the medical director, the risk manager, the senior patient experience and the deputy director of nursing. Although no formal minutes were taken, there were significant actions from these meetings, such as never event reviews and human factor reviews. The medical director commented that “this was good as it was much quicker than formal governance routes”.

The trust had been an outlier for mortality indices such as Hospital Standardised Mortality Ratios (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) since 2015 which since then had been getting worse. In September 2018 the trust entered the ‘higher than expected’ range for SHMI. However, through a deep dive of issues have changed coding processes to improve the accuracy of data and reduce the scores. This resulted in a change to practice with ongoing actions related to it.

Finances Overview

NHS Improvement had reviewed financial governance and they told us that the trust understood the risks and current weaknesses to its financial position and was taking proactive actions to mitigate/address them. There was assurance, through the board assurance framework, that the trust was monitoring strategic and operational programmes of work and that reporting to the board was effective. There was evidence in board minutes that finances were discussed and that the board were sighted and informed of the trusts financial position. The trust 2018/19 plan submission clearly articulated the financial challenges and assumptions made were well defined.
<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£452.1m</td>
<td>£505.8m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£16.9m)</td>
<td>£13.0m</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£469.0m</td>
<td>£492.8m</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

The trust had achieved a score of two in the NHS Improvement Finance and Use of Resources year to date, in line with plan. The trust was forecasting a planned risk rating of one as at the end of 2018/19, which is in line with the planned rating.

Additionally, NHS Improvement told us:

- The trust met its 2016/17 and 2017/18 Control Totals and was on track to deliver its 2018/19 plan (CT of £5,950k deficit pre-PSF).
- The trust had a 4.4% Cost improvement programme target for 2018/19 (£23,250k) and was forecasting achievement of this plan although it should be noted that 70.0% of the efficiency plan was loaded into Q3 and Q4.
- At M8, the trust was broadly on plan for total CIP (£12.16m against a M8 target of £12.24m) but was reporting a £4.76m under-achievement against its recurrent CIP target YTD (i.e. £5m Vs £9.8m target). This suggests that the trust is relying on non-recurrent schemes or technical solutions to meet its CIP plan. This increases the CIP requirement and risk taken forward into 2019/20.
- Efficiencies due to a new computer system have not yet materialised (the trust is in the process of developing/launching the new patient record system).
- At M8, the trust was £9.2m behind its capital plan (£9.1m against a plan of £18.3m) and is forecasting a full year under-achievement of the capital plan by £5m.
- The trust is £6.6m over its cash plan for M8 (probably linked to the capital performance as above) and is forecasting a year end cash balance of £69m against a plan of £64.2m (i.e. £4.8m over plan).

Not all risks around supporting people with mental health were as mitigated as they could be. Staff demonstrated an understanding of the Mental Capacity Act 2005 and told us that they received training in this. However, the application of the Act could have been better. We observed capacity assessments that were not decision specific. Deprivation of liberty safeguard (DoLS) applications did not always adequately describe the treatment proposed or the restrictions to be placed upon somebody. Staff told us that DoLS was for preventing people from leaving the ward as opposed to being applied to other situations in which liberty was being deprived.

The systems to promote flow were effective. The hospital had experienced an unprecedented demand for the service, which presented as surge of patients attending the hospital. The pressure was created by increased numbers of patients in the emergency department and assessment medical unit. This pressure was compounded by delayed patient discharges into the community.
On the first day of our inspection the hospital was in Operational Pressures Escalation Framework (OPEL) 4 and declared an internal incident. For Acute Trusts, OPEL escalation levels have been nationally defined as being levels one to four, with four being the highest level of operational pressure. The Operational Pressures Escalation Framework (OPEL) details how the Trust identifies and responds to pressures within its system daily as well as times of extraordinary pressure.

The escalation procedures implemented were effective to return a flow of patients through the hospital. Flow was maintained by a process of evaluation and prioritisation with an ultimate focus on risk and safety. Actions were taken in line with the OPEL framework. For example, short term escalation areas were opened to increase bed capacity and increased numbers of consultants were brought to the emergency department to enable early decision making. A series of management review meetings took place throughout the day to identify issues with flow, escalation, discharge planning and breaches. The operations lead took the lead role in the meetings, following a fixed agenda and providing a summary of the operational position. There was a constant oversight of all departments looking at the hospital in a wider community context. This ensured staff across all areas of the hospital and community services prioritised patient safety, whilst maintaining whenever possible the flow of patients through the hospital. Actions required to be undertaken at each level were monitored through the management review meetings.

The hospital had a de-escalation plan for day two. Contingency measures were planned to sustain the de-escalation, for example, orthopaedic elective surgery was postponed for one day to enable beds to be utilised and flow sustained. While on day two, the OPEL state was level three, actions taken remained at OPEL four to ensure the trajectory of improvement was maintained.

Staffing levels were monitored to ensure safe staffing of all areas. At each meeting staffing was considered and a review was completed of the projected staffing needs for the remaining day and night shifts. Extra staffing was needed to ensure the escalation ward areas were safe. Staff from the wider hospital were selected to staff these areas with support from agency and bank staff. The site management team visited all escalation areas to ensure staff were supported. Facilities and housekeeping staff were responsive to the needs of the escalation areas and worked with the site team to ensure the required furniture and facilities were suitable. Staff planning was undertaken on the day of escalation, for the following day, this included medical, nursing, pharmacy, therapy, housekeeping and transport staff.

Each meeting we saw considerable effort was put into maintaining the emphasis on safe discharge. The site team met three times a week with the ward senior staff to review all patients who had been in hospital for over seven days. This was to ensure that safe discharge remained a priority while ensuring that plans facilitated patients leaving the hospital in a timely way.

A prediction tool used to anticipate numbers of patients attending the hospital. The tool identified the predicted level of attendance and identified the number of discharges needed to ensure a flow of patients through the hospital. Increased demand had exceeded predictions and so the site team planned for increased numbers, reviewing and increasing throughout the day. Following de-escalation, a review of trends and potential causes of the surge were considered. The review planned to take actions to mitigate against any repeat in such activity.
A winter plan had been formulated, using the previous years’ experience, to try and ensure that any obstacles for safe delivery of care and flow of patients through the hospital were minimised. Considerable work had been undertaken to identify risk areas and put in a plan to prevent when possible. If the plan to prevent could not be avoided, there were plans to mitigate any risks. The winter plan was evident around the hospital. Flow was a wider hospital issue which required all staff to work together. The plan was produced as both a policy and as a poster for staff with short videos available to provide a briefing if needed.

The trust met the recommendations the ‘health and social care act 2008, code of practice on the prevention and control’ to ensure good management and organisational processes essential to safe and effective care. There were systems to manage and monitor the prevention and control of infection. The trust board were given detail on hospital-acquired infections and antimicrobial prescribing through the integrated performance report which was presented monthly. This included details on clostridium difficile, MSSA blood stream infections, and E. coli blood stream infections comparing current performance with past performance and national standards and objectives. Additionally, an annual report was last presented in July 2018 which was produced by the trusts directors in infection prevention and control.

The Directors of infection prevention and control (DIPC) were an infection prevention doctor and an infection prevention nurse who were responsible for leading the trusts infection prevention programme and provided oversight and assurance on this to the board. They managed the infection prevention and control (IPC) team of microbiologists and infection control nurses who provided a 24 hour, seven days a week on call service.

The trust ensured prompt identification of patients who had or were at risk of developing an infection to ensure timely and appropriate treatment to reduce the risk of transmitting infections to other people. All patients attending the hospital, either through the urgent and emergency care services or through direct ward admissions, who have risk factors for carrying Carbapenemase Producing Enterobacteriacease (known as CPE), are screened. These are bacteria such as E. coli which are resistant to antibiotics and patients are risk assessed if found to be positive. Additionally, there was rapid testing for norovirus and C. Difficile to identify risks and manage them to reduce the risk of spreading the infection.

The trusts antimicrobial stewardship (AMS) group oversaw the development and the implementation of the trusts annual antimicrobial stewardship programme of work and met quarterly. AMS is a process to optimise the treatment of infection and minimise the risks of infections spreading. In the 2017/2018

The DIPC team described good working relationships with the site management team to control the spread of infections. Some examples were given around support from the bed team when wards needed closing and working together when side rooms were required for patients due to infection risks. One of the directors said it “Genuinely feels like staff appreciate the IPC team as being there to support and help, not to police. There is good engagement and the IPC teams do a lot of education on wards”.

Most risks around facilities were managed well. The trust had good oversight of where investment was needed both in the acute setting and in the community and the lead for facilities could give examples where there were risks and what the actions were to manage them. Although this was not done in conjunction with a strategy which was being developed at the time of the inspection.
The trust had a maintenance backlog register which was reassessed in 2018. None of the risks were identified as being high risks. Monthly the trust produced a report identifying statutory compliance around estates. Most of the items were no risk. However, where there was risk identified (such as a backlog of electrical inspections, lift inspections, fire door inspections, emergency lighting inspecting, and fire safety training compliance) there were action plans and programmes of work to address them.

**Information management**

The board received holistic information on service quality and sustainability. The board was updated with the trust’s performance at each board meeting through the presentation of the quality and performance report. The report looked at performance of quality and safety through various measurables. A summary page identified key themes, strengths and weaknesses throughout the trust. This was followed by a summary of OPEL status, access and flow, operational performance, patient experience, staffing, and finally financial position. The comprehensive report focused on significant indicators such as waiting times (including ED performance and 18-week targets), cancer waiting times, falls, infection control compliance and staffing. There were also additional comments to support and explain the data shown.

Information technology systems were used to monitor and improve the quality of care. At the time of the inspection there were multiple systems in use. The current systems in use varied across the trust with some areas of the community having predominantly paper records. We were told the systems currently in use were feeling the pressure of a reduced team, as four members of the IT team were employed to support the roll out of the new system. Staff also expressed some concerns about the age of some of the equipment and its compatibility to the new system. The community services had the support of an information governance manager.

A large transformational project was underway at the time of the inspection to replace the current systems throughout the trust, with an electronic patient record. This was due to be rolled out in 2020. This was seen by the trust as an opportunity to change and influence how services were delivered as well as the introduction of the electronic patient record. The team developing this system were doing so in consultation with medical, nursing and allied healthcare professional staff across the trust to ensure good engagement across the trust. As part of this there was a strong leadership team in position including a chief clinical information officer, two clinical pathway experts, a deputy chief clinical information officer and additional clinical support including 19 consultants, five nurses and five allied healthcare professionals.

The trust had developed a ‘My Care’ board which reported to the board. Delivery of the new system was being reported to the Executive team with identified key links through the operations team and medical director. Challenge at board about information technology was provided by a non-board, non-executive member.

Executives identified the risks relating to the design and implementation of a large IT transformational project. The trust had developed contingencies within that including the use of paper records if necessary for a short amount of time. The trust had also identified that the areas of highest risk to this project were outpatients where there were large amounts of variation in practice.
The trust had processes to ensure good quality of data. The trusts business intelligence tram worked to provide high quality, timely and user-friendly data against national and local standards. The team also provided support in areas such as the modelling of demand and capacity for inpatient beds using a “discrete episode simulation” model. The trust had a forum called the ‘Data Quality Integrity Forum’ which managed risks relating to data for the trust. The trust identified outdated systems as the biggest risk to data quality. However, recognised that the new IT system would mitigate or reduce these risks in the future.

There were arrangements to support the Caldicott guardian to keep information secure. The Caldicott guardian is a senior person who is responsible for protecting the confidentiality of people's health and care information and making sure it is used properly. All NHS organisations and local authorities which provide social services must have a Caldicott Guardian. The trust had an information management steering group which reviewed incidents and a log of information governance concerns. All policies relating to information governance were up to date and the trust were compliant with the Caldicot 2 toolkit requirements. The guardian had a good presence across the trust and was regularly contacted by staff with questions and queries and could give examples where improvements had been made to improve information governance within the trust. This included a project to introduce confidential waste bins which has meant there had been no information governance incidents relating to paper being left unsupervised since they had been introduced.

There were effective arrangements to ensure that notifications were submitted to external bodies as required. The trust submitted, as requires, data regularly to NHS England. There had been no concerns from external bodies raised with CQC about the quality of timeliness with regards to incidents. Incidents, including serious incidents, were reported as required to the NHS national reporting and learning system or the NHS strategic executive information system.

NHS Improvement reviewed financial governance and told us that there were no issues with the trust around reporting to NHS improvement. The trust 2018/19 plan submission clearly articulated the financial challenges ad assumptions made were well defined. The trust board had sight of the trusts financial deficit and plans to improve the in-year financial position. The trust’s use of costing data was well-embedded at a divisional and specialty level. It was used for a range of different purposes including operational plan development, identification of efficiency opportunities, and as a source of data for strategic development/business cases. Data was refreshed on a quarterly basis.

The trust achieved a ‘satisfactory’ rating in the self-assessed information governance toolkit assessment. This is an annual self-assessment which measures assurance, including management of information, confidentiality and data protection, the quality of information, the secondary use of information, and a measure for the overall performance. For 2017/18 the trust scored 73% which was slightly less than the 2016/17 score of 74%. We were advised that the review of cyber security review gave clean bill of health but had also picked up as a concern the age of equipment and inadequate operating system. Monitoring of staff use of the systems was difficult as there are so many systems and so an effective overview of activity was a challenge.
Engagement

Staff were engaged so that their views were reflected in the planning and delivery of services including in community services. There had previously been a culture where staff felt that changes were made without consultation and without being made aware that changes were happening. There was a general feeling that this was changing, and we heard of examples where staff had been or were being engaged with to help develop services. There had been the introduction of workshops and workstreams. The trust responded to staff engagement feedback and took appropriate action. The trust had an Engagement Steering Team, which had representatives from across the trust, including matrons, business partners and governors. However, end of life services and minor injury unit felt more could have been done in the community to engage with their staff.

The trust had good working relationships with clinical networks across the south west and England. The trust also worked well with the Eastern Devon A&E Delivery Board and the South, East and Northern Devon Collaborative network. The delivery board comprised of acute providers, community, primary care, social care, mental health, ambulance providers commissioners and regulators, reviewing system performance and identifying opportunities for further improvement of services and was chaired by the trusts chief operating officer. The trust worked well with the collaborative network to identify networked solutions to operational problems and was a group made up of the medical directors and the chief operating officers from the local acute trusts. The trust also worked collaboratively with the peninsular cancer alliance to ensure shared pathways between organisations.

In response to the 2017 staff survey findings, the trust's seven divisions developed staff engagement plans which were presented to Trust Executives at Performance Accountability Framework (PAF) meetings. In addition some departments were supported by the Engagement Team to put together customized response to their local findings. A team consisting of representatives from Staffside, Matrons, Divisional Directors, Human Resources business Partners and Staff Governors were brought together to review the 2017 findings and share best practice, that were shared with departments and teams with lower scores in the survey. The Engagement Team alongside a Human Resources business partner was piloting a scheme working with Junior Doctors and Doctors in Training to create an engagement plan for this staff group.

Following the analysis of both quantitative and qualitative 2017 survey findings, seven trust wide priorities were developed, with action owners in the corresponding departments. The seven priority areas: Operational Demands, Improve the Appraisal Process, Effective use of Patient / Service User feedback, Overall staff engagement, Developing the potential of people & Car Parking. Updates on progress for these areas were provided to staff via HUB and all staff emails. The Engagement Team has researched external best practice and is developing ideas for elevating staff engagement further within the Trust during 2019.

Division leaders/middle managers, on behalf of front line staff, engaged with external stakeholders such as commissioners and Healthwatch. We were given lots of examples during the core service inspection where services were engaging with external stakeholders. End of life care leads attended the sustainability and transformation plan end of life care group. This was a county-wide forum that was led by the clinical commissioning group and included representatives from multiple providers in health and social care. Also, the community adults service was working well with GP’s to improve pathways for patients. The trust has developed a positive on-going relationship with the Health and Wellbeing Scrutiny Committee of Devon County Council over recent years and continues to enjoy positive relations with local charities and worked together with Devon Healthwatch to improve services and share information and concerns.
The trust was fully-engaged and working effectively with system partners as part of the Devon STP. There was cooperative working with external partners within the strategic transformation partnership. This involved the trust, local councils, and other organisations in Devon to develop and implement shared proposals to improve health and care for the county. One area where this had been productive was with a ‘mutual aid’ agreement between trusts in Devon. This had, for example, allowed trusts to jointly respond to surges in demand or capacity shortages. This had been successfully implemented for support in stroke and maternity services. While we were on inspection the trust accepted ‘mutual aid’ from other trusts to support de-escalation during a surge in demand through the emergency department.

The trust gave time for staff to discuss challenges around patient care. These forums allowed staff to talk about the emotional and social challenges around caring for patients. The aim of this was to provide a safe environment for staff to share their stories and to offer support for one another. These were facilitated externally but were supported and attended by senior staff.

To engage staff in the ‘My Care’ transformation project the trust had run a set of workshops which were successful and engaged with local stakeholders. This had included over 700 staff being involved and included to build clinical engagement within the trust. Staff we spoke with were confident in the process and were engaged and excited about being part of this transformation project. In addition, the trust had developed a GP’s reference group to gain their knowledge and experience on the pathway and had been working with other trusts to learn from their electronic patient record roll out.

The council of governors had time to interact with members and staff but said they would welcome more support in terms of engagement. The governors described different forums where they were able to interact with the public and staff. These included performing patient-led assessments of the care environment (PLACE) and attending ‘staff say’ events to have conversations with staff. However, some governors recognised they did not get out to wards and listen as much as they would like and felt some events could be better attended. The governors also recognised more could be done to encourage public members to engage. Although turnout was good for annual general meetings, there were some constituencies that did not have governors and felt their voices were not always being heard. They also recognised a lack of younger governors and felt the views of the younger population also were not being captured.

Many of the senior management team in the trust consistently felt more could be done to engage with other trusts outside of the South West and felt they were missing opportunities for learning. They felt this was an area they would investigate in the future and were building it into their plans for service development.

Learning, continuous improvement and innovation

There was a strong incident reporting culture. Incidents are investigated but the processes used do not evidence a systematic recording process. The systems and processes used to document investigations and outcomes were not consistent. We reviewed 10 investigations of serious incidents and saw that the systems do not always identify the whole process. We saw
incomplete records of times and dates, no follow up documents to family members and there was no audit available to ensure outcomes had been reviewed. As a result, it was not always possible to identify a completed process and there was no evidence of review, learning or challenge.

The trust was actively participating in clinical research studies. The trust had fostered a strong partnership with the University of Exeter and hosted regional research facilities on site. The trust encourages participation in research and has performs well in the recruitment of patients to trials. There was good support from the Board, from the medical director, in encouraging and supporting people to get involved with research. There was a clear application of research in improving services and outcomes for patients.

There were organisational systems to support improvement and innovation work. However, these were limited to medical staff and some allied healthcare professionals. A plan to improve and develop quality improvement over the next five years in the trust was ongoing.

Staff had improvement methodologies and used standard tools and methods but did not receive training in quality improvement processes. They did, however, have the support of a mentor throughout the process. At the time of the inspection we were told by some executives that there had not been a systematic role out of quality improvement training and some felt that this was a big factor to the lack of nursing buy in.

Within the quality improvement programme staff involved had time to support and consider opportunities for improvement and innovation. Junior doctors and pharmacists were invited to quality improvement meetings where they share ideas and create themes for these ideas to generate a project. They developed projects then presented a monthly update to a panel, which sometimes included the chief executive officer. At the end of each year the trust held a quality improvement conference where they present their project which then gets summarised for an hour presentation to trust board. In addition to this the doctors mess ran a ‘pizza and beer’ session to review projects and evaluate what support was available.

There were examples where there had been improvements made because of a quality improvement project outside of the medical and pharmacy staffing groups. We were given an example of work ongoing to reduce the amount of waste produced by the trust which had resulted in better recycling and a cost saving. We were also given examples in maternity of a quality improvement project which looked at supporting smoking free pregnancy including introducing meaningful conversations with mothers, providing support to help mothers stop smoking and train smoking free champions to be exerts in this area.

There were mechanisms to provide staff at every level with the development they need. The trust had previously decided, as part of a cost saving plan, to provide only mandatory training to staff. Management and leadership training had not been offered for two years and this had had a negative impact, particularly for those staff who had been promoted to their first management role in that time. The trust has since appointed a Head of Talent Management and a great deal of work has been undertaken to address this gap, including the formation of a School of Learning and Management Development. The Talent and Leadership Strategy was part of the overall People Strategy and there was a long-term plan for delivery. The offer for staff now was comprehensive and reflected national best practice in development. There was evidence that the courses were having an impact in terms of individual development and wider trust performance. An overhaul of the appraisal system had led to a focus on meaningful conversations and at the time of the
inspection the trust was meeting their target (80%) of completed appraisals. An innovative approach to mandatory training, making it part of an extended induction programme, had significantly increased the number of staff completing their training. The trust also had a plan to capture the “never trained”, identifying and supported those staff who had missed some of their mandatory topics.

Executives within the trust had identified areas of learning from Northern Devon Healthcare NHS Trust which they planned to implement at Royal Devon and Exeter NHS Foundation Trust. Some executives gave examples where they had adopted some innovative and creative systems and processes to improve patient care.

Not all areas of complaints were addressed in completion. As such there were missed opportunity for learning and did not ensure reliable governance to lead change. We looked at ten complaints and found that not all areas of the complaints had been reviewed and addressed. We saw that in three complaints, when two issues were raised, only one area was evidenced as being investigated and responded to. The responses to the complainant were not in full and lacked sufficient assurance that follow up would happen to prevent reoccurrence. For example, when patients complained about missed or delayed appointments, the responses lack assurance that the issue would be addressed and prevented in future. There were missed opportunity for learning for staff and for shared learning outside of the trust, for example GP’s and community services.

The requirements for the complaints annual report were met and identified learning and improvement from receiving and investigating complaints. As per the requirements of the Local authority social services and national health service complaint (England) regulations, 2009, an annual report was presented to board highlighting complaint activity. Although this report identified the numbers of complaints and the percentage of acknowledgement letters received, it did not demonstrate the percentage of overdue responses or outstanding responses which, although not a requirement, is good practice.

Of the complaints received, 98% received an acknowledgement letter within three days of it being received. Of the complaints received in 2017/18 31.7% were upheld, 18.9% were partly upheld and 49.5% were not upheld.

There were examples in the annual report where learning had been identified and practices changes because of receiving a complaint with the main themes being communication, provision of information, and length of wait for treatment. Actions included delegating actions to cluster managers and progressing action plans to drive improvement.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months. However, some data was not provided which was available from their annual report.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3</td>
<td>Not provided</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>45</td>
<td>Not provided</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints, please indicate what that is here</td>
<td>No set target as it depends</td>
<td>N/A</td>
</tr>
</tbody>
</table>


Number of complaints resolved without formal process in the last 12 months? | Information not recorded | N/A

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

The trust received 274 complaints from June 2017 to May 2018. The outpatients core service received the most complaints with 87 (31.8%). However, it is important to recognise that outpatients would be the busiest department in the hospital, so may generate the most complaints.

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatients</td>
<td>87</td>
<td>31.8%</td>
</tr>
<tr>
<td>Medical care</td>
<td>52</td>
<td>19.0%</td>
</tr>
<tr>
<td>Surgery</td>
<td>39</td>
<td>14.2%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>20</td>
<td>7.3%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>18</td>
<td>6.6%</td>
</tr>
<tr>
<td>Community adults</td>
<td>14</td>
<td>5.1%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>12</td>
<td>4.4%</td>
</tr>
<tr>
<td>Not core service specific</td>
<td>11</td>
<td>4.0%</td>
</tr>
<tr>
<td>Maternity</td>
<td>10</td>
<td>3.6%</td>
</tr>
<tr>
<td>Diagnostic imaging</td>
<td>5</td>
<td>1.8%</td>
</tr>
<tr>
<td>Community inpatients</td>
<td>3</td>
<td>1.1%</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td>Community urgent and emergency care</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td>Critical care</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>274</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

From June 2017 to May 2018, the trust received a total of 435 compliments. A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent and emergency services</td>
<td>92</td>
<td>21.1%</td>
</tr>
<tr>
<td>Surgery</td>
<td>82</td>
<td>18.9%</td>
</tr>
<tr>
<td>Medical care</td>
<td>79</td>
<td>18.2%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>67</td>
<td>15.4%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>23</td>
<td>5.3%</td>
</tr>
<tr>
<td>Community adults</td>
<td>23</td>
<td>5.3%</td>
</tr>
<tr>
<td>Maternity</td>
<td>19</td>
<td>4.4%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>13</td>
<td>3.0%</td>
</tr>
<tr>
<td>Diagnostic imaging</td>
<td>11</td>
<td>2.5%</td>
</tr>
<tr>
<td>Community inpatients</td>
<td>9</td>
<td>2.1%</td>
</tr>
<tr>
<td>Not core service specific</td>
<td>7</td>
<td>1.6%</td>
</tr>
<tr>
<td>Critical care</td>
<td>4</td>
<td>0.9%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>3</td>
<td>0.7%</td>
</tr>
<tr>
<td>Community urgent care</td>
<td>2</td>
<td>0.5%</td>
</tr>
</tbody>
</table>
Kidney dialysis  |  1  |  0.2%  
Total        |  435 |  100%

The trust reported that the main theme of the compliments was around the positive attitude of both nursing and clinical staff. Most of the compliments gave praise and thanked the staff for how they treated and provided care for the patient.

(Source: Routine Provider Information Request (RPIR) – Compliments)

Investigations into deaths appeared to be completed thoroughly. We were provided with a small number of investigations into deaths where harm had been identified during the structured judgment review process. There had been seven deaths subject to an incident investigation in the last 12 months, of which two were still under investigation and three had not met the criteria of a serious incident.

We reviewed a structured judgement review for a patient with learning difficulties who had died. Although the initial review was poorly written, it was possible to understand the findings and relate these to the judgement. A second review was required, and this was clearly documented. No harm was identified so a more thorough investigation was not completed.

For the two serious incidents that were complete, the trust had partly complied with the duty of candour regulation by informing relevant persons promptly, however in one case a verbal apology was not given for just over five weeks and in the second incident no verbal apology was documented. The investigations themselves were logical and appeared to explore the incidents well. Learning was identified, and action plans agreed to improve future care.

Opportunities to learn from deaths were potentially being missed. The trust was only reviewing a very small number of deaths as part of their learning from deaths processes. In the board papers from September 2018 the quarterly board update reported there had been 1,699 inpatient deaths ‘in scope’ in the 12-month period from July 2017 to June 2018. However, only 156 deaths had been reviewed through a structured review process and six deaths through a serious incident process. This meant only 9.5% of all inpatient deaths that were considered to be appropriate for the learning from deaths process were actually being reviewed.

The trust’s ‘responding to and learning from deaths’ policy required each death in care to be “subject to one of three levels of scrutiny:

- Death certification
- Case record review: A structured case review programme of deaths
- SIRI Framework” (Serious Incidents Requiring Investigation – out-dated terminology for what are now simply known as Serious Incidents)

In the minutes of the Patient Safety and Mortality Review Group from January 2019, it was reported “the bulk of the SJR activity is being driven by alerts and there has been limited capacity to review ‘in time’ deaths”.

NHS Improvement reviewed financial governance and told us that the trust was undertaking a comprehensive review of external opportunities to improve. This included using the model hospital toolkit. The model hospital programme is a digital information services designed by NHS Improvement to help providers improve their productivity and efficiency. The trust was engaging at
speciality level to identify where improvements could be made. The trust engaged with the Getting It Right First Time (GIRFT) programme and has received all relevant GIRFT reports and ‘Deep Dive’ visits that have been rolled out so far. GIRFT is a national programme designed to improve the quality of care within the NHS by reducing unwarranted variations. This is led by an external team that use a set methodology to assess and report on care. Action plans and reports following these visits were taken to the trust’s Clinical Effectiveness Committee. A number of the reports highlighted areas of best practice.

The trust had not participated or invited external governance reviews since 2013. NHS Improvement guidance recommends that trusts perform governance reviews every three years to facilitate continuous improvement of governance which draws from the latest research and evidence to identify and develop key barriers to improvement. The last time the trust had received a review of this kind was by Monitor (now part of NHS Improvement) in 2013. When asked about this the head of governance stated that although they had been looking into it, they felt the time was not right for them. They also felt that the CQC well led inspection process would provide this assurance. However, the guidance specifically states that governance reviews are different from CQC well led reviews.

We identified in board papers that the trust had been nominated for an award by the local college for its non-clinical apprentice programme because of the positive impact the trust has had on training new starters, and upskilling existing staff. Non-clinical apprenticeships included finance, administration, engineering and catering. There were clinical apprenticeships available with support from support worker to advanced clinical practitioner.

The trust was able to report on a number of accreditations it had achieved. NHS trusts can participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed to continue to be accredited.

The table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>The trust was JAG accredited until April 2018. In April 2018, the trust was successful in 18 out of 19 standards (rated A and B). The trust did not meet one standard (booking and access) which was awarded a C rating. The trust has a workforce recovery plan, including the appointment of three new consultants who started from July to October 2018.</td>
</tr>
<tr>
<td>Gold Standards Framework Accreditation process, leading to the GSF Hallmark Award in End of Life Care</td>
<td>The trust currently has three wards at the RD&amp;E accredited to GSF. These are: - Yeo (March 2018) - Yarty (March 2018) - Creedy (September 2018)</td>
</tr>
<tr>
<td><strong>Imaging Services Accreditation Scheme (ISAS)</strong></td>
<td><strong>Medical Imaging</strong> - ISAS 3rd year accreditation maintained 21 June 2017; currently going through year 4 assessment.</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189</td>
<td>Cellular pathology - UKAS ISO accredited 7 December 2017</td>
</tr>
<tr>
<td></td>
<td>Microbiology - CPA accredited; currently awaiting UKAS confirmation of transition to ISO.</td>
</tr>
<tr>
<td></td>
<td>Chemical pathology - CPA accredited; currently awaiting UKAS confirmation of transition to ISO.</td>
</tr>
<tr>
<td></td>
<td>Haematology/immunology/transfusion - CPA accredited; currently awaiting UKAS confirmation of transition to ISO.</td>
</tr>
<tr>
<td>Commission for the Accreditation of Rehabilitation Facilities (CARF)</td>
<td>Not registered with CARF. Orthotics workshop has BSI accreditation ISO9001.</td>
</tr>
<tr>
<td>CHKS Accreditation for radiotherapy and oncology services</td>
<td>The radiotherapy department is not accredited under CHKS, but the Quality Management System is certificated under LRQA to the ISO9001: 2015 standard (achieved 7th October 2016).</td>
</tr>
<tr>
<td>MacMillan Quality Environment Award (MQEM)</td>
<td>Not registered. Funding for environments is sourced through the Teenage Cancer Trust and the trust's local charities FORCE and ELF.</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).
Acute services (Mardon)

Rehabilitation services

Facts and data about this service

The Mardon Neuro Rehabilitation Centre is part of the Royal Devon & Exeter NHS Foundation Trust. The unit is managed by the trust’s neurology service and is part of the medicine directorate. The Centre was built in 1993 and has been part of the Royal Devon & Exeter NHS Foundation Trust since 2000. The unit has 12 beds and cares for patients with a variety of neurological conditions who are not severely ill but need rehabilitation help and support. One of the beds is used for a long-term resident and one bed is also used to accommodate sleep studies over 48 hours. This is managed by the neuro physiology team in the acute hospital.

The unit is a specialist rehabilitation unit for patients who need prolonged specialist treatment and is led by a consultant accredited in rehabilitation medicine. The centre does not provide care to patients who are under 18 years. The unit provides care and services to adult patients in Exeter, North, East and Mid Devon and to patients who may be out of county.

There was a total of 78 admissions for the previous year (January 2018 – December 2018) and 89 discharges in the same period. The length of stay is usually between two and six months.

Before the inspection we reviewed a range of information we hold about the service and asked other organisations to share what they knew. We carried out an announced visit on 15 and 16 January 2019.

One CQC inspector carried out the inspection of Mardon Neuro Rehabilitation unit with the support of a CQC mental health inspector and a CQC pharmacist. During our inspection we spoke with
five patients and two relatives. We observed how people were being cared for and reviewed six patients' care records. We also spoke with 18 staff including doctors, nurses, therapists, psychologists, health care assistants, domestic/housekeeping staff and the maintenance/driver for the unit.

We previously inspected the Mardon Neuro Rehabilitation unit in November 2015. The unit was rated as requires improvement for safe and well led with ratings of good for effective, caring and responsive. Since that time, work has been undertaken by the staff on the unit and the medicine division to meet some of the previously identified shortfalls. The ratings have improved. Some areas of development are in their infancy and so cannot yet evidence the sustainability of the improvements.

Is the service safe?

Mandatory training

Mandatory training was completed by nursing, medical and non-clinical staff. The trust set a target of 75% for completion of all mandatory training modules which had been exceeded for both nursing and therapy staff.

Mandatory training completion rates – Mardon House

As of May 2018, all nine qualified nursing staff at Mardon House had completed the 14 mandatory training modules for which they were eligible. These modules were:

- Basic life support
- Conflict resolution (level1)
- Dementia and delirium
- Domestic abuse
- Equality & diversity
- Exeter pressure risk assessment tool
- Falls, slips and trips (patients)
- Fire competency
- Food safety awareness
- Infection prevention & control (including hand hygiene)
- Information governance
- Manual handling
- Pressure ulcer classification (PUCLAS)
- Waste management

The trust’s mandatory training included moving and handling, fire safety, infection prevention and control and basic life support. Some training was delivered as face-to-face training sessions and some was completed by e-learning. The matron emailed staff to ensure they were prompted to complete training when it was due.
Safeguarding

**Safeguarding systems, processes and practices were used to keep patients safe.** The trust safeguarding policies included contact details for the trusts safeguarding team to enable further support for staff if needed.

Staff we spoke with could explain their role in the recognition and prevention of abuse. They described what actions they would take should they have safeguarding concerns about a patient. Any safeguarding alert would be made directly to the local authority and the trust safeguarding team would be included for their reference. The safeguarding team from the acute trust attended the monthly multidisciplinary meeting to provide advice and support.

Nursing and therapy staff were safeguarding trained to level three relevant to their role and responsibilities. As of May 2018, all nine qualified nursing staff at Mardon House had completed the two safeguarding training modules for which they were eligible. These were safeguarding adults and child protection group 2.

**Staff were trained in the recognition of different types of abuse.** Training for staff was provided to recognise patients at risk or subject to female genital mutilation (FGM) and take the action to protect them.

Cleanliness, infection control and hygiene

**The service controlled infection risk and all areas we visited were visibly very clean.** There was a dedicated team of cleaner/housekeepers who ensured the areas were clean and tidy. There were daily schedules and weekly tasks seen to be completed, alongside deep cleaning as and when required. Patients told us how much they valued the cleaning/housekeeping staff.

There were reliable systems to monitor and maintain standards of cleanliness and hygiene. The Mardon unit had an infection control lead nurse. This role included attending training and cascading the information the ward teams. The hand hygiene assessments and audits were undertaken with results for most months being 100% compliant.

The unit had good infection rates. Heath care settings are required to report on all MRSA bacteraemia (the presence of bacteria in the blood causing a serious infection) to ensure they did not exceed national threshold targets. The centre had no recorded cases of MRSA bacteraemia and Clostridium difficile at any time.

Staff followed trust policies on infection prevention and control. This ensured all patients were cared for as safely as possible. All staff were bare below the elbow, used antibacterial gel, washed their hands between patients and wore personal protective equipment, gloves and aprons when needed. We saw clinical waste disposed of correctly. Clinical and household waste was segregated and disposal of sharp implements was managed to ensure staff and patient safety.
Environment and equipment

The maintenance and use of facilities, premises, and equipment generally kept people safe. **Refurbishment was taking place to ensure the environment was in good repair.** We saw ongoing maintenance taking place throughout our inspection to ensure the environment was functioning and safe.

The Mardon Unit was built in 1993. The layout was spacious and suitable for the safe movement of wheelchairs and other moving and handling equipment. All bedrooms were single occupancy and included a bathroom, small kitchen area and treatment/recreational room. Each individual apartment had a front door and the patient had their own key, staff had a key in case of emergency. The unit had communal space including a dining and lounge area and a patient laundry room. There were treatment areas for rehabilitation including a gym and kitchen area.

There were call bells in bed bays for patients to alert staff when needed. When patients moved around for example to the lounge and dining areas, portable call bells went with them to ensure they could summon assistance when needed.

Staff had access to equipment for moving and handling and pressure relief. All hoists for moving and handling were ground level with no gantry hoists. All equipment had been checked annually for safety and dates recorded.

Emergency equipment checks were consistently completed. Equipment for urgent and emergency situations was kept in a tamper evident box and this was checked daily by staff. Records of these checks were signed and dated daily. Should there be a cardiac arrest or other emergency, due to the location of the unit off the acute hospital site, and the lack of medical staff in the unit, the staff would call the emergency services. Limited emergency medicines were available as there were no medical staff to administer them. There was no access to a defibrillator, however the trust confirmed one was ordered and due delivery in January 2019.

Access to new wheelchairs was not always timely with significant delays impacting on patient's ability to mobilise. Staff explained the problem was due to an 18-week waiting time from referral to assessment and delivery of new wheelchairs. These wheelchairs were measured for each patient and specific to their needs. This risk has been identified through neurorehabilitation governance meetings and been agreed at governance level for inclusion on the Mardon unit risk register. As an interim measure if needed patients were using the units standardised, non-specific wheelchairs.

Assessing and responding to patient risk

Each patient was assessed to ensure their needs were identified and managed. These assessments included pressure ulcer risk assessment, falls risk assessment and nutrition risk assessments. The trust used the Extra Pressure Risk Assessment tool (ESPRAT) for patients’ pressure risks assessments and care plans ensured each risk was appropriately managed.

Patients were assessed for falls risks and managed relating to the risk. Those who were assessed as low risk of falls did not have a care plan. Staff said this was normal practice for the centre. When any risks were identified staff monitored patients as part of their intentional rounding system. This prompted staff to visit the patient on a timed basis to monitor risks and outcomes.
Physiotherapist and Occupational therapists undertook assessments of patients physical and cognitive ability as part of an ongoing process of rehabilitation and in preparation for discharge. Home visits for risk assessments were also undertaken prior to discharge. The aim of these were to assess the risks and undertake any mitigating action in the patient’s own home.

Staff assessed the psychological needs of individuals. Psychological wellbeing was routinely discussed and all staff seemed to be alert to the risks of depression and anxiety. All staff were aware of how to refer to the acute trust psychiatric liaison team and demonstrated an understanding of which diagnoses carried the greatest risk of depression and anxiety. The psychologists and the medical team would support and treat anybody who was experiencing signs or symptoms of depression. Those exhibiting any higher risk symptoms would be referred to psychiatric liaison team with a view to further mental health support.

Medical staff completed risk assessments for venous thromboembolism (VTE) (formation of blood clots) in line with the National institute for Health and Care Excellence NG89 (2018). Each patient had a VTE assessment recorded on the medical administration record. This was then reviewed as part of the prescription record review and treatment prescribed and monitored as needed.

Staff used an early warning scoring (EWS) to identify patients who had deteriorated. The Acute Medicine Quality Standards (2013) and the Royal College of Physicians (2012) recommend the use of a numeric scoring system of patients’ vital observation to identify deteriorating patients and advise staff of actions to take. The staff do not undertake routine vital observations as the unit is a rehabilitation service and not an acute setting. Baseline observations such as temperature, pulse and blood pressure were taken when patients were admitted and this would be repeated if the patient became unwell. However due to the extended length of staff for each patient, staff knew patients well and felt confident they would recognise any deterioration in patient’s condition. They provided an example of how they had recognised sepsis, used the EWS tool and escalated the concerns for immediate action. There was some but not consistent access to medical staff and as such any patient deterioration which needed urgent attention would require a transfer to the acute hospital.

The unit provided sleep studies for one patient each week, as planned by the acute hospital. The sleep studies patients stayed at the unit between Monday and Wednesday and were in-patients for no longer than 48 hours. Should the patients become unwell, protocols were accessible in the staff office for staff to follow to ensure the patients were managed safely and transferred to the acute trust if they become unwell or did not respond to medication provided.

**Nurse staffing – Mardon House**

**Staffing levels and skill mix were planned, implemented and reviewed to keep patients safe.** Staffing was based on the British Society of Rehabilitation Medicine (BSRM) Standards for Rehabilitation Services. The Mardon Unit used an accredited staffing tool to assist to determine optimal nurse staffing levels. Shifts were agreed in advance against the planned registered nurse to patient ratios required for each shift. Midweek the unit had planned two registered nurses to cover the day shifts and one registered nurse overnight. Six health care assistants were on duty each morning, three throughout the day and two at night. At weekends there was one trained nurse
on day and night and six health care assistants each morning, four during the day and two at night. Matron was on duty in a non-clinical role Monday to Friday. 

Staff confirmed that the staffing levels were generally maintained and they considered them to currently be stable. 

**Sufficient staff were available to meet the needs of the patients.** There were 33 nursing and admin staff on the unit. Staff used their bank staff to cover shortage, but most shifts were covered by the unit’s own staff. Patients told us that there were enough staff to ensure they received prompt care when needed. They told us that if they called the bell, staff answered promptly.

Nursing staff told us that they considered there to be sufficient staffing levels most of the time and that should the dependency of patient need increase, further staff could be requested. These staff were mostly from the Mardon unit bank but sometimes were provided by the acute hospital.

Out of hours the staff on the unit could contact the clinical lead nurse at the acute hospital for advice and support and there was an escalation plan to manage any unplanned events.

The trust reported their qualified nursing staff numbers as below for Mardon House as of March and July 2018.

<table>
<thead>
<tr>
<th>Service</th>
<th>March 2018</th>
<th>May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
</tr>
<tr>
<td>Mardon House</td>
<td>9.2</td>
<td>10.0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) –Vacancy tab)

**Therapy Staff**

**Occupational therapy staff numbers** were lower than the British Society of Rehabilitation Medicine (BRSM) guidelines. Staff used the BSRM guidelines in relation to the number of therapy staff needed to provide effective care and support for patients. The total cover was 2.75 whole time equivalent against a guideline of 3.5 whole time equivalent. Staff told us that while the staffing level was an improving picture, it did not meet the guideline. The shortfall was caused by a lack of funding.

There were three physiotherapy staff and four occupational therapy staff in total employed on the unit. There were a further two generic rehabilitation assistant who could work in both areas. Staff confirmed that there were shortages in therapy staff but this did not impact on patients. Therapy staff worked to meet the shortfall by working extra shifts. The risk register recorded that the unit was understaffed compared to national standards (BSRM) for psychology, occupational therapy and physiotherapy.

Therapy services were provided six days a week at the Mardon unit. There was one overarching lead for occupation and physiotherapy, however, there was no clinical lead role for physiotherapy. The levels as indicated by the BRSM level 2B rehabilitation service should be 3.5-4 whole time
equivalent therapist occupational and physiotherapist for every 20 beds. The unit also had one full
time rehabilitation assistant and one full time rehabilitation support worker.

Some staff worked across acute neuro and acute stroke services and the Mardon unit. Staff told
us the cross hospital/unit working was effective in wider communication and learning between the
two units. There were no therapy staff on a Monday which meant there was no representation at
the Monday ward round but therapy staff attended the daily board review of patients. All information
was communicated between therapy and nursing staff at a Tuesday morning meeting.

Patients felt there was adequate therapy staff. They confirmed that a plan was set for both therapies
each day with rest days at the weekend. They confirmed all sessions were met.

Vacancy rates

From June 2017 to May 2018, the trust reported a vacancy rate of 7.2% for qualified nursing staff
at Mardon House. The trust set no target for vacancy rate.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From June 2017 to May 2018, the trust reported a turnover rate of 8.1% for qualified nursing staff
at Mardon House. The trust set no target for turnover rate.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From June 2017 to May 2018, the trust reported a sickness rate of 6.1% for qualified nursing staff
at Mardon House. This was higher than the trust’s target of 4.0%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

From May 2017 to May 2018, excluding February 2018, the trust reported that at Mardon House
20 shifts (1.7 per month on average) were filled by bank qualified nurses and 177 shifts (14.8 per
month on average) were worked by bank nursing assistants. There was no agency nursing staff
usage at Mardon House. In addition, over the shorter period from May 2017 to January 2018, four
qualified nursing shifts, and 28 nursing assistant shifts, were not filled by bank or agency staff to
cover staff absence. This meant that shifts were left unfilled.

It should be noted that:
Data was provided from May 2017 to May 2018, excluding February 2018, to provide 12 months
of data. The trust was unable to provide data for February 2018 due to the migration to a new
computer system that took place in that month. Bank and agency shifts booked in advance were entered on both systems, therefore due to the risk of double counting providing inaccurate data the trust decided to omit this month.

The trust was only able to provide unfilled shifts for the period from May 2017 to January 2018. They explained this as also being due to issues related to the change to the new roster system in February 2018 leading to a risk of double-counting.

The trust was unable to supply the total number of shifts worked by all permanent and temporary staff. Therefore, it was not possible to calculate the percentages of shifts worked by bank and agency staff and left unfilled.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

The Mardon unit was consultant led. Registrar cover was not consistent and impacted negatively on the time provided to the unit’s patients.

The consultant in Rehabilitation Medicine worked up to six periods of programmed activities (PA’s), which were usually four hours per activity. The consultant was available on the Mardon unit four days a week. Two of those PA’s were used for looking at in reach clinics, follow up clinics and looking at head injury pathways. Out of Hours medical support was provided by Devon Doctors and this cover included after 5pm, overnight and weekends.

All admission referrals came through the consultant and a referral meeting took place every Wednesday. All readmissions were referred to the consultant who would decide on the appropriateness of re admission.

The Mardon Unit was allocated two registrars to work in rotation to provide one registrar cover during the day for the unit. This cover included attendance Tuesday mornings, Thursday afternoons and potentially Wednesday multidisciplinary meeting. However, this cover was not consistently available. Staff told us that often the registrar was not available. We saw evidence of this in an incident report. The issue was also discussed in the April 2018 speciality neurological governance meetings and June 2018 heads of department meeting.

We also saw evidence of this during our inspection. On day two, both registrars were not available, and no advanced provision had been arranged to mitigate this. As a result, there was no medical cover to action prescription updates that were needed. The unit had to ring the acute trust and try to organise a replacement. The meant staff had to take the prescriptions to the trust to get them signed for use, taking up time and their clinical time. A further outcome of the lack of registrar support was that a patient who needed a review of an injury, had no medical staff to undertake this. The consultant who was involved in something else on the unit, then had to interrupt their work to undertake the review.

Patients could access psychological support but this did not meet national guidelines. A
psychologist was employed from another trust under a service level agreement. Their role was to assess and assist with the psychological aspect of patient care. This included providing a cognitive neurological status on admission and any behavioural consequence and management work with patients and some members of the patient family. The psychologist was involved with approximately 80% of patients. Psychology cover was being covered by the clinical lead neuro psychologist four sessions a week, dependant on patient need. This level was below the BRSM guidelines which advises one whole time equivalent with only a 0.6 WTE in role. This equated to attendance at the Mardon unit three days a week.

**Records**

Patient records were well completed and were seen to be legible, signed and dated. There were integrated medical, nursing and therapies paper records.

Records included risk assessments, care plans and scoring systems for patient monitoring. For example, the rehabilitation complexity score was used to identify needs, the Northwick Park therapy dependency assessment looked at Neurological needs, the Rivermead monthly index, cognitive measurement and linguistic abilities.

Goal planning was completed monthly and records were clear and concise with details of current function, recommendations and long-term goals, how they would be achieved, and review dates. Care plans were reviewed and updated regularly as part of ongoing records audits.

The records had daily updates about the patients care from the nursing and therapy teams. The records provided an audit trail of actions agreed, completed, reviewed and adjusted. There was no dedicated discharge coordinator or social worker involved in discharge and so all plans were managed and recorded by the unit teams to provide a clear audit trail of decisions made and actions planned and taken.

Records were stored securely in a staff office which could only be accessed by relevant staff. Records audits were completed monthly. Therapy record audit outcomes were reviewed and showed in May 2018, 55 records were reviewed and demonstrated some shortfalls in recording of names and dates. A smaller sample review was undertaken in January 2019 which showed improvements in those areas.

**Medicines**

*There have been improvements in how medicines are managed at the Mardon centre.*

At our previous inspection in 2015 staff did not manage medicines safely and did not take account of people’s rights and risk assessments had not been completed for patients to safely administer their own medicines.

Medicines were stored securely behind locked doors with access restricted to appropriate staff. Patients had individual lockers to store their medicines and could self-administer their own medicines. There was an appropriate system to allow them to do this and we saw that risk assessments had been completed. There was no one receiving covert medicines (medicines given
without their knowledge) at the time of inspection but staff could explain in what circumstance and how this would be managed. There were arrangements for the recording of medicines administration and prescription charts were completed well. Patient Group Directions (PGDs) were available to allow nurses to administer medicines in line with legislation. Staff could access up to date copies on the intranet however the signed copies had expired.

Medicines orders outside of this time were managed via the main hospital site by remotely screening the medication supplies and photocopies of the Mardon drug charts. Pharmacy supported the unit with controlled drug stock checks, review of stock lists and if required investigation of medication incidents.

**Incidents**

Nursing and therapy staff were aware of their responsibilities to report incidents and were confident to do so. All incidents were reported through an electronic system and staff told us the incidents most reported were falls, absconding patients and general escalation situations. Staff graded the incident on submission and this was reviewed by the unit matron. All incidents were reviewed again by the risk data quality team and could be regraded. Following investigation by the matron or risk and quality team, the outcome was emailed to the staff who made the initial report to ensure they received feedback and agreed with the final rating.

Staff felt confident in using the incident reporting system to raise concerns and told us they felt supported to raise and report issues. Between 01 January 2018 and 31 December 2018 there had been 67 reported incidents. The highest reported incident type was 24 slips, trips and falls, communication caused eight raised incidents and seven security incidents which included absconding patients.

The outcome of incident learning was shared with staff to promote learning and prevent reoccurrence. Learning was shared across the trust through briefings and handovers when significant issues arose.

The medical speciality governance meeting reviewed incidents, risks, complaints and concerns and minutes were circulated and discussed at staff’s meetings. There were rarely deaths on the Mardon unit however, clinical teams had the opportunity to attend mortality and morbidity meetings. Staff told us they were kept updated of incident learning through the “Comm cell” which is an internal system communication board, when discussed various issues affecting standards of care. Staff said this was a useful tool to promote communication across the unit.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2017 to September 2018, the trust reported no incidents classified as never events in medical care.

*(Source: Strategic Executive Information System (STEIS))*. 
Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported six serious incidents (SI’s) in medical care which met the reporting criteria set by NHS England from October 2017 to September 2018.

The breakdown by incident type was as follows:

- Slips/trips/falls: four
- Treatment delay: one
- Apparent/actual/suspected self-inflicted harm: one

The time taken to report these incidents to the Strategic Executive Information System was variable:

- 0 - 14 days: one
- 15 - 30 days: one
- 31 - 60 days: one
- 61 – 90 days: one
- Over 90 days: two

(Source: Strategic Executive Information System (STEIS))

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This Regulation requires the trust to be open and transparent with patients when things go wrong. All staff we spoke with had a good understanding of the duty of candour and could describe when it would be used.

Safety Thermometer

The results of the safety thermometer were not publicly displayed to enable patients and staff to see the results.

The Safety Thermometer was used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. This is a national audit which allows the establishment of a baseline against which improvement can be monitored. There are four key measures as part of the safety thermometer which included falls, pressure ulcers, venous thromboembolism and urinary tract infections in patients with catheters.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 15 new pressure ulcers, 10 falls with harm and 10 urinary tract infections in patients with a catheter in medical care from October 2017 to October 2018. The information was not displayed publicly for patients and relatives.
Prevalence rate (number of patients per 100 surveyed) of patient harms at Royal Devon and Exeter NHS Foundation Trust

1. Total Pressure ulcers (15)

2. Total Falls (10)

3. Total CUTIs (10)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Urinary tract infections in patients with a catheter

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

Policies and guidelines had been developed in line with national policy including the National Institute for Health and Care Excellence (NICE) guidelines. Staff could access to clinical guidelines policies and procedures through the trust intranet. The use of NICE guidance was used as part of day to day practice, for example, The National Institute of Clinical Excellence QS 61 Statement states that people should receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. We saw staff consistently wash their hands between patients and hand hygiene audits consistently scored 100% which confirmed this was a routine action.

The British Society of Rehabilitation Medicine Standards (BSRM) for care of acute brain injury and rehabilitation of adults were used as a guideline for practice. The frameworks and guidance provides guidance around provision of rehabilitation services and staffing establishment. However,
staffing as a guideline was not met for therapist.

Each patient’s assessments were specific to their therapy needs. Therapist used a patient’s centred approach in the assessment and therapy-focused goals with patient and their family involved in the goal setting. The Functional Independence Measure/Functional Assessment Measure (FIM/FAM) tool was used in the assessment of patients which looked at the physical and psychosocial functions which were often the main factors limiting outcome in brain injury patients.

Therapy staff used the Rivermead index tool to assess patients’ functional mobility. This is a tool specifically developed for patients who had neurological deficits.

**Nutrition and hydration**

**All patients had their nutrition needs and hydration needs met.** Where a need was identified the patients were assessed and a care plan documented.

Staff assessed patients’ nutritional and hydration needs in line with national guidance. NICE guideline was used as part of assessments tools to assess patients’ needs. We saw these included the use of the Malnutrition Universal Screening Tool (MUST) to assess patients’ risk of malnutrition. Care plans were used to meet any risks and included information about nutritional care and fluid needs and how they were to be met.

There were different menus to meet patients’ nutritional and varied needs. Because patients had a longer length of inpatient stay than with the acute hospital, the rotating hospital menu had been supplemented with an a la carte menu. Patients told us that the menu was sufficiently varied and that staff could provide alternative snacks and lighter meals. Nursing staff supported patients who needed assistance to eat and drink.

Staff felt supported by the acute hospitals dietician service. Although dieticians were not on the unit, any referral to them was actioned quickly.

Speech and language therapists carried out assessments and care plans to ensure patients continued to receive food and fluids safely. For those patients were needed specially textured meals this was provided by staff. Dietician staff were available from the acute trust when needed. Staff and patients told us that accessing the dieticians was not a problem and that they were very supportive.

**Pain relief**

**Staff assessed and managed patients’ pain effectively.** Pain assessment tools were used as part of the patients checks and advice was available from pain specialist from the trust if needed.

When patients’ pain was assessed, pain relief was provided as needed. Support and advice was taken from nursing, therapy and psychology staff. Medication charts reflected when pain relief medicine had been administered and the rationale for any omissions or delays.
Patient outcomes

Standard and non-standard assessments were undertaken and monitored to show that sufficient therapy support was provided and that the rehabilitation service met patient’s needs.

A quality assessment tool was used to audit areas of in patient stay including respect and dignity, food and nutrition, safe environment, infection control and pressure areas. The areas were calculated and scored and for 2018 the score was 92% achievement. The areas with the highest overall score were food and nutrition, elimination, self-care, record keeping and pressure ulcers. The areas with lower scores were mental health, pain management and communication. However, it should be noted that the lower scores still exceed 80% compliance.

Data had been collected monthly but senior staff told us that the data was not reliably inputted and so the collective figures were not truly representative of the service provided. Mardon took part in the UK specialist Rehabilitation Outcomes Collaborative (UKROC) which was setup in September 2008 through a Department of Health initiative to develop a national database for collating case episodes for inpatient rehabilitation. The numbers of patients and times of discharge were not relevant to the actual patient’s admissions and discharges. Work was underway to ensure that data collected was input correctly.

The therapy staff gathered data for trust and local standards and used the data to monitor the service provided. The data included times seen, length of therapy time and outcome measures. It was evident from the data when progress improved or faltered. Each month the therapy lead would review the outcomes to enable any changes in service needed.

An activity audit looked at therapies provided. This took the form of a time and motion study every 15 minutes. The outcomes went to the head of therapies and was used to look at commission expectations and benchmarks. The results showed that patients received the therapy activities planned for them.

_Mardon Neuro-rehabilitation Centre – elective admissions_

From June 2017 to May 2018, patients at the Mardon Neuro-rehabilitation Centre had a higher than expected risk of readmission for elective medical admissions compared to the England average for neurology. However, this may reflect the nature of the service, as the comparator group consists largely of inpatient neurology services.

_Elective Admissions – Mardon Neuro-rehabilitation Centre_
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

National Audit of Inpatient Falls 2017

Falls incidents were monitored at the bimonthly Neurorehabilitation Specialty Governance meetings and through the Datix reports and in the monthly snapshot for the Safety Thermometer. There had been 24 falls reported between January 2018 and December 2018.

(Source: Royal College of Physicians)

Competent staff

Appraisal rates – Mardon House

Mardon House received an appraisal, less than the trust target of 80%. This may mean that staff were not reviewed and supported to ensure updated practice was maintained. From June 2017 to May 2018, 58.8% of staff at Mardon House received an appraisal, less than the trust target of 80%. The 80% target was also not met for qualified nursing staff. Staff told us they had regular annual appraisals; however, the data provided by the trust demonstrated that appraisal completion rate varied.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number completed</th>
<th>Number of individuals required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative and clerical</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>80%</td>
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<tr>
<td>Qualified nursing staff</td>
<td>7</td>
<td>10</td>
<td>70.0%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>10</td>
<td>21</td>
<td>47.6%</td>
<td>80%</td>
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</tr>
</tbody>
</table>

Staff had the right skills and knowledge to provide safe care and treatment for patients. Newly appointed staff were provided with a trust induction. Staff spent a period of supernumerary time on the unit shadowing staff and learning the role. Staff told us that the induction period was sufficient to enable them to learn their role. Staff competencies were not recorded as an audit trail of training provided.
The department did not have an educational facilitator to provide further learning, however, staff could undertake further service specific training to support the patient’s individual needs. Matron confirmed that should staff identify training relevant to their role they could request attendance. Staff told us that if they found courses or conferences they thought would be of value to the unit, they were supported to attend and feedback learning.

Clinical supervision and support was available to nursing and therapy staff in the form of one to one observation of practice, private discussion when needed and group activity such as meetings and learning opportunities. Formalised recorded individual supervision did not take place.

Some staff had link roles to cover a variety of areas. These included infection control, safeguarding and mental capacity. These roles meant staff attended extra training and then cascaded the learning to the ward.

Therapists received annual appraisals and data seen showed was fully completed by all staff.

**Multidisciplinary working**

Staff worked collaboratively with other health professionals and across health care disciplines to ensure individualised care for patients.

Each Monday a full ward round took place including medical, nursing, therapy and psychology staff. Patients told us they felt involved and were encouraged to be fully involved in the decisions about their care.

All necessary staff, including those in different teams and services, were involved in assessing, planning and delivering people’s care and treatment. Weekly multi-disciplinary team meetings were held on a Wednesday. Staff told us that multi-disciplinary working was a strength of the unit and that the meetings were productive and effective. Patients records provided a clear audit trail of how multidisciplinary working was used to support each patient.

Further to the weekly meeting each patient had a monthly meeting with the consultant, named nurse, physiotherapist, occupational therapist, and other key staff to discuss goal setting, progress with their rehabilitation and discharge. The previous months goals were discussed and reflected upon and the next month’s goals were set.

Pharmacy supported the unit with a pharmacist visiting each week. There was regular pharmacy support provided to Mardon on a weekly basis from both a Pharmacist and Medicines Management Technician; during this visit all medicines are reviewed, and any relevant support given. At all other times the lead pharmacist for neurology was contactable.

Staff could receive training in caring for patients with additional needs. Training regarding specific mental health problems was available and training about learning disabilities was available from the learning disability liaison service services on request. The psychologists on site were proactive in ensuring that the staff had the correct training to assist with the management of any specific mental health needs pertinent to the patient group.
There was no dedicated discharge coordinator and so all discharge planning was undertaken as part of a multi-disciplinary process with the full involvement of medical, nursing, therapy, psychology and pharmacy teams. Physiotherapy and occupational therapy liaised with the community teams to ensure continuity of care post discharge.

Patients had access to specialist teams from the acute hospital, for example respiratory nurses, tissue viability nurses and the specialist pain team. Access to support for patients with mental illness was met by the psychiatric liaison team and staff also reported input from community mental health teams.

**Seven-day services**

Medical and health cover was available to support patient care; however, seven-day services were not available in all areas. Out of hours medical assistance was provided by Devon doctors. Any emergency would be transferred to the accident and emergency department.

Nursing staff were available seven days a week. Patients received 24 hr nursing care. Therapy staff provided care and treatment Monday to Friday with a half a day on Saturday and no therapy access on Sundays. Patients told us they liked this system as it afforded them a rest period.

The pharmacy department was open seven days a week, but with limited hours on Saturday and Sunday. An on-call pharmacist was available to dispense medicines and offer urgent advice over the weekends.

Psychiatric liaison services were described as very responsive during the day, however overnight they primarily focussed on the acute hospital emergency department. Staff confirmed they had access to the on-call psychiatrist and juniors overnight.

The learning disability liaison team were very proactive in facilitating admissions for people with a learning disability, however this was not a regular occurrence. If required, they would contact the person and their carers prior to admission, and also facilitate a site visit if required. They would liaise with the admitting service to ensure adjustments had been made and would accompany the individual if required. They were on hand to offer support and advice to staff looking after the individual.

**Health Promotion**

**Health promotion information was available for patients.** Notice boards had information for patients, the information covered health and wellbeing, local services and a wider range of the specialist service available. The leaflets were of good visual quality and could be photocopied to increase the size if needed. The leaflets were not available in other languages but there was a translation service available for staff so that the information could be provided verbally.

Patients told us that staff had a wide knowledge of local support systems and an excellent local knowledge of the area and the facilities available. One patient who was going out for the morning, had been provided a list of ‘the best toilets in town’ for their mobility needs by staff. The staff had also provided details of the best car parks to enable easy access to shops and facilities. Patients
told us this level of local knowledge made their lives so much easier.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

Training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) is included in the trust’s safeguarding adults training module.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical staff</td>
<td>256</td>
<td>302</td>
<td>84.8%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>298</td>
<td>352</td>
<td>84.7%</td>
<td>75%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

As of May 2018, this training module had been completed by 90.9% of staff at Mardon House, including all nine qualified nursing staff. Therefore the 75% target was met both overall and for qualified nursing staff. Not all staff had received training about the Mental Health Act. However, staff confirmed they were very well supported by the site management team to understand and act as required.

Training for mental capacity was included in the mandatory safeguarding training. Training records showed that almost all staff had completed this training. Discussions had recently taken place with the safeguarding team regarding some training to registered nurses and allied health professionals at Mardon to allow more people to feel confident in completing these specific documents. Dates for specific training were being arranged.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff had a good understanding of consent, mental capacity act and deprivation of liberty safeguards and had access to further supporting information on the trusts intranet. Those staff interviewed could talk about the mental capacity act and how it may be applied.

Patients gave their consent when they were mentally and physically able. The patient’s records reviewed included that consent had been agreed prior to any treatment and we observed staff discussing procedures and agreeing consent. Staff we spoke with understood the relevant consent and decision-making requirements of legislation, including the Mental Capacity Act 2005. Staff explained that they did not undertake care for patients who lacked capacity, however, if capacity fluctuated due to ill health they understood their responsibilities to ensure patients best interest.

Patients told us clear explanations about their care and therapy had been discussed with them and they felt involved in their care.

There were occasions when patients needed deprivation of liberty safeguards to ensure their safety. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. Staff understood the legal scope and their role in the process. However, there was a lack of clarity from staff regarding when a best interest
meeting should be held and a lack of clarity regarding when a DoLS should be applied for, with the focus being on people trying to leave the ward as opposed to other forms of deprivation.

**Mental capacity assessment for one patient had not been fully completed. This means that the correct and legal paperwork was not always available to safeguard the patient.**

At the time of inspection, for the two patients who needed a capacity assessment only one had a record which showed a detailed capacity assessment had been completed. This included assessment with input from a psychologist and speech and language team. The other patient record had not been fully and correctly completed. This was raised at inspection to be addressed immediately.

Referral records to the local authority for a deprivation of liberty safeguard showed that staff had followed the correct process and referral was made to the local authority team for assessment. A recent review of the DoLS application had been completed which meant staff were aware that DoLS were time limited to safeguard patients. The trust safeguarding team checked all DoLS applications and kept an overview of any safeguard extensions needed. The trust safeguarding team monitored the patients under DoLS to ensure that people were regularly reviewed.

### Is the service caring?

**Compassionate care**

*Throughout our inspection, we observed patients were treated with the highest levels of compassion, dignity and respect. Patients told us they considered the time staff spent with them to be valuable to their recovery and the care they received to be outstanding.*

Staff were kind and supportive to patients and their relatives. We spoke with five patients and two relatives, they all told us about how the kindness and support of the staff had helped them.

**Staff were kind and supportive to patients and their relatives. Patients told us about the relationships they had with staff and how they felt staff were with them on their journey to recovery.** Patients admission duration was often longer than it would be in the acute hospital and so building relationships and trust were considered important to staff and patients. One patient told us “The most outstanding thing is, they know me, they know when I am good and when I am tired, the health care assistants know me the best and are intuitive to my needs”. Another patient told us “they pick up the pieces of me every day”.

Staff were friendly, approachable and professional. One staff member described the privilege of working with the patients and they were humbled by how patients managed their health problems.

*We observed interactions between staff and patients and their families and saw all staff encouraged patients to be partners in their own care. One patient told us “staff couldn’t be better, they are superb and it’s a pleasure to know the staff here”.*

Care from the nursing, medical staff, therapists and support staff was delivered with kindness and patience. The atmosphere was calm and professional without losing warmth and reassurance. Patients and families wanted us to know how much they appreciated all the staff, including medical, nursing, therapy and domestic and housekeeping. Patients told us “they all look after us, all of them. They know when we need more help and its always there”.

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We looked at patient satisfaction questionnaires from June 2017 to June 2018. The results identified that 21 out of 25 patients felt the Mardon rehabilitation programme was tailored to meet their needs and specific requirements.

Out of 25 patients, 19 felt that family and carers were sufficiently involved in the planning of rehabilitation including goal setting and timetables.

**Emotional support**

Staff understood the impact the care, treatment or condition might have on patients and families. Patients were supported to safely go out with family members, maintain social relationships and pets were welcomed to the unit. One patient described how important it was to their recovery that their pet dog visited. A visiting Pat Dog also attended the unit to provide that animal contact for patients.

Religious and cultural needs of patients were met and respected. There was a chapel space in the main hospital which patients could access 24 hours a day. Staff respected that religion was sometimes an important aspect of patient’s life and recovery. The chaplaincy provided emotional support for patients and staff, and was available during office hours with on call arrangements 24 hours a day. Staff could arrange contact with a minister of any faith or support from a layperson through the switchboard and gave an example of when this was done.

There was a very positive attitude towards people with mental health issues and learning disabilities. All language used was respectful and positive. The multidisciplinary team included clinical psychologists who provided treatment and support in the unit. Patients confirmed this helped them in their recovery.

**Understanding and involvement of patients and those close to them**

Patients told us that they felt involved and included in decisions about their care. Patients and their families were involved with their care, goal setting and decisions made. One patient described how staff knew what they were capable of, even when the patient themselves wasn’t sure, “they know the best of me, even when I don’t”. They told us that when it was identified that certain times of the day the patient struggled with fatigue, the therapy team adjusted the day to ensure the patient was at their best and as involved as possible. To enable this to happen nursing staff had adjusted the routine to ensure the patient was ready for therapy.

Patients had privacy for therapy. Each patient had access to private therapy room which gave patients the opportunity for one to one care away from their bed space. This means that the bed space was a place for relaxing and not associated with therapy which can be distressing.

The unit had a series of social groups which provide a group exercise for example, baking group, breakfast group and newsletter group. These groups were based on research about the value of
meaningful activity, including the value of social interaction. We attended the baking group and saw it was used to include problem solving, upper limb exercise and following instructions. The newsletter group was on a ten-week cycle to discuss, plan, write and produce the newsletter. The process then restarted to involve new patients. The groups were social, supportive and inclusive for patients, relatives and staff to work together.

### Is the service responsive?

#### Service delivery to meet the needs of local people

Services were planned and delivered in a way that met the needs of the local population. The unit provides care and services to adult patients in Exeter, North, East and Mid Devon and to patients who may be out of county. The Mardon unit provided level category 2B rehabilitation care to patients following brain injury. This means for this unit that patients admitted do not have any assisted respiratory needs and the any tracheostomy patients admitted must be able to self-manage their tracheostomy. Staff confirmed that this was the case but if extra training was needed to support patients this was provided.

We were advised that while it was considered that there was a dedicated bed used for the assessment of patients with functional neurological disorder, this was not actually the case. When a bed was available and a suitable patient had been identified an assessment period of four weeks could be provided. To have a dedicated bed for this use was not effectively achieved due to bed availability and long stay patients. However, the work undertaken with this specific group of patients was valuable as there were such limited options for their treatment elsewhere.

Mardon centre carried out sleep studies three days a week. This service was not part of the rehabilitation service and was only providing accommodation. The studies were carried out by the acute hospital. One inpatient flat was designated for sleep investigations. The flat has specialised equipment for the sleep studies.

The sleep studies service was planned to meet the patients of varying needs and varying length of stay requirements. Patients could be admitted for one night over the weekend. However, there was also a provision for those patients who required more lengthy studies and needed additional night’s stay. The two types of overnight study carried out were; Video Telemetry - Video telemetry simultaneously measures brain activity (EEG) while videoing the patient (Monday – Wednesday) and Polysomnography- Polysomnography records your brain waves, the oxygen level in your blood, heart rate and breathing, as well as eye and leg movements during the study (PSG) (Wednesday – Friday). Additional investigations carried out were multiple sleep latency tests (MSLT) - which tests for excessive daytime sleepiness by measuring how quickly you fall asleep in a quiet environment during the day. and maintenance of wakefulness.

#### Meeting people’s individual needs
Patients were treated as individuals with treatment and care being offered in a flexible way and tailored to meet their individual needs.

Each patient had a therapy timetable for the week, this timetable accommodated patient’s appointments and family activities. Therapy staff tailored the therapy to the patient and goals set each week were updated. Patients told us the timetable was followed and all sessions booked were completed.

Patients had access to a purpose-built garden. This garden was adapted to ensure patients could access outside space. There was a patient computer area where patients could access information and all patients had free access to a television and wi-fi.

Translation services were easily accessible to all patients who required it. Staff described how to access the service to support communication with families who were non-English speakers, or for whom English was a second language.

Some patients who lived with dementia may not be suitable for rehabilitation because of the level of understanding needed. Staff confirmed they did not accept this patient group, as it was difficult for them to be rehabilitated effectively in the unit’s environment.

Notice boards were available for patients and visitors and contained a range of patient literature covering advice and general information relating to health and social care and services available locally. Patient information leaflets were not displayed in languages other than English. However, the trust had an interpretation and translation service and face to face interpretation and translation was available.

All clinical areas had access to picture boards and other communication aids. Clinical areas used the “this is me” document for people with cognitive difficulty. If somebody did not have the documents the staff prompted family or carers to complete or would complete it with the person

**Access and flow**

**Mardon Neuro-rehabilitation Centre**

The needs of each patient were considered when planning and delivering the service. There was a clearly defined admission criterion to the unit, such as patients should have a primary neurological condition, over 18 years of age and not in full time education. Referrals were received from the acute and community teams. GPs contacted the consultant neurologist and all referrals were discussed as part of the weekly multidisciplinary meetings before admission was considered. Assessments were carried out within a week of referral in line with the centre’s standard operational procedures. The staff were very aware of the link between neurological disorders and depression. Full psycho-social assessments underpinned the care and treatment provided.

Numbers of admissions and discharges were recorded but the unit did not have any comparable data to establish if the levels were acceptable. Total admissions for the previous year (January 2018 – December 2018) were 78 and discharges in the same period were 89. Mardon Delayed
Discharges (January 2018 – December 2018) varied from month to month with the data being collected in days of delay. They ranged from none in June, November and December and 50 days in July and 59 days in August.

From July 2017 to June 2018 the average length of stay for medical elective patients at Mardon Neuro-rehabilitation Centre was 13.3 days, which was longer than England average for neurology of 7.6 days. This comparatively long average length of stay probably reflects this location’s function as a rehabilitation service, the comparator group consists largely of acute inpatient neurology services.

The service did not record data relating to delayed discharges. We were advised that the main cause of delays was the complexity of patients’ needs and the provision of community services. Some of these included care home placements, to meet patients’ ongoing needs. There was no outreach service or specific neurological support in the wider community and as such all discharges had to be risk managed to avoid readmission. Access to the neurological community team was geographically dependant with services only being available in certain local areas.

Discharge was a challenge for people with complex mental health and learning disability needs. Finding placement for people with mental health needs and functioning neurological disorder proved to be challenging.

### Elective Average Length of Stay - Mardon Neuro-rehabilitation Centre

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This site</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology</td>
<td>13.3</td>
<td>7.6</td>
</tr>
</tbody>
</table>

*Note: Top three specialties for specific site based on count of activity.*

The centre had fewer than six non-elective admissions over the year. Therefore, it was not practical to calculate an average length of stay for non-elective admissions.

*(Source: Hospital Episode Statistics)*

### Learning from complaints and concerns

**Summary of complaints**

Patients had access to information about how to make a complaint and complaints were taken seriously by the trust. There was information displayed for patients and their relatives.
about how to make a complaint. The trust website contained information on raising concerns and making complaints. Complaints were handled in line with trust policy. Staff directed patients to ‘Patient Advisory Liaison Service (PALS)’ if they were unable to deal with their concerns directly and advised them to make a formal complaint.

Patients and relatives knew how to make a complaint if they needed to and felt they could raise concerns with the clinical staff they met. Most patients told us if any issues arose they would talk to the nursing or therapy staff.

There had been only one concern/complaint raised between January 2018 and December 2018 which related to staffing levels.

Is the service well-led?

Leadership

Ward leaders had the skills, knowledge and experience to lead teams effectively. Considerable work had been undertaken to develop inclusivity between the acute hospital and the Mardon unit. The unit had a management team consisting of the matron, the senior nurse, the cluster manager and the consultant in rehabilitation medicine.

The leadership, both within medical and nursing staff, clearly understood the challenges to delivering good quality care. They could identify areas where the department needed to improve and what it would take to address these areas. These areas included the issues raised as part of the risk register and areas identified as part of a staff review of service.

There were varying levels of visibility of the leaders. The Mardon centre had a matron who provided day-to-day leadership to the staff. Staff felt leadership worked well at local level. Staff told us senior management from the trust were not all visible at the centre.

Leaders were approachable. Most staff felt able to openly discuss issues and concerns with senior staff and their managers. They believed they would be listened to, and actions taken when necessary.

Action had been taken to improve relationships between the centre and the trust. At the previous inspection in 2015 staff felt there was a disconnect between the centre and they did not all consider themselves as part of the trust. There had been a greater visibility of senior management and improved links with the acute hospital. Staff felt this had been effective and now felt part of the trust and represented in the trust.

Vision and strategy

Staff could tell us about the visions and values of the trust and of the Mardon unit. The vision for the service was to see Mardon build on its current position as an inpatient neuro-rehabilitation service and focus on community based neuro-rehabilitation to ensure long term cost effective sustainability of service.
The plan was to increase the consultant neuro-rehabilitation cover, this had been completed. The plan for functional neurology disorder patients, and for more acutely unwell patients to start the rehabilitation process early and relieve the pressure on acute hospital beds remained ongoing. There continued to be a plan to identify the opportunities for a dedicated hydrotherapy facility at Mardon and as an interim measure a hydro bath had been purchased.

The utilisation of the service was unclear. The historical expectation of the criteria for admission also varied. Work was being undertaken to clarify the appropriate use of the service and the alternative pathways available for patients to ensure that they were in the right place.

Culture

There was a positive culture amongst staff. The staff we spoke with during the inspection said they were proud to work on the unit and were passionate about the care they provided. They told us they felt the care provided was proactive with positive outcomes for patients. The staff talked about being patient focussed and wanting to work hard for patients.

All action had been taken, there was still a disconnect with the acute hospital. While staff were positive about working for the trust, they explained there had been times when they felt isolated from the acute hospital.

Staff said they were encouraged to raise concerns. Staff felt comfortable about raising any concerns with their line manager. Most staff were aware of the arrangements for reporting poor practice without fear of reprisal. However, not all staff were aware of Freedom to Speak up Guardian role or that they could raise concerns about patient care and safety, or any other anxieties they had. The Freedom to Speak up Guardian is there to enable staff to speak up safely within their own workplace.

The staff teams told us that they were always supported to learn and develop the service. Innovation and improvement was encouraged with a positive approach to achieving best practice.

Governance

The trust and the Mardon unit together now had processes to manage current and future performance together. Staff from Mardon centre took part in clinical governance arrangements and felt that the unit had a voice at divisional level of the trust.

Each month there was a Mardon rehabilitation sub speciality governance meeting. These meetings were in their infancy and were planned to alternate monthly between governance and business plans. These meeting had replaced the heads of department meetings. The governance meetings were chaired by the consultant in rehabilitation medicine and the agenda was set by the cluster manager. The governance business meetings are used for service improvement and development with the whole Mardon team. They have developed a five-point strategy because of an internal service review. The strategy was being addressed to consider how the five points can be delivered.

Neurorehabilitation governance meetings commenced in October 2018 and were bimonthly with alternate business meetings prior to this Mardon was included in neurology governance.
The directorate clinical governance and risk meeting minutes showed senior clinical staff reviewed and discussed incidents and developed action plans. This was cascaded to the staff at local level through the matron and cluster manager at the ‘Comms Cell meetings’.

Any areas for escalation are taken through the neurological governance meetings. For example, the neurological governance meetings were informed of the establishment of the Mardon unit local risk register. This meeting reviewed any morbidity and mortality investigations.

Management of risk, issues and performance

There was process being developed to identify, monitor and address current risks. At the time of our inspection, there was a process being developed to identify, monitor and address current risks. The risk register was under development and so the management of the trust could not provide us with the current version but could provide the content.

Issues identified for the local risk register were reviewed monthly and were scored between 1-16 and anything that scored higher than this was included in the trust corporate risk register. All divisional risks between 10 and 15 would need signing off by the medical division and any speciality risks scoring between 8-10 would be signed off by the governance committee chair person for inclusion in the risk register. All risk register items were included in the safety and risk group committee for review. This then would feed the information to the governance committee meeting which informs board meetings.

Staff could clearly describe the risks identified on the risk register. The risks identified for Mardon unit were submitted for approval on the neurorehabilitation governance meeting in October 2018 and all had a deadline for action between February and April 2019. The risks highlighted were,

- Psychology cover during maternity leave from December 2018 – 2019. The leave was currently being covered four sessions per week.
- Junior Medical Cover, this was the limited and varied availability of registrar doctors to support the unit. The limits were caused by having to share the registrars with the acute trust who had a greater workload.
- Understaffed compared to national standards (BSRM) for psychology, occupational therapy and physiotherapy.
- Absence of social worker within multidisciplinary working, leading to delays in discharge of complex patients. The service historically had admission and discharge coordinators who when they left were replaced by a social worker link.
- Absence of admission and discharge coordinator contributing to delays in admission and discharge of patients
- Insufficient appropriate seating/wheelchairs for inpatient population. The concern related to the 18 week wait to access specific and specialist wheelchairs.
- Security of premises regarding patient safety. Security was provided by the acute hospital in the form of visits and telephone access.
Each area of risk was planned to be addressed within a timescale. At this time it was not possible to identify if the timescales were not met as the register was in its infancy.

**Information management**

There was a paper record system currently in use. There was a plan for electronic records to be implemented within the next two years. Records were audited monthly and feedback provided to staff. Records were stored securely to ensure patient confidentiality. When patients were transferred, discharge letters were sent to the patients GP and discharge records completed for any ongoing care services. The risk register did not raise any issues around information management.

**Engagement**

**There were systems to engage with the public to ensure regular feedback on services. This was used for and learning and development.**

Therapy feedback cards were used to gather the views of patients and were used to influence changes in practice. The last survey was in June 2017 to July 2018. In that time 49 patients were discharged and 25 of those completed the feedback questionnaire. Most of the answers were responded to in a positive way. Feedback was provided to staff and themes were discussed at the “Comm cell” as “what you said” and “what we did”, this showed how staff made changes in response to feedback.

The centre had good links with the League of Friends who supported them in caring for the patients by providing essential equipment.

**Learning, continuous improvement and innovation**

**The leadership and staff were continuing to review the service provided.**

The governance systems newly implemented to the Mardon unit were reviewing the vision and strategy for the unit and are looking to establish the Mardon unit’s role and place in wider rehabilitation. The speech and language team had a plan to include developing formal and informal assessment processes to up skill the support provided in neuro rehabilitation and to work in collaboration and without duplication with the neuro rehabilitation team. The psychology staff were working with the unit staff with patients with functioning neurological disorder. They were looking at the assessment process pathways to support this group of patients effectively.
Acute services (Wonford)

Medical care (including older people’s care)

Facts and data about this service

The trust’s main acute site, Royal Devon and Exeter Hospital (Wonford), has 423 medical inpatient beds located across 22 wards and units:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Speciality or description</th>
<th>Inpatient beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute medical unit east</td>
<td>General medicine</td>
<td>22</td>
</tr>
<tr>
<td>Acute medical unit west</td>
<td>General medicine</td>
<td>22</td>
</tr>
<tr>
<td>Ashburn ward</td>
<td>Healthcare for older people</td>
<td>28</td>
</tr>
<tr>
<td>Avon ward</td>
<td>Cardiology</td>
<td>22</td>
</tr>
<tr>
<td>Bolham ward</td>
<td>Neurology</td>
<td>24</td>
</tr>
<tr>
<td>Bovey ward</td>
<td>Healthcare for older people</td>
<td>24</td>
</tr>
<tr>
<td>Cherry brook</td>
<td>Clinical oncology</td>
<td>0</td>
</tr>
<tr>
<td>Clyst ward</td>
<td>Stroke medicine</td>
<td>28</td>
</tr>
<tr>
<td>Coronary care unit</td>
<td>Cardiology</td>
<td>7</td>
</tr>
<tr>
<td>Creedy ward</td>
<td>Nephrology</td>
<td></td>
</tr>
<tr>
<td>Culm East ward &amp; high dependency unit</td>
<td>Respiratory medicine</td>
<td>26</td>
</tr>
<tr>
<td>Culm West ward</td>
<td>Respiratory medicine</td>
<td>31</td>
</tr>
<tr>
<td>Endoscopy unit</td>
<td>Gastroenterology</td>
<td>0</td>
</tr>
<tr>
<td>Kenn ward</td>
<td>Healthcare for older people</td>
<td>24</td>
</tr>
<tr>
<td>Lowman ward</td>
<td>Endocrinology</td>
<td>28</td>
</tr>
</tbody>
</table>
Medical specialties provided at this hospital include cardiology, clinical haematology, diabetes, gastroenterology, healthcare for older people, neurology, respiratory medicine and stroke services.

The trust has two satellite kidney dialysis units, the East Devon and South Devon Dialysis Units.

(Source: Routine Provider Information Request (RPIR) Sites tab)
The trust provided additional detail on individual specialties:

- The healthcare for older people service has seven wards, including one designed specifically for infection control requirements and two wards for patients with cognitive impairment.
- The cardiology service includes two interventional catheterisation labs and a pacing lab, in addition to the coronary care unit and Avon and Taw wards.
- The gastroenterology service runs the endoscopy unit and Okement ward.
- The neurology service shares a ward base with the healthcare for older people service for patients who require acute neurology.
- Diabetes services are operated from a specialist centre, with outpatient facilities and an inpatient ward.
- There is a dedicated renal unit for dialysis along with an inpatient facility.

The medical care service provides an ambulatory care service that is used to reduce unnecessary elective and emergency admission.

(Source: Acute Provider Information Request (RPIR) Context acute tab)

The trust had 64,289 medical admissions from July 2017 to June 2018. Emergency admissions accounted for 22,956 (35.7%), 3,693 (5.7%) were elective, and the remaining 37,640 (58.5%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 20,415
- Gastroenterology: 8,497
- Clinical haematology: 8,178
Is the service safe?

Mandatory training

Staff were provided with a mandatory training programme to reflect the safety systems, processes and practices. Staff were meeting the trust target of 75% completion for their mandatory training. Clinical leads and managers reported the compliance levels of staff to their divisional meetings.

Staff we spoke with said they were supported to complete their training by their line managers and received reminders of the training they needed to complete.

Sepsis management was included as part of the mandatory training and nursing staff we spoke with were aware of this aspect of their training. Staff received training in dementia care and staff working on the elderly care wards also competed training around managing challenging behaviours and conflict management. There was no specific mandatory training provided in relation to mental health or learning disabilities, though staff we spoke with able to demonstrate their understanding of these needs.

All staff received training in dementia and delirium. Training regarding specific mental health problems was available and the acute medical unit (AMU) had a rolling program provided by the psychiatric liaison service. Other wards could request training to be provided.

In the AMU mental health training was taken seriously, with regular sessions for staff. The unit had introduced some simulation training which proved popular with the staff. During the board round there was discussion about a patient with mental health issues who may have needed to be detained in accordance with the Mental Health Act 1983. Staff showed good awareness of the issues involved and this provided a teaching opportunity for the junior doctor managing the patient.

All staff had completed Mental Capacity Training. However, staff were not routinely trained in the application of the Mental Health Act. However, they were very well supported by the site management team

A breakdown of compliance for mandatory training courses as of May 2018 for qualified nursing staff in medical care excluding Mardon Neuro-rehabilitation Centre and the trust’s satellite kidney dialysis units is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality &amp; diversity</td>
<td>352</td>
<td>354</td>
<td>99.4%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Domestic abuse</td>
<td>332</td>
<td>341</td>
<td>97.4%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Exeter pressure risk assessment tool</td>
<td>318</td>
<td>332</td>
<td>95.8%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Pressure ulcer classification (PUCLAS)</td>
<td>320</td>
<td>335</td>
<td>95.5%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution (level1)</td>
<td>335</td>
<td>354</td>
<td>94.6%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia and delirium</td>
<td>332</td>
<td>354</td>
<td>93.8%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling</td>
<td>325</td>
<td>354</td>
<td>91.8%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>316</td>
<td>354</td>
<td>89.3%</td>
<td>75%</td>
<td>Yes</td>
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</tbody>
</table>
There was an overall training compliance rate of 87.6% for qualified nursing staff. The 75% target was met for 17 of the 18 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses as of May 2018 for medical staff in medical care excluding Mardon Neuro-rehabilitation Centre and the trust’s satellite kidney dialysis units is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic life support</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>302</td>
<td>335</td>
<td>90.1%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia and delirium</td>
<td>300</td>
<td>335</td>
<td>89.6%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution (level1)</td>
<td>273</td>
<td>335</td>
<td>81.5%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>208</td>
<td>260</td>
<td>80.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire competency</td>
<td>264</td>
<td>334</td>
<td>79.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling</td>
<td>260</td>
<td>335</td>
<td>77.6%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Transfusion safety</td>
<td>191</td>
<td>249</td>
<td>76.7%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls, slips and trips (patients)</td>
<td>187</td>
<td>258</td>
<td>72.5%</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Waste management</td>
<td>232</td>
<td>321</td>
<td>72.3%</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention &amp; control (including hand hygiene)</td>
<td>218</td>
<td>335</td>
<td>65.1%</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>211</td>
<td>335</td>
<td>63.0%</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Domestic abuse</td>
<td>165</td>
<td>287</td>
<td>57.5%</td>
<td>75%</td>
<td>No</td>
</tr>
</tbody>
</table>
There was an overall training compliance rate of 75.6% for medical staff. The 75% target was met for eight of the 13 mandatory training modules for which medical staff were eligible. The lowest completion rates were for infection prevention and control (65.1%), information governance (63.0%) and domestic abuse (56.5%).

Safeguarding

The trust had systems and processes to safeguard adults and children and protect them from harm. All staff we spoke with had completed safeguarding training and told us they were up to date with this. The trust was meeting its overall target for this training.

Training was provided for staff around guidance, policies and procedures on how to safeguard adults and children. This included information about how to safeguard women and/or children at risk of female genital mutilation and child sex exploitation.

Staff were aware of their responsibilities for safeguarding and provided examples of referrals that had been made and alerts raised. On the wards detailed and clear information was displayed about safeguarding, including advice, referral pathways and other points of contact. Staff were aware of who to contact for further advice and who the safeguarding lead for their area was, including the lead for the trust.

Information about referrals was audited, and submitted through the appropriate governance process. Safeguarding reports were produced which ensured the trust were aware of the number of alerts received, actioned and closed within the required deadlines.

Safeguarding training completion rates - medical care excluding Mardon House and satellite kidney dialysis units

The trust set a target of 75% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses as of May 2018 for qualified nursing staff in medical care excluding Mardon Neuro-rehabilitation centre and the trust’s satellite kidney dialysis units is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child protection group 2</td>
<td>302</td>
<td>352</td>
<td>85.8%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>298</td>
<td>352</td>
<td>84.7%</td>
<td>75%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

There was an overall safeguarding training compliance rate of 85.2% for qualified nursing staff. The 75% target was met for both safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses as of May 2018 for medical staff in medical care excluding Mardon Neuro-rehabilitation centre and the trust's satellite kidney dialysis units is shown below:
Training module | Number trained | Number eligible | Completion rate | Target | Met Yes / No
---|---|---|---|---|---
Child protection group 2 | 260 | 301 | 86.4% | 75% | Yes
Safeguarding adults | 256 | 302 | 84.8% | 75% | Yes

There was an overall safeguarding training compliance rate of 85.6% for medical staff. The 75% target was met for both safeguarding training modules for which medical staff were eligible.

Cleanliness, infection control and hygiene

Systems and processes to manage the control of infection, cleanliness and hygiene were consistently followed to keep patients safe. Standards of cleanliness and hygiene were maintained. There were systems and processes to prevent and protect people from healthcare-associated infection. All wards were regularly audited for infection control purposes and action taken when a concern was identified.

All wards had side rooms where patients with infections could be isolated to reduce the risk of the spread of infection. We observed the procedures form these rooms being correctly followed by all staff on the wards.

All areas we visited appeared clean and hygienic, this included storage rooms, meeting rooms for relatives and medicine storage areas. Staff we spoke with confirmed they were aware of the standards of cleaning which were expected on the wards and the checks they had to complete. The Control of Substances Hazardous to Health (COSHH) Regulations 2002 were followed. Cleaning materials and substances were stored in locked cupboards or rooms.

We observed that all staff followed the trust guidelines for dress code. This including being bare below the elbow and having hair tied back. Senior nurses we spoke said they would speak directly to any staff who were not following trust guidance.

Facilities were located throughout the wards and departments to enable patients, staff and visitors to wash their hands. Hand sanitisation gel was located at the entrance and throughout wards and departments. Staff also carried their own individual gel cleaner. Supplies of personal protective equipment (PPE), such as disposable gloves and aprons, were available on each ward. We observed this being used when care and treatment was provided to patients.

Infection control nurses worked within the hospital and provided support and guidance to staff and visited all wards on a regular basis. The team carried out audits to check compliance with trust infection control policies and procedures. We saw samples of audits that showed compliance had been achieved and where areas had been highlighted as needed attention.

Environment and equipment

The maintenance and use of facilities and premises and equipment kept people safe.

The facilities, environment and equipment were mostly well maintained. Whilst there was a variety of wards of different ages, with some having more space than others, we observed that staff worked to keep areas free from clutter. Generally patient wards, bays and rooms were spacious and bright. Staff worked hard to maintain a clean and hygienic environment that promoted patient safety.

The arrangements for managing waste and clinical specimens kept people safe. Appropriate containers were provided for the safe disposal of sharp equipment such as needles. Containers were labelled correctly on assembly or when ready for collection.
Emergency trolleys, which included resuscitation equipment, were available on each ward and department. The trolleys were tamper-evident to ensure equipment was not removed without being replaced. Staff carried out daily and weekly checks of this equipment to ensure it was ready for use in an emergency. We looked at a sample of these records on several wards, all were up to date and correctly signed. Information was provided for guidance about the emergency procedures and action to take.

**There were procedures for the maintenance and servicing of equipment.** Stickers on equipment and machinery identified the last service date and when the next service was due. Equipment we examined had been serviced or maintained in line with trust policy. Matrons on the wards we spoke said that reported faults were quickly responded to. We looked a sample of equipment including a bladder scanner, feeding pumps and glucose monitors. All had been checked and serviced and the records of this were complete.

**Assessing and responding to patient risk**

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary. Risks were managed positively.

We saw evidence that staff identified and responded appropriately to changing risks to people who used services, including deteriorating health and wellbeing or medical emergencies. Staff were able to seek support from senior staff when they felt this was required.

Within the acute medical unit urgent or un-planned medical admissions were seen and assessed by a relevant consultant within 12 hours of admission or within 14 hours of the time of arrival at the hospital, which complied with national quality standards. Risks to patients were assessed and their safety monitored and managed, so they were supported to stay safe.

On the wards we found that risk assessments were completed by staff to ensure patients’ care and treatment needs were identified and met. These included moving and handling, pressure damage, falls, sepsis, safeguarding concerns, deprivation of liberties, mental health issues, nutrition and hydration. We observed that identified risks were shared at staff handovers and safety briefings. They were also highlighted within patient records. A transfer form was completed and verbal handover given when patients transferred between wards, ensuring risks were highlighted.

Staff we spoke with were aware of the risks to patients from septicaemia (sepsis) and the action to take to escalate a patient identified as at risk. Nursing staff had completed training as part of their mandatory training. Staff had completed training in the latest National Early Warning Score (NEWS 2). The training had been cascaded through the teams and the new system was due to be implemented the week following the inspection visit. This was used by staff to identify deteriorating patients.

Staff carried out regular checks of patients who had a cannula inserted. This ensured they identified early signs of infection and acted accordingly.

If staff were concerned about risks associated with a patient’s mental health they had access to a mental health liaison nurse, and other mental health specialist support, which were available at any time. Psychiatric liaison services were also available to all wards. Staff told us these were very responsive during the day, but at night were primarily focussed on the emergency department and acute medical unit. All wards had access to the on-call psychiatrist and juniors overnight. All patients admitted to the acute medical unit with a mental health presentation were referred to, and then
assessed, by the psychiatric liaison service. Wards who believed a patient was becoming suicidal could request and assessment from the team.

Within the haematology service there was a phone triage system for patients to call out of hours and at weekends. There was a structured list, flagging symptoms as green amber or red, to assist the nurse in deciding whether the patient needed to return to hospital. We were told this was very valuable and built confidence in the patients. A nurse carried the phone during the working day and a form was completed for each enquiry, so these could be audited and reviewed.

The AMU clinical team used care and treatment pathways to ensure patients were reviewed by a consultant-led team and either admitted or discharged as needed.

The risk to patients from falls was assessed and recorded and action taken on the ward to minimise the risk. For example, patients at risk could be co-horted, which provided increased supervision and observation. The number of falls resulting in harm were recorded and all falls were reviewed by the ward nursing team. Incident forms were completed and action taken if required.

Nurse staffing
The trust reported their qualified nursing staff numbers as below as of March and July 2018, for medical care excluding Mardon Neuro-rehabilitation centre and the trust’s satellite kidney dialysis units.

<table>
<thead>
<tr>
<th>Service</th>
<th>March 2018</th>
<th>May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
</tr>
<tr>
<td>Royal Devon and Exeter Hospital (Wonford)</td>
<td>341.3</td>
<td>414.2</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Vacancy rates

From June 2017 to May 2018, the trust reported a vacancy rate of 17.6% for qualified nursing staff in medical care excluding Mardon Neuro-rehabilitation centre and the trust’s satellite kidney dialysis units. The trust set no target for vacancy rate.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From June 2017 to May 2018, the trust reported a turnover rate of 14.2% for qualified nursing staff in medical care excluding Mardon Neuro-rehabilitation centre and the trust’s satellite kidney dialysis units. The Trust’s turnover rate target is between 10% to 12%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates
From June 2017 to May 2018, the trust reported a sickness rate of 4.4% for qualified nursing staff in medical care excluding Mardon Neuro-rehabilitation centre and the trust’s satellite kidney dialysis units. This was higher than the trust’s target of 4.0%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and agency staff usage**

It should be noted that:

- Data was provided from May 2017 to May 2018, excluding February 2018, in order to provide 12 months of data. The trust was unable to provide data for February 2018 due to the migration to a new computer system that took place in that month. Bank and agency shifts booked in advance were entered on both systems, therefore due to the risk of double counting providing inaccurate data the trust decided to omit this month.

- The trust was only able to provide unfilled shifts for the period from May 2017 to January 2018. This was also due to issues related to the change to the new roster system in February 2018 leading to a risk of double-counting and inaccurate information being provided.

- The trust was unable to supply the total number of shifts worked by all permanent and temporary staff. Therefore, it was not possible to calculate the percentages of shifts worked by bank and agency staff and left unfilled.

From May 2017 to May 2018, excluding February 2018, the trust reported that in medical care, excluding Mardon Neuro-rehabilitation centre and the trust’s satellite kidney dialysis units, 3,753 shifts (312.8 per month on average) were filled by bank qualified nurses and 2,915 shifts (243.0 per month on average) were worked by agency qualified nurses. In addition, over the shorter period from May 2017 to January 2018, 1,265 qualified nursing shifts (105.4 per month on average) were not filled by bank or agency staff to cover staff absence.

Over the same period, the trust reported that in medical care, excluding Mardon Neuro-rehabilitation centre and the trust’s satellite kidney dialysis units, 6,642 shifts (553.5 per month on average) were filled by bank nursing assistants and 93 shifts (7.8 per month on average) were worked by agency nursing assistants. In addition, over the shorter period from May 2017 to January 2018, 1,526 nursing assistant shifts (127.2 per month on average) were not filled by bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Agency</th>
<th>Unfilled*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nurses</td>
<td>3,753</td>
<td>2,915</td>
<td>1,265</td>
</tr>
<tr>
<td>Nursing assistants</td>
<td>6,642</td>
<td>93</td>
<td>1,526</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10,395</strong></td>
<td><strong>3,008</strong></td>
<td><strong>2,791</strong></td>
</tr>
</tbody>
</table>

*May 2017 to January 2018

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)
Bank and agency staff usage

It should be noted that:

- Data was provided from May 2017 to May 2018, excluding February 2018, in order to provide 12 months of data. The trust was unable to provide data for February 2018 due to the migration to a new computer system that took place in that month. Bank and agency shifts booked in advance were entered on both systems, therefore due to the risk of double counting providing inaccurate data the trust decided to omit this month.

- The trust was only able to provide unfilled shifts for the period from May 2017 to January 2018. They explained this as also being due to issues related to the change to the new roster system in February 2018 leading to a risk of double-counting.

- The trust was unable to supply the total number of shifts worked by all permanent and temporary staff. Therefore, it was not possible to calculate the percentages of shifts worked by bank and agency staff and left unfilled.

From May 2017 to May 2018, excluding February 2018, the trust reported that across its two dialysis units 138 shifts (11.5 per month on average) were filled by bank qualified nurses and 60 shifts (five per month on average) were worked by bank nursing assistants. There was no agency nursing staff usage at either dialysis unit. In addition, over the shorter period from May 2017 to January 2018, two qualified nursing shifts, and two nursing assistant shifts, were not filled by bank or agency staff to cover staff absence.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Staffing levels and the required skill mix was planned and reviewed so that people received safe care and treatment. Rotas ensured staff did not work excessive hours. Cover was provided for staff absence. Staffing levels were maintained generally with the use of bank and agency staff. There was ongoing recruitment from overseas, with a number of nurses having recently started, and more due in the coming months. Staff we spoke with told us staffing numbers presented their biggest challenge, though all believed the trust was being fully proactive in its recruitment activity. Challenges over staffing numbers were more acute on the elderly care wards we visited but we saw how staff would flex between wards to ensure that safe cover was provided.

The matrons from the medical wards met every morning, after visiting their respective wards, to discuss cover and agree any movement of staff that was required. If cover was not available to for a planned shift this could mean the senior nurse on duty would not be able to work in their supernumerary role. The safety and standard of care and treatment was maintained through the high-quality team work that was evident on all wards we visited. We observed nursing staff and care assistants communicating over the prioritising of work and supporting colleagues to ensure patients’ needs were met.

Medical staffing

The trust reported their medical staff numbers in medical care as below as of March and July 2018.

<table>
<thead>
<tr>
<th>Service</th>
<th>March 2018</th>
<th>July 2018</th>
</tr>
</thead>
</table>

20171116 900885 Post-inspection Evidence appendix template v3 Page 72
### Actual staff (WTEs)  | Planned staff (WTEs)  | Fill rate  
---|---|---
Medical care  | 271.1  | 279.5  | 97.0%  

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

### Vacancy rates

From June 2017 to May 2018, the trust reported a staffing surplus of 2.6% for medical staff in medical care at Royal Devon and Exeter Hospital (Wonford). The trust set no target for vacancy rate.

The highest annual vacancy rates were reported for medical staff in clinical genetics (21.7%), gastroenterology (15.3%) and senior haematologists (11.8%) (excluding reporting units with less than five staff).

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

### Turnover rates

From June 2017 to May 2018, the trust reported a turnover rate of 26.8% for medical staff in medical care at Royal Devon and Exeter Hospital (Wonford). The Trust’s turnover rate target is between 10% to 12%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

### Sickness rates

From June 2017 to May 2018, the trust reported a sickness rate of 0.8% for medical staff in medical care at Royal Devon and Exeter Hospital (Wonford). This was lower than the trust’s target of 4.0%. All medical specialties reported sickness rates of under 3%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

### Bank and locum staff usage

Please note that:
- The trust was unable to calculate bank medical staff usage due to deficiencies with their data. They provided only locum staff usage.
- The trust was not able to calculate the total number of shifts left unfilled to cover medical staff vacancies, sickness and absence.
- The trust was not able to provide the total number of shifts worked by temporary and permanent medical staff. Therefore, percentage usage of agency staff in each core service could not be calculated.
The trust reported that they do not record bank and agency medical staff usage on a centralised system.

From June 2017 to May 2018, the trust reported that in medical care at Royal Devon and Exeter Hospital (Wonford) 422 shifts (35.2 shifts per month on average) were filled by locums. Most of this usage was accounted for by haematology. From September 2017 to May 2018, 289 haematologist shifts were filled by locums (on average 32.1 shifts per month).

(Source: Routine Provider Information Request (RPIR) – Medical locum agency tab)

The trust had systems to meet the needs of the medical outlier patients. A group of consultants met every morning in the acute medical unit (AMU) and discussed the current list of outliers. Patients were then seen by members of this team, called the medical “flying squad”. If on occasion there were too many patients for the team to see, there were other consultants on a standby list who could be contacted to see patients. Consultants and nursing staff, we spoke with, were very positive about this practice, as it ensured that these patients were seen early in the day, rather than having to wait until other ward rounds had been completed. This also helped in the cases of patients who were near to discharge as this can be organised earlier in preparation.

Staffing skill mix

In July 2018, the proportion of consultant staff reported to be working in medical care at the trust was similar to the England average. The proportion of junior (foundation year 1-2) staff was lower than the England average.

Staffing skill mix for the 245 whole time equivalent staff working in medicine at Royal Devon and Exeter NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>43%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group</td>
<td>33%</td>
<td>27%</td>
</tr>
<tr>
<td>Junior*</td>
<td>19%</td>
<td>25%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital - Workforce Statistics - Medical (01/06/2018 - 30/06/2018))

Records
Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care. Records were individualised and there were clear procedures for the storing of records on the wards. The information needed to deliver safe care and treatment was available to relevant staff in a timely and accessible way. However, records were not stored in lockable cabinets, though they were in trolleys that were in eyesight of staff.

At the previous inspection we had found that records were sometimes left on counters and out of eyesight of sight, posing a potential risk to patient confidentiality. We did not see any evidence of this practice during this visit. Senior nursing staff told us that frequent reminders had been provided around ensuring the confidentiality of the records. We were also told that the move to electronic records, planned for 2020, meant that there was a reluctance to invest in a lot of new lockable storage cabinets.

During our inspection we looked at 19 sets of patient records, sampled from all the wards we visited. We found that notes were clearly written with the appropriate detail and signed and dated by the relevant professional. Notes had regular entries against any ongoing monitoring and charts for needs such as nutrition and fluid intake, and general observations were completed fully and dated.

Medicines

The trust generally followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time. However, we found some minor shortfalls in recording and the monitoring of room temperatures.

Medicines were stored securely in locked treatment rooms and were only accessible to authorised staff. Patients had individual lockers to store their medicines. Fridge temperatures were recorded daily to ensure medicines were kept at appropriate temperatures. However, on Torridge ward when temperatures were not in the recommended range there was not always evidence action had been taken to address this.

The room temperature on Kenn ward was not being monitored, the temperature at the time of our visit was 26 degrees. The medicines policy stated that it is not mandated the room temperature should be taken unless there are concerns, in which case monitoring should be undertaken. On the day of the inspection arrangements were made to monitor the room temperature.

Opening dates were not always recorded on liquid medicines to ensure they were discarded within the required time range and were safe to use. On Kenn ward there was a bottle of Potassium chloride solution which had no opening date, and had a reduced shelf life of 8 weeks after opening. This was disposed of on the day of the inspection. There was also no date of opening on liquid oramorph solution. There were also no opening dates on eye drops in patients own lockers. On Clyst ward there was also no opening date on bottle of oramorph. Ventolin nebulés, levetiracetam solution epilum liquid, furosemide, spironolactone, digoxin and metformin liquid also had no opening dates recorded.

Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored securely. However, the Controlled drugs cupboard on Clyst ward did not comply with their medicines policy and regulations. Patient Group Directions (PGDs) were available to allow nurses to administer medicines in line with legislation. Staff could access up to date copies on the intranet. However not all nurses had signed to confirm they had read the current versions on Kenn ward.
On Torridge ward fridge temperature records had not been completed since October 2018. On Clyst ward there were gaps in the recording of the check on the resus trolley. Daily checks had not been completed on 1,2,6,7,8,9,13,14,15,16,19, 20,21,22,25,26,27,28,29,30,31st December nor on the 3,4,5,6,8,9,10,11,12th January.

On Kenn ward and Clyst ward the resus trolley had a hypo kit which contained glucagon and this was not stored securely, compared to the other medicines in the trolley and staff could not explain why.

There was a wooden CD cupboard on Clyst ward which did not meet The Misuse of Drugs (Safe Custody) Regulations (1973) The medicines safety action plan did show that the cupboard was to be changed however, the action had been marked as complete when the locks had been changed instead of the actual cupboard.

We found variety of evidence of good and safe practice across the wards we visited. A regular ward based clinical pharmacist and technician service ensured that patients' prescribed medicines were reviewed. To reduce the delays in discharge the wards had pre-packs of frequently used medicines available. There were appropriate arrangements for the recording of medicines administration and prescription charts were completed well.

Drug recalls and alerts were disseminated to wards. Medicine incidents and errors were recorded as incidents. We were given an example how changes had been made to practice following some recent incidents. Incidents from elsewhere in the trust were also cascaded if they related to medication errors.

Wards were able to access the pharmacy tracking system to check the status of discharge medicines. Staff told us medicines on discharge could possibly be managed better and some of the medicine management technicians were due to start a course on discharge facilitation to improve this.

Every month an audit on antibiotic use is completed by pharmacy staff on the indication and review dates to ensure these are being prescribed in accordance with guidelines.

A medication safety thermometer was completed every other month, which looked at a range of measures including if allergies had been recorded and medication reconciliation rates.

Medicines management in AMU – a pharmacist checked all prescriptions and could call up the GP data on the computer in addition. Medicines for individual patients were locked in boxes by the bed and could not be accessed by the patient.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff we spoke with in each area had demonstrable knowledge of learning from incident
investigations and could explain how processes had changed as a result. For example, one nurse explained how communication with the discharge team had been improved following a mistake around medication. A consultant told us how they had completed an incident report following a concern around a diagnosis they had made. They explained how they had been fully supported, and that the learning was shared with all the ward staff and other medical staff.

One of the consultants on the acute medical unit explained how they had managed two serious incidents, which involved prompt discussion with the patients, and later reflection and learning with other consultants. This was evidence of appropriate reporting and learning. Neither patient was harmed in these incidents.

All staff we spoke with told us the trust, and ward, culture supported and encouraged openness and transparency. We observed that learning was disseminated through safety briefings and information bulletins as well as being discussed in team meetings. Staff told us they received feedback from incident that they reported.

Examples of incidents that had been reported included, medicine errors, aggressive patient behaviour that had to be managed, staffing shortages, movement of staff to other hospital areas, patient falls and pressure sores.

There was a process for morbidity and mortality (M&M) reviews. The medical team responsible for each death reviewed the patient’s care and treatment and findings were discussed at team meetings. Consultants we spoke with told us they were confident there was a culture of learning from the outcomes of M&M reviews.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2017 to September 2018, the trust reported one incidents classified as never events in medical care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported six serious incidents (SI’s) in medical care which met the reporting criteria set by NHS England from October 2017 to September 2018.

The breakdown by incident type was as follows:

- Slips/trips/falls: four
- Treatment delay: one
- Apparent/actual/suspected self-inflicted harm: one

The time taken to report these incidents to the Strategic Executive Information System was
variable:

- 0 - 14 days: one
- 15 - 30 days: one
- 31 - 60 days: one
- 61 – 90 days: one
- Over 90 days: two

(Source: Strategic Executive Information System (STEIS))

Safety Thermometer

The Safety Thermometer is used to record the prevalence of patient harm and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harm and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 15 new pressure ulcers, 10 falls with harm and 10 urinary tract infections in patients with a catheter in medical care from October 2017 to October 2018.

Prevalence rate (number of patients per 100 surveyed) of patient harms at Royal Devon and Exeter NHS Foundation Trust

![Graph 1: Total Pressure Ulcers (15)]

![Graph 2: Total Falls (10)]
Total CUTIs (10)

1. Pressure ulcers levels 2, 3 and 4
2. Falls with harm levels 3 to 6
3. Urinary tract infections in patients with a catheter

(Source: NHS Digital)
Is the service effective?

Evidence-based care and treatment

Patients’ needs were assessed and care and treatment was delivered in line with legislation, standards and evidenced-based guidance. Policies and procedures provided for staff referenced national guidelines and legislation. These included the National Institute for Health and Care Excellence (NICE) guidelines.

Staff used national and international best practice guidance and benchmarks to ensure new projects and care pathways were evidence-based. The clinical effectiveness committee meet a minimum of six times a year and reported up to the trust governance committee. The committee was tasked with ensuring clinical services were delivered using local, national, guidelines, standards and statutes. The committee received formal reports and action plans from sub groups. These included for example, dementia and delirium steering group, end of life group and the clinical audit and development group. The committee received and reviewed any proposals for new clinical procedures.

Patients admitted onto the acute medical unit were seen and reviewed promptly by a consultant to maximise continuity of care. There were two acute medical units (AMUs), East AMU was for men and West AMU was for women. Each with 22 beds. These had recently undergone an upgrade with funding from NHS-improvement. The units included an area of medical triage, one side is for patients brought in on trolleys, the other is ambulatory. The use of these two areas has resulted in improved throughput. For example, on the Friday prior to the inspection visit there had been 87 admissions, and 14 were turned around in the ambulatory area. In the morning consultants from the various specialties come to see the patients in these areas. The junior staff were well supported at consultant level, and were provided with opportunities for learning.

Once transferred from the acute area to a general ward, patients were reviewed during a consultant-delivered ward round at least once every 24 hours. On the acute stroke ward patients were admitted directly from the emergency department, where thrombolysis would have been started, this could then be continued on the ward. Once admitted to the ward patients had an immediate inter-disciplinary assessment completed. The ward held meetings called communication cells, where all the team met three times a week to understand performance and discuss any learning.

The haematology ward and the associated day case unit were situated adjacent to one another. This enabled staff to be shared between the two when required. The six haematologists also had their offices located in the same area. The 6 consultant haematologists had their offices and outpatient facilities in the same location. This supported the delivery of effective and seamless care and treatment for patients.

There were further examples of care and treatment based on national guidance and evidence of its effectiveness. On the stroke ward the Glasgow Coma scale was being completed appropriately. This was used to communicate about the level of consciousness of patients. The Royal College of Physicians outline the guidelines for acute stroke management, highlighting the importance of early identification to enable prompt and effective treatment. The clinical assessments of stroke patients using a clerking proforma was completed. Also in use was the Modified Rankin Scale. This system
is used to measure the degree of disability or dependence in the daily activities of patients who have experienced a stroke or other causes of neurological disability.

Patients were also screened for the presence of dysphagia to identify those who could or could or could not swallow safely.

Relevant staff were trained and supported to deal with any violence and aggression in an appropriate way. Staff explained how they managed aggressive behaviours and the challenges this presented. Whilst this could be stressful staff told us they felt well supported by other staff, that the security staff when required were responsive and professional and that training was provided in managing aggressive and challenging behaviours. We saw that incidents relating to aggressive behaviours were correctly recorded.

The psychological and emotional needs of patients, as well as their relatives or carers were understood and supported by treatment. Staff handovers and the ward rounds routinely referred to any issues, concerns or treatment relating to these needs. Recording in relation to these needs were seen in the respective care plans and medical notes.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences.

Patients’ nutrition and hydration needs were assessed and met in line with national guidance. The trust used a nationally recognised tool, the malnutrition universal screening tool (MUST), to identify patients at risk of being malnourished.

Staff monitored and recorded the intake and output from patients by completing food, fluid balance, weight and bowel charts. These were reviewed and escalated when concerns were identified. We looked at a sample of these on the wards we visited and observed they were all completed and up to date.

Patients were given a choice of food and different choices which accommodated religious or cultural needs were available. Ward staff had access to dietary and nutritional specialists if they needed advice or needed to make a referral. Staff we spoke with said the services were responsive and worked well with the staff on the wards.

Patients we spoke with were generally very positive about the quality of the food and the choice. The wards operated a protected mealtime scheme, but did encourage support from relatives at mealtimes who wished to support their relatives with their meals. On two wards we visited we spoke with the housekeepers. They explained how they ensured the dietary preferences of the patients were catered for and that any specialist cutlery was available when needed. They also made sure they got feedback from patients regarding any concerns about the food. Both housekeepers told us they felt fully part of the team on the wards and were very proud of the work they were part of.

**Pain relief**
Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

We saw that pain was assessed and recorded, and for patients who were living with dementia, the Abbey Pain scale assessment tool was used. In all the patient records we looked at staff had monitored pain scores at appropriate intervals and escalated care where needed. Patients we spoke with confirmed they received adequate pain relief. On the ward medicine round, we observed staff asking patients about their pain levels and if they required pain relief.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

The trust took part in the Sentinel Stroke National Audit. On a scale of A-E, where A is best, the hospital’s overall SSNAP level was grade B for the three most recent audit periods available, covering the 12 months from April 2017 to March 2018. However, on this inspection we saw evidence of improvement on this rating with an increased number of “A” being scored. The improvement over the previous months was largely due we were told to improved staffing levels. The service was in line with the national average in terms of patients treated and the “door to needle” time was above average when compared to the other regional units.

The endoscopy service lost its JAG accreditation status in 2018 due to not meeting 2% of its waiting targets. JAG (Joint Advisory Group) accreditation is the formal recognition that an endoscopy service has demonstrated it has the competence to deliver against the criteria set out in nationally agreed standards. The scheme was developed for all endoscopy services and providers across the UK in the NHS and independent sector. The service was on course to regain its accreditation in October 2019 following compliance with the required two-week wait target for cancer patients. During the recovery period since losing the accreditation the service has managed with long term sickness. The service had now recruited three new consultants and a nurse endoscopist, and had also been running additional clinics at weekends.

The trust was part of a national dementia audit and work was being led into making wards more dementia friendly. There was a Dementia and Delirium Steering group. This was providing advice and guidance to senior nurses on the wards.

Relative risk of readmission

Trust level – elective admissions

From June 2017 to May 2018, the trust’s patients had a higher than expected risk of readmission for elective medical admissions compared to the England average.

- Risks of readmission for clinical oncology and clinical haematology were both higher than expected.

- Patients in general medicine reportedly had a risk of readmission of approximately five times the expected rate for elective admissions.
• However, prior to the inspection the trust provided evidence that the readmission data was inaccurate. This was due to patient’s admissions being recorded twice when they went through the acute medical unit pathway.

Elective Admissions – Trust level

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity.

Trust level – non-elective admissions

From June 2017 to May 2018, patients at the trust had a lower than expected risk of readmission for non-elective medical admissions compared to the England average.

Patients in general medicine, clinical oncology and geriatric medicine had lower than expected risks of readmission for non-elective admissions.

Non-Elective Admissions - Trust level

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity.

Royal Devon and Exeter Hospital (Wonford)

From June 2017 to May 2018, readmission rates for the top three elective and non-elective specialties by volume of readmissions were the same for Royal Devon and Exeter Hospital (Wonford) as at the trust level in all cases.

Sentinel Stroke National Audit Programme (SSNAP)
Royal Devon and Exeter Hospital (Wonford) takes part in the Sentinel Stroke National Audit programme.

The hospital’s performance is shown in the tables below.

### Overall Scores

<table>
<thead>
<tr>
<th></th>
<th>Dec 16 - Mar 17</th>
<th>Apr 17 - Jul 17</th>
<th>Aug 17 - Nov 17</th>
<th>Dec 17 - Mar 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>A↑</td>
<td>B↓</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>B↓</td>
</tr>
<tr>
<td>Combined total key indicator level</td>
<td>A↑</td>
<td>B↓</td>
<td>B</td>
<td>B</td>
</tr>
</tbody>
</table>

On a scale of A-E, where A is best, the hospital’s overall SSNAP level was grade B for the three most recent audit periods available, covering the 12 months from April 2017 to March 2018.

### Patient-centred performance

<table>
<thead>
<tr>
<th>Domain 1: Scanning</th>
<th>Dec 16 - Mar 17</th>
<th>Apr 17 - Jul 17</th>
<th>Aug 17 - Nov 17</th>
<th>Dec 17 - Mar 18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B↑</td>
<td>B</td>
<td>C↓</td>
<td>B↑</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>B</td>
<td>B</td>
<td>C↓</td>
<td>B↑</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>B</td>
<td>B</td>
<td>C↓</td>
<td>B↑</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>A</td>
<td>B↓</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>A↑</td>
<td>B↓</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>B</td>
<td>C↓</td>
<td>B↑</td>
<td>B</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>A</td>
<td>A</td>
<td>B↓</td>
<td>B</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
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<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Patient-centred total key indicator level</td>
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<td>B↓</td>
<td>B</td>
<td>B</td>
</tr>
</tbody>
</table>

The hospital’s patient-centred stroke unit indicator was consistently grade C for the four most recent audit periods, covering the 16 months from December 2016 to March 2018.

The hospital’s patient-centred total key indicator level was consistently grade B for the three most recent audit periods, covering the 12 months from April 2017 to March 2018.
### Team-centred performance

<table>
<thead>
<tr>
<th>Domain</th>
<th>Dec 16 - Mar 17</th>
<th>Apr 17 - Jul 17</th>
<th>Aug 17 - Nov 17</th>
<th>Dec 17 - Mar 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>B↑</td>
<td>B</td>
<td>C↓</td>
<td>B↑</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>B</td>
<td>B</td>
<td>C↓</td>
<td>C</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>B</td>
<td>B</td>
<td>C↓</td>
<td>B</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>A</td>
<td>B↓</td>
<td>A↑</td>
<td>B</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>A</td>
<td>B↓</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>B</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Team-centred total key indicator level</td>
<td>A</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
</tbody>
</table>

The hospital’s performance for team-centred stroke unit indicator was consistently grade C for the four most recent audit periods, covering the 16 months from December 2016 to March 2018.

The hospital’s team-centred total key indicator level was grade B for the three most recent audit periods, covering the 12 months from April 2017 to March 2018.

(Source: Royal College of Physicians London, SSNAP audit)

### Lung Cancer Audit

The trust participated in the 2017 Lung Cancer Audit.

The crude proportion of patients seen by a cancer nurse specialist was 88.8%, which did not meet the audit aspirational standard of 90%. The figure for 2017 was 88.8% compared with a national mean of 72%.

The case-mix adjusted proportion of patients with Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 13.8%. This was within the expected range compared to other trusts. In 2016 the trust’s performance for this metric was significantly worse than the national level.

The proportion of fit patients with advanced NSCLC receiving systemic anti-cancer treatment was 57.9%. This was within the expected range compared to other trusts. The trust’s performance in the equivalent measure from the 2016 audit was not significantly different from the national level.

The proportion of patients with Small Cell Lung Cancer receiving chemotherapy was 74.7%. This was within the expected range compared to other trusts. In 2016 the trust’s performance for this metric was not significantly different from the national level.

The case-mix adjusted one-year relative survival rate for the trust in 2017 was 38.5%. This was within the expected range compared to other trusts. In 2016 the trust’s performance for this metric was 38.5%.
was not significantly different from the national level.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017

At Royal Devon and Exeter Hospital (Wonford) the crude proportion of patients who had a vision assessment (if applicable) was 6.7%. This did not meet the national aspirational standard of 100%. Results of less than 50% for this metric are rated as poor.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 4.3%. This did not meet the national aspirational standard of 100%. Results of less than 50% for this metric are rated as poor.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 50.0%. This did not meet the national aspirational standard of 100%. Results of between 50% and 79% for this metric are rated as fair.

The crude proportion of patients with a call bell in reach (if applicable) was 75.9%. This did not meet the national aspirational standard of 100%. Results of between 50% and 79% for this metric are rated as fair.

(Source: Royal College of Physicians)

Competent staff

Appraisal rates - Royal Devon and Exeter Hospital (Wonford)

From June 2017 to May 2018, 54.7% of staff in medical care at the trust received an appraisal, less than the trust target of 80%.

The 80% target was not met for any staff groups.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number completed</th>
<th>Number of individuals required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied health professionals</td>
<td>5</td>
<td>7</td>
<td>71.4%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Medical staff</td>
<td>106</td>
<td>150</td>
<td>70.7%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>160</td>
<td>296</td>
<td>54.1%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>161</td>
<td>320</td>
<td>50.3%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>8</td>
<td>24</td>
<td>33.3%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>5</td>
<td>16</td>
<td>31.3%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>

Patients had their assessed needs, preferences and choices met by staff with the appropriate skills and knowledge.
Specialist teams and individuals provided a range of targeted, ad-hoc and structured training, learning and development opportunities. This was both for members of the immediate specialised service and to staff from other areas. Nursing staff we spoke with said their learning needs were discussed regularly with their senior staff and they were supported to access specialised learning. Medical staff and nursing staff told us they were encouraged and supported to develop their learning and skills.

Staff were having regular clinical supervision and annual appraisals. There were also opportunities for group supervision and learning through regular team meetings.

**Multidisciplinary working**

Staff, teams and services worked well together to deliver effective care and treatment. Multidisciplinary team (MDT) meetings were held on wards and departments. These brought together clinicians with the necessary skills and knowledge to work together to provide patients with the best plan for their care and treatment.

We observed board rounds on several wards, including Ashburn, Clyst and Kenn wards and the acute medical unit. They were all well attended by members of the multidisciplinary team (MDT) including medical teams, therapists, dieticians, the discharge coordinator, specialty consultants and in several cases the ward housekeeper. The team used board rounds to carry out quick reviews of each patient to identify their immediate needs and progress with discharge planning. A full ward round followed each review.

On Lowman ward a consultant told us the team work was excellent with no hierarchical structure between nurses, therapist and doctors.

All necessary staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. In all the patient records we looked at we saw evidence of consistent and proactive MDT intervention and review. This included the acute medical unit where patients could be cared for on a short-term basis. In the acute medical unit, the daily 11 am board rounds were used as a teaching opportunity. The patient surnames were displayed on a whiteboard on the ward which could be freely read by all but had no confidential information regarding diagnosis. Discussion of these patients enabled discharge planning, follow up of referrals and organising of tests that needed to be done. It was led by the consultant for the day with the senior nurse; the nurses from each of the bays who describe their patients, a physiotherapist, occupational therapist, pharmacist and the ward housekeeper.

**Seven-day services**

Services were available that supported care and treatment to be delivered seven days a week. The trust met the NHS seven-day services priority standards. There was consultant presence in the hospital seven days a week with ward rounds taking place every day. Diagnostic services provided a seven-day service.

**Health Promotion**

Staff actively promoted and encouraged patients to live healthily to support their recovery and recuperation. Patients were encouraged to take responsibility for and be fully involved
in their recovery and treatment plans. Health promotion agencies and organisations were allowed and encouraged to promote their services within the trust. During the inspection we saw fitness and activity group promoting healthy lifestyle information in the restaurant area. This was for the benefit of staff, patient and relatives.

Health improvement and lifestyle information was available in all medical areas and signposts to organisations that could help with health trends in the local population, such as alcoholism, were freely available.

Health promotion material specific to medical specialties was available on each ward supplied by appropriate organisations.

We observed physiotherapists and occupational therapists explaining and supporting patients to understand their discharge care plans. It was well explained to patient how lifestyle choices had an impact on their recovery and recuperation.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

All staff had Mental Capacity Act (MCA) training, but they were not routinely trained in the application of the Act. However, they were very well supported by the site management team.

Staff spoken with were able to talk about the MCA and how it may be applied. There was a lack of clarity regarding when a Deprivation of Liberty Safeguard (DoLS) should be applied for, with the focus being on people trying to leave the ward as opposed to other forms of deprivation. Likewise, with best interest decisions there was a lack of clarity from some staff as to when a best interest meeting should be held.

Overall there was a clear process for the application of MCA/DoLS and best interest, that protected patients and respected their rights. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff followed the trust policy and procedures when a patient could not give consent. The DoLS applications were all filled in, but with varying completeness. The descriptions of the treatment to be provided, and the nature of the restrictions, was in some records too vague. Blanket statements were used rather than specifics. At the time of the inspection the local authority had requested that DoLS extensions were not submitted following the initial seven days, as they did not have the capacity to process them. The trust safeguarding team monitored the patients under DoLS, to ensure that people were being regularly reviewed. However, some of files were incomplete, with missing capacity assessments.

The site management team managed the mental health act within the hospital. They ensured that the correct paperwork was used and that people are made aware of their rights under the Act.
Mental Capacity Act and Deprivation of Liberty training completion

Training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) is included in the trust’s safeguarding adults training module.

As of May 2018, this training module had been completed by 87.4% of staff within medical care (excluding Mardon House and the two satellite kidney dialysis units), including 84.7% of qualified nursing staff and 84.8% of medical staff. Therefore the 75% target was met overall, and for both staff groups.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical staff</td>
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<td>302</td>
<td>84.8%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>298</td>
<td>352</td>
<td>84.7%</td>
<td>75%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Training tab)

Is the service caring?

Compassionate care

Patients were treated with kindness, dignity, respect and compassion when in receipt of care and treatment. On all the wards we visited we saw staff were respectful and promoted the dignity of their patients. Staff introduced themselves by name to new patients. Curtains were drawn when staff were delivering personal care.

We spoke with 18 patients in total and all made positive comments about the ward staff teams. We were told that they were treated with compassion and that all staff were friendly and helpful.

Wards were able to support carers through the national “John’s Campaign”. This scheme enabled carers to visit the patients they cared for and support them at mealtimes and with their personal care. We spoke with two carers who were supporting partners. They told us they were well supported by the nursing and healthcare assistants if they needed anything, and that all the staff were friendly and helpful.

Staff took the time to interact with patients and those close to them in a respectful and considerate way. Comments from patients included, on Ashburn ward, “the staff are always busy but always friendly”, on Lowman ward, “I cannot fault any of them they are all brilliant”, on Bovey ward “they are great I have no complaints”. On Kenn ward we spoke with a patient who had been readmitted to the ward. They told us “I was very happy knowing I was coming back on this ward, they remembered me and have been very kind”.

We also spoke with five relatives who were visiting patients. They were very positive about the staff and their friendly approach.

Staff responded in a compassionate, timely and appropriate way when people experienced physical pain, discomfort or emotional distress. We observed some excellent care being delivered
on the elderly care wards to patients who were living with a degree of dementia. Nursing staff and health care assistants responded to confused patients providing reassurance and kindness. On Yarty ward, which specialised in treating haematology patients, staff described several instances were good and kind caring had made a great difference to families at a difficult or traumatic time.

**Friends and Family test performance**

From October 2017 to September 2018 the Friends and Family Test (FFT) response rate for medical care at Royal Devon and Exeter Hospital (Wonford) was 19.1%. This was based on 3,780 responses. This was lower than the England average of 25%.

A breakdown of FFT performance by ward for medical wards at this hospital over the same period is shown below.

With the exception of the acute medical units, all wards scored over 90% for the 12 month period overall.

The response rate of 146% for Bovey ward is the result of an error in the data submitted by the trust to NHS England. This should be queried with the trust if required.

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</thead>
<tbody>
<tr>
<td>Culm West ward</td>
<td>555</td>
<td>50%</td>
<td>100%</td>
<td>95%</td>
<td>90%</td>
<td>100%</td>
<td>98%</td>
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<td>96%</td>
<td>99%</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>Yeovil ward</td>
<td>410</td>
<td>37%</td>
<td>100%</td>
<td>90%</td>
<td>98%</td>
<td>100%</td>
<td>97%</td>
<td>94%</td>
<td>100%</td>
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<td>97%</td>
<td>98%</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>Acute medical unit</td>
<td>383</td>
<td>37%</td>
<td>100%</td>
<td>95%</td>
<td>94%</td>
<td>100%</td>
<td>97%</td>
<td>97%</td>
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</tr>
<tr>
<td>Torridge ward</td>
<td>362</td>
<td>50%</td>
<td>100%</td>
<td>95%</td>
<td>94%</td>
<td>100%</td>
<td>97%</td>
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<td>97%</td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>Bovey ward</td>
<td>359</td>
<td>146%</td>
<td>98%</td>
<td>97%</td>
<td>98%</td>
<td>91%</td>
<td>97%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>96%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
</tr>
<tr>
<td>Lowman ward</td>
<td>286</td>
<td>22%</td>
<td>95%</td>
<td>91%</td>
<td>96%</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<td>100%</td>
<td>96%</td>
<td>94%</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>Oxenford ward</td>
<td>219</td>
<td>20%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>98%</td>
<td>100%</td>
<td>100%</td>
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<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Creedy ward</td>
<td>211</td>
<td>41%</td>
<td>98%</td>
<td>99%</td>
<td>100%</td>
<td>98%</td>
<td>96%</td>
<td>90%</td>
<td>95%</td>
<td>100%</td>
<td>94%</td>
<td>92%</td>
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<td>97%</td>
</tr>
<tr>
<td>Taw ward</td>
<td>187</td>
<td>10%</td>
<td>99%</td>
<td>99%</td>
<td>97%</td>
<td>95%</td>
<td>100%</td>
<td>90%</td>
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<td>95%</td>
</tr>
<tr>
<td>Bothenham ward</td>
<td>151</td>
<td>69%</td>
<td>99%</td>
<td>99%</td>
<td>95%</td>
<td>100%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>92%</td>
<td>92%</td>
<td>92%</td>
<td>92%</td>
<td>92%</td>
<td>92%</td>
</tr>
<tr>
<td>Acute medical units</td>
<td>130</td>
<td>14%</td>
<td>99%</td>
<td>99%</td>
<td>97%</td>
<td>95%</td>
<td>100%</td>
<td>97%</td>
<td>97%</td>
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<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
</tr>
<tr>
<td>Culm East ward</td>
<td>123</td>
<td>20%</td>
<td>98%</td>
<td>96%</td>
<td>96%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>88%</td>
<td>94%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
</tr>
</tbody>
</table>

1. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above).
2. Sorted by total response.
3. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)
Emotional support

Patients were given appropriate and timely support and information to cope emotionally with their care, treatment or condition. Feedback messages on cards displayed on the notice boards on every ward provided evidence of how patients appreciated the support the staff had provided. Patients expressed their gratitude for example for the “support of the whole team”. Numerous cards thanked the staff for “supporting them through their stay” in hospital.

Patients and their relatives were advised how to find other support services. Information about support services and support groups for various specialities were displayed and available on all the wards. Information provided contact details and information about various locations in the community where help and ongoing support could be accessed. Chaplaincy support was available within the hospital when required.

The mental health liaison team supported patients and staff when required.

Clinical specialist nurses visited patients on the wards to support them emotionally with their conditions and care and treatment. For example, the diabetes specialist team and the learning disability team.

Understanding and involvement of patients and those close to them

Staff communicated with people so that they understood their care and treatment. We observed that on ward rounds the consultants communicated effectively with patients. Patients we spoke with told us they were given all the information they needed about their care and treatment. We were told they felt they were kept well informed and in a timely way.

We observed nurses explaining discharge arrangements to patients and ensuring they were clear about where and when they were leaving the ward. One patient we spoke with who was leaving later that day told us how the nurse and a pharmacist had explained exactly what their medication was and for any side effects they needed to be aware of.

When required speech and language therapists worked with relatives to develop communication strategies for patients who had experienced a stroke. This helped families understand how they could communicate with patients receiving treatment and helped them to plan for their discharge.

All clinical areas had access to picture boards and other communication aids. Interpreting services were available to staff when these were required. This ensured patients could get the information they required.
Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people. Where shortfalls were identified action was planned or being taken to address the issues.

Average length of stay

Trust Level

From July 2017 to June 2018 the average length of stay for medical elective patients at the trust was 5.9 days, which was similar to the England average of six days.

Average length of stay for elective specialties:

- Average lengths of stay for elective patients in general medicine and cardiology were similar to the England averages.
- Average length of stay for elective patients in clinical oncology was shorter than the England average.

Elective Average Length of Stay – Trust Level

![Average Length of Stay Graph]

*Note: Top three specialties for specific trust based on count of activity.*

For medical non-elective patients, the average length of stay was 6.9 days, which was similar to the England average of 6.3 days.

Average length of stay for non-elective specialties:

- Average lengths of stay for elective patients in general medicine and geriatric medicine were longer than the England averages.
- Average length of stay for elective patients in clinical oncology was shorter than the England average.
Non-Elective Average Length of Stay – Trust Level

Royal Devon and Exeter Hospital (Wonford)

From July 2017 to June 2018 the average length of stay for medical elective patients at Royal Devon and Exeter Hospital (Wonford) was 5.5 days, which was similar to the England average of six days.

- Average lengths of stay for elective patients in general medicine and clinical oncology were shorter than the England averages.
- Average length of stay for elective patients in cardiology was similar to the England average.

Elective Average Length of Stay - Royal Devon and Exeter Hospital (Wonford)

For medical non-elective patients, the average length of stay was 6.8 days, which was similar to the England average of 6.3 days.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine was longer than the England average.
- Average length of stay for non-elective patients in clinical oncology was shorter than the England average.
- Average length of stay for non-elective patients in geriatric medicine was similar to the England average.
Non-Elective Average Length of Stay - Royal Devon and Exeter Hospital (Wonford)

Note: Top three specialties for specific site based on count of activity.

Referral to treatment (percentage within 18 weeks) - admitted performance

From September 2017 to August 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was worse than the England average in 10 out of 12 months.

<table>
<thead>
<tr>
<th>Month and year</th>
<th>Trust score</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 2017</td>
<td>84.3%</td>
<td>89.1%</td>
</tr>
<tr>
<td>October 2017</td>
<td>89.9%</td>
<td>88.9%</td>
</tr>
<tr>
<td>November 2017</td>
<td>87.6%</td>
<td>88.2%</td>
</tr>
<tr>
<td>December 2017</td>
<td>90.1%</td>
<td>89.4%</td>
</tr>
<tr>
<td>January 2018</td>
<td>85.5%</td>
<td>88.3%</td>
</tr>
<tr>
<td>February 2018</td>
<td>83.7%</td>
<td>88.0%</td>
</tr>
<tr>
<td>March 2018</td>
<td>84.4%</td>
<td>88.9%</td>
</tr>
<tr>
<td>April 2018</td>
<td>82.9%</td>
<td>88.0%</td>
</tr>
<tr>
<td>May 2018</td>
<td>85.1%</td>
<td>89.3%</td>
</tr>
<tr>
<td>June 2018</td>
<td>82.9%</td>
<td>88.7%</td>
</tr>
<tr>
<td>July 2018</td>
<td>84.6%</td>
<td>89.2%</td>
</tr>
<tr>
<td>August 2018</td>
<td>88.7%</td>
<td>90.0%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

From September 2017 to August 2018 the trust performed better than the England average for admitted RTT (percentage within 18 weeks) for seven out of eight medical specialties.
### Specialty grouping

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medicine</td>
<td>100.0%</td>
<td>96.6%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>100.0%</td>
<td>96.9%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>99.7%</td>
<td>93.4%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>99.6%</td>
<td>93.7%</td>
</tr>
<tr>
<td>Neurology</td>
<td>98.8%</td>
<td>90.9%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>97.7%</td>
<td>94.7%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>87.2%</td>
<td>82.0%</td>
</tr>
</tbody>
</table>

The only specialty where the trust performed worse than the England average for admitted RTT was cardiology:

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>67.4%</td>
<td>81.9%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

### Patient moving wards per admission

The trust supplied data for the two reporting units in medical care with the largest numbers of ward moves for the 12 months from June 2017 to May 2018. These were the two acute medical units. Of the patients on these two wards, 31.9% did not move wards during their admission, and 68.1% moved once or more.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

### Patient moving wards at night

From June 2017 to May 2018, there were 1,787 patient moves at night on medical wards. The highest numbers of ward moves were reported in January 2018 (201), May 2018 (199) and December 2017 (182). Additionally, 28 moves at night were reported for the trust’s renal dialysis units and were clinically justified.

The highest numbers of patient ward moves at night over this period were reported for the two acute medical units, west (737) and east (636) and the medical triage unit west (110).

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

### Meeting people’s individual needs

Care and treatment was consistently delivered with consideration of patients’ individual needs, including those in vulnerable circumstances.

Staff were provided with guidelines, policies and procedures to meet the additional needs of patients attending the hospital.

The mental health liaison team saw patients on the ward and offered guidance and support to staff when necessary.
Staff at all levels of clinical responsibility demonstrated a consistent focus on dementia awareness and provided care tailored to the needs of people living with the condition. All staff received training in dementia and delirium. On Bolham ward we saw staff communicating with sign language and lip reading. Several staff members had learnt basic sign language to aid communication. Action had been taken to make the environment on wards and departments more user-friendly, where this was possible, for patients living with dementia. For example, there were limited posters displayed through some corridors, with information concentrated in certain areas. Staff also had a supply of books, which they could use for reminiscence and reassurance for patients living with dementia. The noticeboards on wards provided information to patients and staff about dementia care. For example, we saw information on communicating with people living with dementia and details of community support groups for patients and their carers.

On Lowman ward, which was primarily an endocrine ward, they also specialised in treating patients with eating disorders. There were care plans and guidance to best meet these needs. This included clear escalation guidance for managing behaviours, close supervision of meal times and other patient routines. Patients were seen at least two to three times a week, unless their compliance with treatment required them to be seen daily. We saw that clear clinical pathways were recorded in the patient notes and detailed records of all monitoring that was being completed. There were arrangements to transfer, if required, very complex patients to national centres. Whilst staff were providing a high standard of personalised and specialist treatment, the ward staff expressed a desire to receive more training in how to work with people with eating disorders. Staff felt this would enable to build on the practice that had been established.

Training regarding learning disabilities was available from the learning disability liaison service on request. The learning disability liaison team were proactive in facilitating admissions for people with a learning disability. They would contact the person and their carers prior to admission, and arrange a site visit, if this was considered to be of potential benefit to the patient. They would liaise with the admitting service to ensure adjustments had been made and would accompany the individual if required. They were available to provided support and advice to staff looking after the patient after admission. The team provided a link with community learning disability services. All clinical areas had access to picture boards and other communication aids. Interpreting services were available to staff when these were required.

**Access and flow**

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

We found the trust had been proactive in making improvements to the access and flow of patients. Action had been taken to improve the flow of patients on their respective pathways, avoid admission where appropriate and possible, and improve the coordination of patient discharge.

The trust had undertaken an analysis of the winter pressures experienced over 2017/18, which included what worked well and plans for the next winter. There was a winter plan for this year. The aim of the winter plan was to reduce the pressures on beds. Initiatives had been introduced to promote and facilitate prompt, and in some cases early discharges.

The new refurbished acute medical unit had a seated triage area for ambulatory patients. The new system had resulted in increased numbers of patients being treated without being admitted to the wards. For example, on the day we visited, the senior nurse told us that at least eight patients had
been discharged who previously may well have been admitted. Consultants and nurses, we spoke with were very positive about the process and the teamwork that was making this effective.

Once a week a matron from each ward attended a meeting with the bed flow co-ordinator to discuss all patients that had been longer than seven days after being declared medically fit. This enabled any issues beyond the scope of the ward staff to be escalated and addressed, if this was possible. Ward staff told us this was a positive and supportive process.

There were thrice daily bed meetings attended by representatives from all medical wards. These were coordinated by the site management team and the duty site manager. This ensured there was always oversight of the flow and occupancy of the wards at a senior level.

We observed a number on board rounds on different wards and saw that discharge was discussed and planned for all patients. Nursing staff were working closely with the occupational therapists, physiotherapists, discharge team and families to ensure patient were being discharged safely and with as little delay as possible. We saw that the reasons for a delayed discharge were clearly identified and recorded. Delays beyond the control of the ward were, funding for community placements, the availability of community hospital beds and the availability of complex care packages in parts of the community.

The trust had employed two nurses as “trusted assessors”. These staff had been in post for just under a year at the time of the inspection. These nurses completed care assessments on elderly patients, using a standardised assessment format that had been agreed in conjunction with nursing homes in the community. This system saved the need in some cases for nursing homes to complete their own assessments, and could improve discharge waits. There were plans to expand this process, if it was sustainable, to include care assessments for residential homes as well. Based on the learning from the process so far, the reduced average stay was 5.3 days.

The acute medical unit had a consultant meeting every morning at 8.30am, with other specialist consultants, to inform them where patients were across the hospital. All these outliers were then seen by one of these consultants every day.

Every patient had a treatment escalation plan and resuscitation decision record completed on admission. This also confirmed that the patient had discussed this, and if relatives had been told. The original copy of these documents accompanied the patient and a copy placed in the medical notes. In general discharge planning was always high up on the list of priorities as the staff continuously worked on patient flow. There was not a discharge ward, as with this system of follow up, patients could usually be discharged straight to home. Early review in the day meant this was easier to organise.

There had been delays in accessing cardiology services patients due to increased demand. The trust had acted and there was a recovery plan. This was being monitored through the governance system and was on the divisional and corporate risk register. This included recruitment of new staff to increase capacity and the investment in new equipment. Monthly reports were also being sent to the safety and risk committee. A temporary modular catheter lab was due to come into service in February 2019, it was planned for this to be used for three to four months. A catheterisation laboratory, or catheter lab, is an examination room with diagnostic imaging equipment used to visualize the arteries of the heart and the chambers of the heart and treat any stenosis (narrowing) or abnormality found.

In cardiology a few patients required coronary artery bypass surgery, which cannot be done percutaneously, and these patients were referred mostly to Plymouth, but had the choice to go elsewhere, for example to Bristol or London for treatment. From there they were usually discharged home.
The trust had worked on an improved winter plan to cope better with the increased demand for services during period of bad weather or other emergencies. Each speciality had been asked to consider what improvements could be made and if required put in a funding bid. Staff were well informed of the plan and contingency arrangements, and the access and flow for patients was being effectively managed. This was done by the flexing of staff, the managing of any patient outliers and the new process for triaging patient through the acute medical unit. The work being done around admission avoidance with community teams and the improved working around joined up approaches to discharge were also having a positive impact. For example, the single point of access team, staffed by the local authority staff were now based on the trust site, this had helped particularly with complex discharges. The use of the trusted assessors for patients ready to be discharged to a nursing home was also having a positive impact.

Another new service which was contributing to admission avoidance was an advice and guidance line for local GPs. They could send in a question and were assured of getting a response within 48 hours.

Appropriate discharge arrangements were used for people with complex health and social care needs, however, there was a shortage of appropriate mental health beds in the community. All clinical areas had access to the psychiatric liaison team or the on-call psychiatrist and juniors. This cover was provided 24/7. However, the learning disability liaison service was only available during office hours. Discharge could be a challenge for people with complex mental health and/or learning disability needs. There were no specific placements for older people with learning disabilities, these patients were expected to attend normal residential homes registered for older people.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. Details of the trust complaints policy was on display in all clinical areas. Information was displayed on wards and departments and included in a patient information pack on how to make a complaint.

Concerns and complaints were used as an opportunity to learn and drive improvement.

Senior nursing staff told us how learning form complaints was shared through staff meetings and safety briefings and cascaded through the minutes from governance and other divisional meetings. We were told of two examples, one about communication over discharge arrangements and one about medication, were learning had been disseminated. We also saw that appropriate feedback was provided to the complainant.

The medical division had made improvements in the timeliness of responding and dealing with complaints, but was still outside the trust target of 35 days for standard complaints and 45 days for more complex ones. The average time has risen from 63% to 70% in the most recent quarter. The division stated a target of closing 90% of all complaints within the target figure.

Summary of complaints

From June 2017 to May 2018 the trust received 52 complaints about medical care. For the 41 complaints that had been closed at the time of data submission, the trust took an average of 63.6 working days (mean) to investigate and close these complaints. This was not in line with their complaints policy, which states complaints should be responded to within 45 working days.
The 11 complaints that had not yet been closed had been open for an average of 59.1 working days at the time of data submission. This was also not in line with the policy statement that complaints should be responded to within 45 working days.

The breakdown by subject can be seen in the table below.

<table>
<thead>
<tr>
<th>Subject</th>
<th>No. of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care</td>
<td>13</td>
</tr>
<tr>
<td>Clinical treatment</td>
<td>11</td>
</tr>
<tr>
<td>Communications</td>
<td>10</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>7</td>
</tr>
<tr>
<td>Prescribing</td>
<td>3</td>
</tr>
<tr>
<td>End of life care</td>
<td>2</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>1</td>
</tr>
<tr>
<td>Mortuary</td>
<td>1</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>2</td>
</tr>
<tr>
<td>Other (specify in comments)</td>
<td>1</td>
</tr>
<tr>
<td>Admin/policies/procedures (including patient record)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>52</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From June 2017 to May 2018 the trust received 79 compliments about medical care. The trust did not provide a breakdown by subject for compliments received.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

The leadership of the medical division had the necessary skills, knowledge and integrity. Their vision and values reflected the vision and values of the trust. They encouraged openness and transparency, and promoted good care. All staff we spoke with spoke highly of the leadership and their visibility and approachability. Staff told us they were listened to and responded to when they raised concerns or issues.

There was a clear management structure, and clear lines of governance which were well understood by staff. Ward matrons led the nursing teams on the wards, and staff made positive comments about this leadership across all the medical wards. We were told, and observed, that business and clinical managers had a regular and responsive presence on the wards. All staff we spoke with told us that managers were friendly and helpful.
Staff we spoke with were aware of the trust whistleblowing policy and how they could access the details of this. Staff also told us that they would be confident in speaking up about concerns and issues when they arose.

Vision and strategy

The trust had a clear vision and a set of values and these were well promoted through the hospital.

An identified risk around staffing had promoted the strategy of overseas recruitment. A number of nurses had already been recruited, with more to follow over the next months.

The medical division had a clear set of objectives and targets around performance and the improvement of care. These included the delivery of the cardiology recovery plan, nurse recruitment and the development of the clinical pathway in conjunction with other providers for services such as stroke care and, acute medicine.

The service had a mental health strategy appropriate for patients with mental illness that is approved by the Board and reviewed annually.

The Trust had a very strong mental health strategy driven by the Trust’s Medical Director. The board annually approved the mental health strategy, however, the director had an aspiration to move away from having a separate mental health strategy, in favour of mental health being present within the strategy for all clinical areas.

The Trust was working closely with a neighbouring mental health trust and was jointly enrolled onto a national quality improvement program. There was a Service Level Agreement with this trust for mental health liaison and Mental Health Act management. They also provided psychiatric liaison and Learning disability liaison services. The liaison team offered assessments and advice across the acute hospital site.

Culture

There was a positive culture in the hospital. Staff felt staff supported, respected and valued. Staff told us they were proud to work for the trust. The culture encouraged candour, openness and honesty.

Staff we spoke with said worked well together with their immediate colleagues and their wider teams. We were told departments and services worked well together.

The senior management of the medical division spoke highly of staff team across all the specialities. They were proud of the commitment and positive approach of the staff in all roles and different services.

Staff in all areas told us they could raise incidents and were confident action would be taken, and they would be listened to.

The majority of staff we spoke with said they felt morale was high, though many were concerned the shortage in some areas of nursing staff. Staff told us they thought the trust was doing all it could to address and manage this issue. Staff said they enjoyed working in the hospital. One example was the acute medical unit. In the acute medical care unit, the staff had a strong sense of belonging,
and were very positive about their work. The nursing leaders told us the senior management staff were visible and approachable and that they knew who all the executive team were. The unit was consultant led with enthusiasm. The consultants were proud of what they have achieved in improving the flow through the emergency department to the acute medical unit and to wards, or discharge. The junior doctors had also been involved in these quality improvement projects. We were told the consultants were seen as role models.

Also, staff on the haematology ward and day-case unit were very enthusiastic about their roles, and the way they all worked as a team.

**Governance**

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. These were regularly reviewed. There was a structure that ensured all levels of governance and management functioned effectively and interacted appropriately. Staff at all levels were clear about their roles and understood who they were accountable to and what they were accountable for.

There was a divisional governance group that met monthly, chaired by the associate medical director, and this was attended by clinical and operation staff form all specialities. These meetings cover a wide range including learning form serious incidents and complaints. There were also regular specialty governance meetings that fed into this meeting. Both meetings would review and update any issues relating to the speciality or divisional risk register.

**Management of risk, issues and performance**

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

There were effective systems and preparations to manage the effects on services due to adverse weather, disruption of utility services or other unpredicted factors. The winter plan had been reviewed and updated. This identified potential increased risks such as seasonal and pandemic flu, increased demand for emergency care, reduced staffing levels and the cancellation of elective admissions. Staff we spoke with were well informed of the winter plan and the actions that were being taken.

The trust had an established "emergency preparedness” plan which was linked to all service provision, including the community hospitals. Plans would be co-ordinated with other statutory authorities.

The divisional governance meetings reviewed the divisional risk register, as did the speciality governance meetings. We saw that the current risk register had identified risks and mitigating actions. These were being regularly reviewed and updated. For example, a risk identified in cardiology of “patients with heart failure” had actions to improve the situation. For example, a proposal had been developed to enhance the service in line with NICE guidance and funding application submitted.
**Information management**

Information was handled correctly, with respect for confidentiality and in line with data management protocols. Information governance was part of the trust’s mandatory training programme.

Personal information relating to individual patients was on display in public areas of some wards on the whiteboards, but this did not have confidential information regarding diagnosis.

Staff knew how to find information they needed and all had access to the trust intranet system, where they could locate policies and procedures and care pathways. Computers were password protected and not left on when unattended. This ensured confidential information stored electronically was secure.

**Engagement**

Patients and staff views and experiences were gathered and acted on to shape and improve the services and culture.

Patients were asked to provide their feedback through the NHS Friends and Family Test. From October 2017 to September 2018 the Friends and Family Test (FFT) response rate for medical care was 19.1%, based on 3,780 responses. This was lower than the England average of 25%. With the exception of the acute medical units, all wards scored over 90% in terms of patient satisfaction for the most recent 12 month period.

Wards displayed action and ideas that had been initiated following suggestions from staff. Staff we spoke with told us they were encouraged to suggest ideas for improvement and these would be listened to and considered.

The trust responded to staff engagement feedback and took appropriate action. The trust had an Engagement Steering Team, which had representatives from across the trust, including matrons, business partners and governors. In the most recent staff survey the trust had scored above the national average for prioritising the health and wellbeing of staff. However, some staff had raised concerns about stress and the trust had acted in response to this. An increased range of health and wellbeing services were being developed. Increased mental health support and training was being made available for managers and staff. This included training, stress awareness courses, mental health champions and staff away days.

**Learning, continuous improvement and innovation**

There were systems to support improvement and innovation work. We saw evidence that leaders and staff strived for continuous learning, improvement and innovation. Standardised improvement tools and methods were available and used by staff.

Examples included the changes and improvements made to the acute medical unit. These had been made in a relatively short space of time and implemented through good teamwork and planning. Improvements to the effective triaging of patients and the avoidance of potential unnecessary admissions had been two identified improvements. The implementation of the “flying squad” of consultants, who reviewed all medical outliers daily, after meeting in the acute medical unit, was
another identified improvement. Medical outliers being seen early in the day was having a beneficial effect on discharge arrangements.

The respiratory service had started a one stop referral clinic for patients with pleural effusions, where consultation and investigation could be carried out in a single visit. This helped patients cut down on appointment visits to the hospitals. At one visit a patient could complete a range of tests and have the necessary consultation completed.

There was a process to support the early discharge of patients diagnosed with chronic obstructive pulmonary. This support helped prevent readmission for some patients.

Improvements had been made to the cardiology service to respond to the increased demand for clinics and treatment. In March 2019 a nurse led rapid access clinic was due to open.

Renal Services

Facts and data about this service

The Royal Devon & Exeter NHS Foundation Trust provides renal services for a population of around 1.2 million people across Exeter, North Devon, East Devon, Torbay and much of Somerset. Renal transplants are not provided by the trust, with these patients either going to Bristol or Plymouth, but care and treatment is provided before and immediately after transplant. The trust has four haemodialysis units. These are based at Honiton (East Devon), Heavitree (Exeter), Torbay (South Devon) and Wonford (Exeter). They also provide input into two other dialysis units, one in Somerset and the other in North Devon, but these are run and managed by private providers.

The renal unit treats patients with:

- Acute kidney failure
- Chronic kidney failure
- Haemodialysis or peritoneal dialysis needs
- Kidney transplants
- Other kidney diseases needing specialist input

Creedy ward at the Royal Devon & Exeter Hospital (Wonford) is a 26-bedded renal inpatient and emergency dialysis ward. The haemodialysis unit has regular patients and provides treatment for inpatients. New patients to haemodialysis are also referred here until they are stable. Haemodialysis involves diverting blood into an external machine, where it is filtered before being returned to the body.

The dialysis units provide haemodialysis treatment closer to home for patients suffering from end stage renal failure. The service provides haemodialysis treatment six days a week. There are three shifts available per day including AM, PM and twilight. The haemodialysis service is provided by qualified nurses and other staff who have completed additional training, for example assistant practitioners and heath care assistants. This is under the supervision of consultant nephrologists. A home haemodialysis service is provided with ongoing support and training for patients who use this and for those who wish to start.
Peritoneal dialysis was another option offered to patients. Peritoneal dialysis is a type of dialysis which uses the peritoneum in a person’s abdomen as the membrane through which fluid and dissolved substances are exchanged with the blood. It is used to remove excess fluid, correct electrolyte problems, and remove toxins in those with kidney failure. Patients could choose from two systems: Continuous Ambulatory Peritoneal Dialysis (CAPD) and Automated Peritoneal Dialysis (APD).

CAPD happens throughout the day, at home or at work, while the person goes about their daily life. Between 1.5 and three litres of fluids are run in four times a day, exchanging the fluid from the previous exchange. This takes about 30-40 minutes.

APD is a treatment in which the dialysate solution is changed by a machine, at night, while a patient is asleep. The machine will exchange eight to 12 litres over eight to 10 hours and then leave one to two litres to dwell during the day. The renal service provided an Assisted Peritoneal Dialysis programme where community staff could support patients at home with setting up the machines.

During our inspection we spoke with 11 patients. We met with 33 staff in various roles, including directorate leads, senior managers, consultants, doctors, nurses, healthcare assistants, allied healthcare professionals and domestic staff. We received feedback cards from 10 patients about Honiton dialysis unit and 14 about Heavitree dialysis unit. We observed interactions between patients and staff in different wards and departments. We reviewed 15 patient records and attended a board round (a daily multidisciplinary staff meeting) on Creedy ward.

This is the first time renal services have been inspected by the Care Quality Commission.

The trust sent us the following facts and data about renal services for the year 2018:

- The renal services saw 3,943 patients.
- 870 patients were receiving haemodialysis across all their dialysis units.
- 24 patients were using home haemodialysis.
- 107 patients were having peritoneal dialysis (this includes both CAPD and APD).
- 51 patients received a kidney transplant.

**Is the service safe?**

**Mandatory training**

The service provided mandatory training in key skills to all staff and made sure everyone completed it. The trust had a programme of mandatory training and updates for all staff to complete. This included information governance, infection control, moving and handling and fire safety.

The figures below from the trust showed staff within the renal services were compliant with the trust’s mandatory training programme. Staff confirmed they could access mandatory training and usually had time to complete this, although at times it was difficult due to workload.

The trust set a target of 75% for completion of all mandatory training modules.

The trust sent us details about their mandatory training courses as of January 2019 for all staff across the trust’s renal services. There was an overall training compliance rate of 94.2%. The 75% target was met for all 19 mandatory training modules. These included infection prevention and control, fire safety, equality and diversity, and food safety.
Staff received effective training in safety systems, processes and practices. Staff had undertaken basic life support training every year to help them manage any emergencies. At Heavitree dialysis unit there were plans to start introducing emergency scenarios based in their environment to support this training for staff. This was planned to start following our inspection.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Safeguarding systems, processes and practices had been developed, implemented and communicated to staff to keep patients safe. The trust had a safeguarding policy that all staff were aware of and knew how to access. Staff could tell us about the different forms of abuse and when they would make a safeguarding referral. Staff were aware of the process they needed to follow to report safeguarding concerns to make sure patients were protected from abuse.

There were arrangements to safeguard adults from abuse and neglect that reflected relevant legislation and local requirements. Staff understood their responsibilities, adhered to safeguarding policies and procedures, and worked with other agencies when required. The trust had a safeguarding lead who could support and advise staff on safeguarding issues. Staff told us they knew how to contact them.

Staff received training in safeguarding systems, processes and practices. Most staff had completed safeguarding training for both adults and children.

The trust set a target of 75% for completion of safeguarding training.

Renal services had a score of 97.6% for child protection level two training and for 96.4% for safeguarding adults. The trust’s data did not confirm what level safeguarding training was provided for adults.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. Staff used control measures to prevent the spread of infection. Standards of hygiene and cleanliness were maintained to protect patients from the risk of infections. The dialysis units, renal day case unit (Sid ward) and Creedy ward were visibly clean and tidy.

In all the dialysis units there was sufficient space for staff to access patients from both sides of the chair or bed, but at Wonford staff had less space to do this. Each dialysis area had disposable or material curtains which could be drawn to protect patients’ dignity. These were all marked with the date they were last changed and were pushed back when not in use. Curtains were changed every six months according to staff, unless they became contaminated and required changing immediately. We saw on curtains dates when these were last changed. This was done by the domestic staff. This was also the same for the renal day case unit (Sid ward) and Creedy ward. Staff disposed of linen such as pillow cases and sheets between each patient and cleaned the dialysis station, bed space or side room ready for the next patient.

The reclining dialysis chairs used in the dialysis units were of a wipe clean material. Staff told us how they cleaned dialysis machines between patients using specialist wipes. We observed this at all dialysis units. Each machine had its own disinfection cycle, which took place between patient use. We observed this taking place.

When other equipment had been cleaned ‘I am clean stickers’ were placed on the items, with the date they were cleaned.
The flooring in the dialysis units, renal day case (Sid ward) and Creedy ward was in good condition and visibly clean.

The dialysis units had several isolation rooms for patients with infections or who had compromised immunity, in line with the recommended requirements set out in the Health Building Notes 07-01 (2013). They also had spare dialysis machines and could therefore isolate a machine for a patient with a blood borne virus as required. These isolation rooms were accessible from the main dialysis area and had viewing windows for staff to be able to observe the patient without necessarily having to go into the room. Creedy ward also had side rooms used to isolate patients who were known to be infectious or patients who were waiting for results from tests to check if they had an infection.

Staff adhered to infection, prevention and control policies and procedures. We observed effective use of personal protective equipment, including face protectors, and effective handwashing. Staff had access to personal protective equipment around the ward and the units. Handwashing sinks were provided by each station in the dialysis units, except in the Wonford site, and in the bays and side rooms on Creedy ward and the renal day case unit. Staff were bare below the elbow to ensure effective and thorough cleaning of their hands between patients.

Staff were trained and their competencies assessed in relation to aseptic non-touch techniques for the management of dialysis vascular access. Aseptic non-touch technique (ANTT) is the method employed to maintain asepsis, protecting the patient from healthcare associated infections and staff from contamination from the patient’s blood, body fluids and toxic substances. Aseptic non-touch technique is a standardised approach that staff are taught to identify and protect the key parts of any procedure, perform effective hand hygiene, institute a non-touch technique and wear only the appropriate personal protective equipment. Staff told us and we saw evidence they received training in this and they had to have their competencies assessed before being able to undertake this task alone.

The latest hand hygiene results were on display in the staff room at Honiton dialysis unit. They scored 100% in December 2018 and 95% for November and October 2018. For Creedy ward, their January 2019 results were on display and they were at 95%. Their results from July to December 2018 ranged from 85% to 95%. From July to December 2018, the Heavitree dialysis unit scored 90% each month. For the Wonford dialysis unit and the renal day case unit (they were assessed together due to being near each other) between July and December 2018 their lowest score was 85% and their highest score was 95%. We did not see this information displayed. The trust did not tell us what their target was for compliance with their hand hygiene audits.

Cleaning audits provided by the trust demonstrated Creedy ward, the dialysis unit and the renal day case unit (Sid ward) were all meeting the trust’s target of 95% and over.

For patients using Continuous Ambulatory Peritoneal Dialysis (CAPD) or Automated Peritoneal Dialysis (APD), changes had been made to how the exit sites on patients’ abdomens were cleaned following a review of infections. Patients used a specialist cleaning wipe. Senior staff said they had seen a reduction in the number of exit site infections, but they had no audit results to confirm this as their audit was ongoing at the time of our inspection.

Standards of cleanliness and hygiene were maintained. Reliable systems had been developed to prevent and protect patients from healthcare-associated infections. Protocols for appropriate infection control practices had been devised. These included methicillin resistant Staphylococcus aureus (MRSA) and methicillin susceptible Staphylococcus aureus (MSSA) screening, blood borne viruses, no-touch aseptic technique and isolation rooms available with barrier nursing. Each patient on haemodialysis had monthly MRSA screening. The screening test
and result was recorded in the patients’ records. If a patient tested positive, they were provided with treatment and would have their dialysis in a side room to reduce the risk to other patients.

Heavitree dialysis unit had treated one patient with MSSA infection in the last 12 months. The MSSA had been attributed to a surgical site infection following a repair of the patient’s fistula and formation of a new fistula. A fistula is created for dialysis. The dialysis fistula is often referred to as an AV fistula. This stands for arteriovenous fistula, as it requires joining an artery to a vein. This is the preferred type of access for dialysis because this method has a low risk for blood clots or infections. Precautions were taken by staff to minimise the risks to other patients. Wonford dialysis unit reported one MRSA infection in 12 months. This was investigated and found to be attributed to a patient’s fistula. The renal day case unit (Sid ward) reported one case of MSSA in 12 months. Creedy ward reported one case of MRSA and one case of Clostridium difficile (C. diff), both were investigated and the C. diff was found to be unavoidable.

Staff followed procedures to assess whether patients were carriers of blood borne viruses (BBV), such as Hepatitis B and C. When a new patient commenced dialysis, they were screened for Hepatitis B and C and Human Immunodeficiency Virus (HIV). Following this, all patients were screened every three months for Hepatitis B and C and yearly for HIV unless indicated following a risk assessment it needed to be done more frequently. If a patient was identified as being infected with a BBV, staff were aware of the actions needed to prevent the risk of cross-infection. For example, staff told us a patient would be placed in a side room for their dialysis and if the infection was severe, a dedicated dialysis machine would be used and kept for that patient. Infection control procedures would be followed. Staff could access advice and guidance from the trust’s infection control lead if they were unsure how best to protect patients and staff from possible infection control issues.

Haemodialysis patients returning from holiday were screened for MRSA and BBV if they had visited a high-risk location. They were also screened for Carbapenemase-producing Entrobacteriaceae (CPE). This is bacteria which usually lives harmlessly in the human gut but can cause infection if it finds its way into another area of the body, for example the bloodstream.

One patient receiving haemodialysis had been diagnosed with CPE. They received their dialysis in one of the side rooms and a member of staff was allocated to provide care to this one patient during their treatment. Following their dialysis, the side room was deep cleaned. The dialysis machine underwent its disinfectant cycle and the outside was cleaned using specialist wipes.

Water used for dialysis was tested and specially treated to reduce the risk of contamination for patients. There was a large water treatment room at each dialysis unit. Technicians from the trust monitored the water supply and water testing was completed weekly to ensure water used during dialysis was free from contaminants. This was in line with national and manufacturer’s guidance on the monitoring of the quality of treated water and dialysis fluid. We saw the record log that recorded test results and these were all completed in full. The trust had a team of technicians who carried out maintenance within the water treatment plant.

Environment and equipment

The service had mostly suitable premises but these were dated in some places. The premises and equipment were looked after them well. The renal services at Royal Devon and Exeter Hospital (Wonford) consisted of Creedy ward, a 26-bedded ward where they could provide emergency dialysis, a renal day case unit (Sid ward) and a dialysis unit. Honiton and Heavitree dialysis units were classed as satellite units as they are away from the main site.
The renal day case unit (Sid ward) and Creedy ward were based in the older section of the hospital. In the renal day case unit, there were issues with peeling paint in some of the side rooms and damage to the door frames. Dry rot had also been found in some places. Staff told us that if there was an issue within the laundry area it had an impact on the first side room, for example it sometimes filled with steam and could not be used. There were seven side rooms, each with toilets.

On Creedy ward there was no natural light in Bay B due to the lack of a sky light and additional building at the rear of the bay. This made the bay appear very dark. We saw in the governance meeting records that funding had been requested to have a sky light fitted. There was a bay where haemodialysis could be undertaken, as well as several side rooms. As there was no water treatment plant close to the ward each machine could undertake its own water treatment. Senior staff told us they would benefit from a procedure room on the ward for out of hours and weekends. This would be used to fit vascular access and prevent staff having to go down to the renal day case unit and open it for this purpose, as this had an impact on the ward staffing numbers.

There was a handwashing sink located at each station in all the dialysis units, except for the Wonford site where there was on sink in the main area.

Storage of equipment was at times an issue for the Wonford unit. Recycling chairs were stored in the middle of the main dialysis area and this reduced the amount of space when patients arrived for treatment on hospital beds. Other equipment was stored by the side rooms because of lack of storage space which limited space and at times it looked like it made accessing the side rooms difficult.

Each dialysis station had a nurse call bell so patients could summon assistance from the nurse if needed. There were also weighing scales at the unit to weigh patients prior to and after their treatment.

Security systems at Honiton Hospital where one of the dialysis units was based were under consideration to ensure the safety of staff and patients. The estates department and trust health and safety representatives were aware the alarm systems used during working hours, which had been suitable previously, were no longer appropriate. This was because there were no longer inpatient beds at this location. The trust was aware the emergency bell system did not alert neighbouring areas when it sounded. A risk assessment had been completed and the trust had identified ways to manage the risk, for example always having two members of staff on duty.

The current alarm systems could not ensure patient safety. The trust told us that loudspeaker telephones in the hospital were available to contact other areas directly. However, staff told us this system was only effective if they could get to the telephone during an incident. The local police service was aware of the current issue and responded promptly to any calls.

This issue was not recorded on the trust risk register, despite the February 2018 Health and Safety report recommending the trust review the effectiveness of current security control systems to include a staff panic alarm.

The units had emergency equipment in case of medical emergencies, which was in accordance with national guidance (Resuscitation Council, 2015). This included automated defibrillators, which staff were trained to use. All staff were trained in basic life support and for the satellite dialysis units, there was a procedure for them to follow to obtain additional medical support if required. At the Wonford site, the dialysis unit, Creedy ward and the renal day case unit had access to urgent medical advice and support via specific telephone numbers.

Resuscitation trolleys were checked in line with trust policy. Daily and weekly checks were completed. Records were completed to confirm checks had taken place and the trolley was safe to
use. These were mostly complete, except at the Heavitree site where several days in the week leading up to the inspection had been missed. We also saw at the Wonford site that if the trolley had been used it was checked for equipment and the log book signed to confirm this. The emergency trolleys were stored in accessible areas.

**The arrangements for managing waste kept patients safe.** We observed on the units, and on Creedy ward, how staff disposed of waste. All waste bags were colour-coded and labelled, for example yellow for clinical waste and black for everyday waste. Some waste could be recycled and staff told and showed us where this was stored. Waste was taken to collection points on the units and the ward to be collected and disposed of.

Arrangements for managing linen kept patients safe. Any linen contaminated with bodily fluids was placed in a specialist bag which could be placed straight into the washing machine.

Sharp bins of different sizes were provided to make sure any sharp objects, for example needles, were disposed of safely. Once full, sharp bins were placed in the waste disposal rooms to be taken away with the waste. The sharp bins we observed in use were labelled as directed and not over full.

**The maintenance and use of equipment kept patients safe.** All staff were trained to use the dialysis machines and medical equipment, and their competency assessed. At the Heavitree and Wonford units there were three different types of dialysis machine in use. This was due to an ongoing machine replacement programme and because one of the manufactures was going to stop making replacement parts in the next two years. Staff told us they had received training from the manufacturers on the new machines and had to complete their competency assessment before using them alone. This ensured all staff were competent and could safely use the machines provided at the unit to keep patients safe.

Staff attended all alarms promptly and dealt with any problems which arose. During the inspection we saw dialysis machine alarms were responded to within a few seconds. Alarms would sound for a variety of reasons, including sensitivity to a patient’s movement, blood flow changes and any leaks in the filters.

Technical staff were employed by the trust to manage and maintain the equipment. They maintained records for the annual servicing of equipment. The technical staff also carried out repairs on the dialysis machines and attended the unit for faults or breakdowns. They also provided an on-call service for weekends and bank holidays.

A programme for servicing dialysis machines had been implemented. Records were maintained of when each dialysis machine had been serviced or had broken down and required a repair. There was an ongoing replacement programme for the dialysis machines. Thirty-one new dialysis machines had been purchased and were in use, with plans to purchase more over the coming years.

Each unit had spare dialysis machines which could be used if a machine stopped working. These had been prepared and were ready to be used. This ensured there was no disruption to the service for patients in the event of equipment failure.

Staff were aware of the escalation process for the reporting of faulty equipment to ensure patients did not experience delays or had sessions cancelled. One machine at Heavitree became faulty during our inspection and following advice from the technical staff was taken out of service to be repaired.

All dialysis sets for the machines were single use and were CE marked (CE marking defines how the equipment met the health, safety and environmental requirements of the European Union). All single use equipment was labelled accordingly and disposed of after use.
The units and the ward had equipment suitable for bariatric patients. This included recycling chairs which could take weights of up to 180kg and beds which could take weights up to 200kg.

**Assessing and responding to patient risk**

**Staff did not always complete and update risk assessments for each patient but kept clear records and asked for support when necessary.** There were systems to assess and manage patient risks, but records did not always demonstrate this. Staff had access to risk assessments, but these were not always completed and reviewed on a regular basis. Senior staff told us they would not complete all available risk assessments for haemodialysis patients if these were not required, for example for pressure ulcers if the patient had told them they had no skin issues.

Falls risk assessments were not completed for all patients attending the dialysis units, as this was dependent on individual health and fitness levels. Staff used their discretion over these. Where these had been completed, we did not see any evidence of ongoing reviews. For example, one patient at Heavitree dialysis unit had a fall but their risk assessment had not been reviewed or updated to show this. However, this patient’s ongoing records were up to date and provided detail about any concerns or problems the patient had experienced.

Patients on Creedy ward had all their risk assessments completed and there was evidence of risk assessments being reviewed. For patients using the Wonford unit who were inpatients, they came with their inpatient nursing and medical records for staff to update.

**Staff identified and responded to changing risks to patients who used services, including deteriorating health and wellbeing, medical emergencies or challenging behaviour. Staff could seek support from senior staff in these situations.** Effective policies and procedures were available to support staff in managing a deteriorating patient. The trust was in the process of introducing the updated National Early Warning Score 2 (NEWS 2). Staff told us they had undertaken or were undertaking on-line training. NEWS 2 is based on a simple scoring system in which a score is allocated to six physiological measurements: respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness. NEWS 2 is used to identify a deteriorating patient, including sepsis. Patients with a NEWS 2 of five or more are at serious risk of clinical deterioration and a poor clinical outcome, and need urgent assessment and intervention. Staff on the three dialysis units had exceeded the trust’s target for sepsis training.

We observed situations where staff responded appropriately. For example, on Creedy ward a patient had been admitted who was very confused and prone to walking around. Staff placed this patient in a bay where they could be observed and requested additional staffing to ensure their safety.

Patients who had reduced kidney function who were close to needing but were not receiving treatment had their blood results monitored on a frequent basis to check for further deterioration in their condition. This was to make sure when they needed a form of dialysis it was started quickly to prevent any delays.

On the renal day case unit (Sid ward), patients who had received a transplant were seen three times a week for the first month so they could have their blood tested. During our inspection, staff had concerns about one patient following their transplant and arrangements were made for additional tests and hospital admission. Staff on this unit had access to a medical registrar and could contact a consultant urgently if required. Patients were given an information leaflet called ‘After a Kidney Transplant’. This leaflet provided detailed information about medicines and feeling unwell. Information was also provided about who patients could contact if they had any concerns. Patients only received dialysis at the Honiton or Heavitree units if they were stable, not acutely unwell or...
requiring hospital admission. If a patient was unwell, they were admitted to hospital and received their dialysis either at the Wonford unit or on Creedy ward.

Staff were alerted to potential treatment issues. Staff could pre-set alarms on the haemodialysis machines to respond to pre-defined parameters as part of each patient’s treatment plan. We saw staff responded quickly when an alarm went off, reviewed the cause of the alarm and checked how the patient was feeling.

Patients had clinical observations recorded prior to, during and post their treatment session. This included blood pressure, pulse rate and temperature. Staff reviewed any variances prior to starting haemodialysis, to ensure the patient was fit for the session. Where necessary, staff could obtain medical advice. Staff on the Wonford unit could obtain medical support from the doctors on-site. For the other two dialysis units they were able to make contact on the telephone or via e-mail. If urgent staff would need to dial 999 and request an ambulance. Patients were monitored throughout their haemodialysis session. Staff recorded a patient’s weight, temperature, pulse and blood pressure prior to dialysis. If a patient was diabetic they also took their blood glucose level prior to and after each dialysis session. Staff used the patient’s observations and their knowledge of the patient to indicate if a patient was deteriorating.

To help staff identify patients, we observed them asking the patient their name and date of birth. This was compared to their dialysis prescription form. Inpatients on the Wonford unit or Creedy ward wore wrist bands which provided their personal details, which staff checked to confirm the patient’s identity.

Patients planning to use peritoneal dialysis completed a comprehensive training programme which emphasised the importance of infection control and hand washing. Patients were given advice about how to monitor for infection and who to contact if they were concerned they had an infection.

**Nurse staffing**

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. The dialysis units based their staffing levels on guidance set out by the Renal Workforce Planning Group 2002. The units used a ratio of one nurse to four patients, except for Wonford, which used one nurse to three patients due to their higher dependency. As well as qualified nurses, two of the units had unregistered staff trained in other skills to be able to take on more complex roles. These staff could take on some of the roles of qualified nurses. Each unit also had a mix of band two and three health care assistants who had different roles based on their grade to meet the needs of the patients.

Creedy ward was piloting the Shelford Safer Nursing Care Tool. The Safer Nursing Care Tool is a simple-to-use, evidence-based digital tool which calculates nurse staffing requirements based on the acuity and dependency of the patients on a ward, and is linked to nurse sensitive outcome indicators. Staff told us they assessed patients three times a day using this tool and it stated how many trained nurses were needed. They were working below the number recommended by this tool, on one day of our inspection the tool said they were 11 hours short of care. This was due to an unfilled shift for a qualified nurse. The ward was very busy and they had a patient who needed extra support but their relatives were present and helping the staff with this.

At night, Creedy ward needed three qualified nurses. Of these, two needed to be able to dialyse patients using the whichever dialysis method the patient was using. Senior staff said for the majority of the time they had these numbers but if for example, due to short term sickness this did not happen
one member of staff would be on call if needed to support the night staff. This was in case patients were admitted as an emergency at night.

The renal day case unit (Sid ward) was run by a band five nurse each day, supported by a health care assistant. The staff told us qualified nurses from Creedy ward worked on this unit and the band five nurse worked on the ward to enable them to cover the day case unit when the main band five nurse was on leave.

Each of the units and Creedy ward used trained and untrained bank staff. For the dialysis units, these tended to be staff who had worked previously on the unit but had retired or left. This provided better continuity of care for the patients and meant the staff maintained their competency levels.

Senior staff across the renal services told us they had a good retention of staff. Many staff had worked in their areas for many years. Staff told us they enjoyed working in renal services.

**Arrangements for handovers and shift changes ensured patients were safe.** At each shift change there was a handover meeting for staff coming on duty. Updates about each patient were discussed, including their condition. This handover also included information about patients coming in and any important safety information.

**Vacancy rates**

Vacancy rates in renal services were low. The trust provided details of their vacancies as of December 2018.

Nursing vacancies:
- Honiton dialysis unit – 0.4 whole time equivalent (WTE) band five.
- Heavitree – 0.87 WTE band six and 2.6 WTE band five.

Healthcare Assistant vacancies:
- Wonford – 0.62 WTE band five and 0.3 WTE band three.
- Creedy ward – no vacancies and over-recruited by two band two posts.

The renal day case unit (Sid ward) had no vacancies.

**Turnover rates**

Turnover rates were mostly within the trust’s target rate of between 10% and 12%. The Wonford dialysis unit was just above the target turnover rate.

From January to December 2018, the trust reported a turnover rate of 9.7% whole time equivalents on its Honiton dialysis unit. For Heavitree dialysis unit, this was 6.1% WTE. Wonford dialysis unit’s turnover rate for the same period was 15%. The turnover rate for the renal day case unit was 14%. However, this was due to one member of staff leaving due to the low number of staff employed in this unit. Creedy ward had a turnover rate of 10.1%.

**Sickness rates**

Sickness levels were variable across renal services, and at times higher than the trust’s target of 4%. From January to December 2018 the trust reported a sickness rate between 0.3% and 10.5%. Honiton dialysis unit had the highest rate of 10.5% in January 2018. For Heavitree dialysis unit, the sickness rate was between 6.5% and 14.7% in with the highest rate being in January 2018. Wonford dialysis unit’s sickness rate ranged from 0.71% to 9.55% between January and December 2018. The highest figure was in July 2018. For five months the unit was below the trust’s target for sickness.
Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Medical staff were available to meet the needs of the service. Staff on Creedy ward, renal day case unit (Sid ward) and the Wonford dialysis unit told us they could access medical staff when required.

There were 11 renal consultants, of which seven were full time, three were part time and one was an honorary renal consultant that was a Diabetes UK Harry Keen Fellow. This fellowship was established in recognition of the life and work of Professor Harry Keen, a clinical pioneer who helped to shape the understanding of diabetes and its treatment. The Diabetes UK Harry Keen Intermediate Clinical Fellowship allows outstanding medically qualified professionals, who have gained a PhD or equivalent, to establish themselves as independent researchers with a view to a long-term career as a clinical research leader in the field of diabetes.

A further four renal consultants who had honorary contracts with the Royal Devon and Exeter NHS Foundation Trust were employed by other NHS trusts and were working at other hospitals in Devon and Somerset.

There were no consultant vacancies.

To increase renal clinical input in the surrounding hospitals, renal services had supported the local recruitment of one renal consultant in North Devon and one in Taunton (both were part-time renal and medicine).

Other medical staff for the renal service consisted of two full time and two part time specialist trainee registrars (STRs), two associate clinical fellows (giving 40-50% supernumerary clinical cover), one clinical assistant and three clinical trainees (Senior House Officers). Previously there had been five clinical trainees, but this was reduced over the last two years due to junior doctor staffing shortages across the trust. Where possible, there was back-fill of clinical trainees from the trust to cover annual leave. All the registrars contributed to the general medical rota as well as renal commitments. There were no current locum posts.

There was a turnover of medical staff in line with set rotations; STRs were allocated for one to two years during their regional rotation. Clinical trainees changed every four months as part of their trust rotation.

Records

Staff kept clear and detailed records of patients’ care and treatment, but care planning documentation was not always up-to-date.

We reviewed 15 sets of patient records across the three dialysis units, renal day case unit (Sid ward) and Creedy ward.

At Honiton, Heavitree and Wonford dialysis units, we found for their regular patients there was no evidence core care plans had been reviewed or amended to reflect changes in patient care. There was a care plan evaluation sheet, but it was not clear if all staff had reviewed the care plans because the care plan number was not recorded on the evaluation sheet. We saw some patients had care plans completed in 2010 but these had not been updated. We spoke with a senior member of staff who told us they needed to review their care planning documentation to make sure it was relevant to their patients.

Patients’ ongoing records were completed each time a patient had dialysis. These records contained all the information about each session and any other relevant information. Inpatients who attended
the Wonford dialysis unit brought their medical and nursing notes with them for staff to update. Documentation audits were not undertaken on any of the dialysis units.

We reviewed four sets of patient records on Creedy ward. We found all the care plans and risk assessments were up to date. In the ongoing records and care plan evaluation it was easy to see which care plans had been reviewed on each shift as these were numbered. All patients had body maps completed describing any areas of skin breakage or discolouration.

We reviewed two sets of records for patients on Creedy ward who were on the end of life care pathway. We found these were completed in full by nursing and medical staff. Both patients had treatment escalation plans (TEPs) detailing their wishes in relation to emergency treatment. Both patients were not for active resuscitation and we saw records in their medical records stating when this conversation had taken place. Both patients had syringe drivers in use for the management of their pain and other symptoms. These patients had a syringe driver monitoring form which included details of when it was changed, the site used, and when the battery had been checked.

We were shown a copy of the care plan used for patients who were planning to use peritoneal dialysis. This was a core care plan which detailed everything patients needed to consider prior to starting and what to expect once established.

**Patients’ individual care records, including clinical data, were not managed in a way that kept patients safe.** Patients records were not always stored securely at the three dialysis units, the renal day care unit and on Creedy ward. The trolleys records were stored in were not able to be locked. Records on the renal day care unit were stored on a shelf behind the nursing station. The storage arrangements also meant some of the records trolleys were stored where patients and visitors had access to them. A senior member of staff told us they were aware of this and the trust was moving to an electronic system in the future. They were waiting to hear from the trust board about how to address this in the meantime. This was not on the renal services risk register. We also saw this issue was discussed at a governance meeting in November 2018. They had some actions to take forward which included lockable trolleys until the trust had their electronic system.

**Information needed to deliver safe care and treatment was available to relevant staff in a timely and accessible way.** Staff had access to the trust’s computer system to access test results. Care records were stored in each dialysis unit, on the ward and on the renal day case unit (Sid ward).

On Creedy ward there was a board round each morning and any changes to patients’ care and treatment were documented in the medical and nursing records.

**Medicines**

**The service followed best practice when prescribing, giving and recording medicines. Patients received the right medicine, at the right dose, at the right time.**

Each patient receiving haemodialysis had a prescription sheet, devised by the consultant in charge of their care, which was printed for each patient. These sheets contained all the information in relation to the setting, fluid needed and any medicines prescribed. Staff followed the details in these sheets and signed for any medicines given.

Patients’ medicines were regularly reviewed at each dialysis units’ monthly patient review meeting. Any changes were communicated to the patient, their GP and staff.

Two patients at Heavitree dialysis unit were written up for 50% glucose solution on their medicines administration record, but there were no instructions for its use and it was not linked to a care plan. Staff told us this was for diabetic patients who may have an episode of low blood sugar during
haemodialysis. Senior staff told us these were out of date and were not being used, but they had not been removed from their care records.

**Medicines were appropriately prescribed, administered and/or supplied to patients in line with the relevant legislation, current national guidance and best available evidence.** Patient Group Directions (PGDs) were used at Honiton and Heavitree dialysis units. We reviewed these at Honiton. The PGDs in use had been signed and authorised by a medical practitioner and senior pharmacist. Staff had also signed the forms to acknowledge they were aware of them and would follow the guidance. A Patient Group Direction is a mechanism that allows for the supply and/or administration of defined medicines to a group of patients for the treatment of specified clinical conditions. Within the information there must also be a list of exclusion criteria. This must be signed by a doctor (or dentist for dental treatment) and a pharmacist. It is good practice to also include signatures of the lead professional for other professions who will be operating under and delivering the PGD.

Pharmacists did not visit any of the dialysis units, but there was a named pharmacist who could provide advice and support as required. Staff said when they had contacted the pharmacist for advice about patients' medicine they always had a prompt and detailed response.

**Staff ensured the safe administration of intravenous medicine to patients.** We observed two staff checking the anticoagulant medicine for a patient receiving haemodialysis. They made sure it was in date and correct for the patient. Staff also formally checked patients' identification before administering intravenous medicines.

**Medicines which were temperature sensitive were not always monitored closely.** Medicines were stored in a locked trolley in the main dialysis units at Honiton and Heavitree. No monitoring of the temperature of the trolleys took place. At Heavitree, a senior member of staff identified this as a risk and told us the room could get very hot in the summer. In the trolley were medicines that needed to be stored a certain temperature as directed by the manufacturer. Staff could not be certain these medicines were being stored as per the manufacturer’s guidance. This was the same on the renal day case (Sid ward). Refrigerator temperatures were recorded daily. These had been maintained within the recommended parameters. We did not check the medicine arrangements on Creedy ward.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. When things went wrong, staff knew to apologise and gave patients honest information and suitable support. Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally. Staff told us they reported all incidents on their electronic system and these were then sent to the matron for each unit or ward to review. Staff told us they could request feedback from any incidents they had reported, but this often took time to come back to them.

**There were arrangements for reviewing and investigating safety incidents and other events where things went wrong.** After an incident happened, staff documented what happened on the electronic incident reporting system and informed their line manager. The incident was reviewed by a senior member of staff before a decision made about the level of investigation required. Senior staff told us most of their incidents related to transport issues for the dialysis units and these were collated and fed back to the local Clinical Commissioning Group.

The trust told us there had been no serious incidents reported in the last 12 months in renal services. Incident trends were monitored as part of the service’s governance arrangements and reported on in the minutes from each meeting. We were sent three sets of minutes which confirmed this.
We observed a transport issue during our inspection where the transport provider was not able to collect a patient. The staff on the dialysis unit had to contact the patient’s family and ask them to collect the patient. Staff told us they would report this as an incident.

**Never Events**

Never events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

In the last 12 months, the trust reported no incidents classified as never events in renal care.

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**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. Current evidence-based guidance, best practice and legislation were used to develop how services, care and treatment was delivered.

Staff had access to policies and guidelines reflecting evidence-based care and treatment, which had been developed in line with national guidance. These included the National Institute for Health and Care Excellence (NICE), for example NICE QS72 ‘Adults receiving haemodialysis have their vascular access monitored and maintained using systematic assessment’. Managers told us they monitored staff compliance with this through review of patients’ care records. We saw in all three of the dialysis units there were posters advising staff on the action to take if they felt the patient had a problem with their vascular access. This included how and when to contact medical support.

Patients on haemodialysis were also advised to follow best practice guidance and evidence-based care. We observed patients washing their arm with the fistula on just prior to dialysis to prevent infection. Patients told us staff had explained the importance of this and they followed this rule. Peritoneal dialysis patients also followed best practice guidance with strict handwashing and exit site cleaning to prevent infection.

Staff followed evidence-based guidance regarding clinical observations and checks before the start of haemodialysis (Renal Association, 2005). This included checking weight and vital signs such as blood pressure, pulse and temperature. We observed how staff discussed results with patients and adjusted treatments accordingly and within the parameters set by the patient’s consultant. This promoted optimum haemodialysis treatments. Managers told us this was recorded in patients’ records and they observed staff completing this.

Water testing and disinfection of the water plant and dialysis machines were all carried out in line with best practice guidelines. The units exceeded the recommendations from the Renal Association, manufacturers’ instructions and the European Pharmacopoeia Standards for the maintenance of water quality for haemodialysis. We spoke with one of the senior technicians who told us about this and showed us evidence they undertook more water testing than the guidance.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and provided dietary support to improve their health. Patients in renal failure require a strict diet and fluid restriction to maintain a healthy lifestyle. Patients and staff at all the units and Creedy ward had access to specialist dietary support. Dietitians attended each of the dialysis units’ patient review meetings every month and as
part of this patients' blood test results were reviewed. Dietitians could review patients individually if required and we observed this during our inspection. Dietitians attended the daily board round on Creedy ward.

Patients were weighed on arrival at each of the dialysis units at each visit. This was to identify the additional fluid weight which needed to be removed during the dialysis session. This varied from patient to patient. We observed patients at all three dialysis units weighing themselves before and after dialysis, and giving this information to the staff who recorded it. Staff told us all patients were encouraged to participate in their treatment.

**Patients had access to food and drinks whilst undergoing their treatment.** Staff provided patients with tea and biscuits during their haemodialysis session. Most patients also chose to bring their own food into the units to eat during their session. Inpatients who used the Wonford dialysis unit could have their meals delivered to them during dialysis. At the Wonford site, the Kidney Patient Association had funded additional snacks for patients, which included a gluten free selection.

Nutritional risk assessments for patients at the three dialysis units were not routinely undertaken. However, staff said they could refer patients to the dietitians as required and dietitians were involved in the monthly review meetings of all dialysis patients and would pick up any concerns. Patients on Creedy ward were assessed for their nutritional risk.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain.** Patients did not routinely receive oral analgesia (painkillers) during their dialysis sessions. However, staff could administer paracetamol if required. Local analgesia was available for cannulating (needling) and would be administered as part of the patient’s individual prescription. Needling is the process of inserting wide bore dialysis needles into the arteriovenous fistula or graft, which some patients found painful when undergoing haemodialysis.

A senior nurse told us that because patients who attended dialysis were mostly outpatients, they could bring in and take their own pain relief. We spoke with several patients who confirmed they could do this.

Patients on Creedy ward were assessed for their pain and staff told us they could provide analgesia. We saw two renal patients who had been prescribed syringe drivers for their pain relief and symptom control. These had been prescribed on their medicine administration record, which also included a syringe driver checklist. PRN or ‘as required’ medicine was also prescribed if the patient had break through pain or symptoms. A syringe driver or syringe pump is a small infusion pump used to gradually administer small amounts of fluid medicines via a subcutaneous needle under the skin.

**Patient outcomes**

**Managers monitored the effectiveness of care and treatment and used the findings to improve them.** They compared local results with those of other services to learn from them. All staff were actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking and peer review were proactively pursued, including participation in approved accreditation schemes. High performance was recognised by credible external bodies. Outcomes for patients who used services were positive, consistent and regularly exceeded expectations.

The renal services participated in relevant quality improvement initiatives, such as local and national clinical audits, research and trials. Relevant staff were involved in activities to monitor and use information to improve outcomes. The renal services were one of the first academic departments at the Royal Devon and Exeter NHS Foundation Trust and they had several senior staff actively
involved in research and teaching. They also had two academic specialist training registrars funded by the National Institute for Health Research (NIHR). All staff, including junior doctors, took part in research trials. We spoke with senior nurses who told us they participated in research and some of their work had been published, for example in the Renal Nursing Journal.

We were given a list of research trials the trust was involved in and ones that had closed to recruitment. The renal services were involved in 15 research projects at the time of our inspection which were open to recruitment, five that were closed to recruitment but in the follow-up stage and two studies in set up. The open research studies included ‘The National Study of Nephrotic Syndrome’ – this is a genetic study in patients with minimal change or Focal segmental glomerulosclerosis (FSGS) nephrotic syndrome. FSGS is a disease in which scar tissue develops on the parts of the kidneys that filter waste out of the blood (glomeruli). FSGS can be caused by a variety of conditions. Another study was ‘Microcirculatory function in Peritoneal Dialysis (MCPD)’, which is peritoneal transport rate associated with structural and functional alternations in other microvascular beds (dermal, retinal and sublingual). A further study was a measure of urinary nitrate concentration to predict kidney transplant rejection (UNREAL).

Renal services routinely collected data and submitted it to the Renal Registry for monitoring. The Renal Registry is part of the Renal Association who collect, analyse and report on data from renal centres in the UK, as mandated by the NHS National Service Specification. The registry also provides access to a clinical database which can be used in renal research. The renal services collected the relevant data which contributed to the registry. The registry provided an annual report for the trust detailing the quality of care and treatment provided for patients by the renal services. Comparisons were then made with other renal services to compare performance against other centres. Senior staff told us they planned to visit one of the top units to look at areas they could improve on. The trust submitted data to the UK Renal Registry for 2016. Of the 44 results which were analysed, eight had results statistically significantly higher (better) than the England average. These were based on blood results for patients undergoing haemodialysis and peritoneal dialysis. Two indicators were lower the England average. The remaining 36 indicators were similar to the England average. Senior staff told us they were aware of the two indictors that were lower than the England average and were reviewing these.

Renal services also submitted similar data to the Renal Register quarterly to the NHS England specialist services quality dashboard.

The renal services had plans to take part in the Kidney Quality Improvement Partnership (KQuIP). The purpose of KQuIP is to improve the lives of adults and children affected by kidney disease by supporting healthcare professionals, kidney units, renal networks and commissioners across the UK to achieve the highest quality of care for patients. It plans to build on, rather than replace existing quality improvement structures by helping kidney services to embed quality improvement into daily practice, understanding and reducing unwarranted variation in care and spreading and sharing good practice. Members of staff from the renal team had been appointed to move this project forward. They were attending the study days during our inspection.

There were national plans to benchmark renal units on the Getting It Right First Time (GIRFT) scheme. The GIRFT scheme is run by NHS Improvement and is a national programme. The programme is led by frontline clinicians and is created to help improve the quality of medical and clinical care within the NHS by identifying and reducing unwarranted variations in service and practice. The first meeting with the GIRFT team was planned for March this year.
The renal services took part in the 2018 Kidney Patient Reported Experience Measure (PREM). The aim of PREM is to help renal unit teams understand how patients feel about their experience of care and show where improvement can be made. PREM also provides a national picture of people’s experience of care. Results to individual questions were analysed by the section they fell into. Of the 14 sections in the report, seven had results higher (better) than the UK average. These were:

- Access to the renal team
- Support
- Fluid intake and diet
- Privacy and dignity
- Transport
- Environment
- Your overall experience

The remaining seven indicators were similar to the UK average. Of these, three had improved scores from the previous survey. The average score across all themes was higher (better) than the UK average.

The trust had been identified as a Dr Foster mortality outlier for chronic renal failure in March 2018. The term ‘outlier’ is used to describe a service that lies outside the expected range of performance. The trust investigated and reviewed this information. It was found that an incorrect coding issue had made them an outlier by one death of patient. An action plan was devised by the trust to identify any areas they felt needed improvement. We asked the trust to tell us how they identified and managed deteriorating patients when arriving for haemodialysis. At this inspection we saw on arrival at all dialysis units’ patients were weighed and this was compared to previous weight. Physical observations to include blood pressure, pulse and respirations were taken. These were also monitored throughout their dialysis. If a patient was diabetic a blood glucose level was also taken. This was all recorded. As the majority of patients were also well known to each unit staff were also able to visually see if a patient was unwell. If the patient was at a satellite unit staff could contact medical staff at the Royal Devon and Exeter Wonford site for advice. If this was an emergency an ambulance would have been called to transfer the patient to the nearest hospital. For patients receiving dialysis at the Wonford site they could ask medical staff to come and review the patient. Staff at all the dialysis units knew how to monitor deteriorating patients.

**Information about the outcomes of patients’ care and treatment was routinely collected and monitored.** Staff in the renal services also participated in local audits to see how their service was performing. For example, the peritoneal dialysis service had identified issues with the number of patients coming off their chosen therapy earlier than expected. Possible reasons were due to peritonitis or peritoneal access infection associated with catheter loss (peritonitis is inflammation of the peritoneum. This is the thin tissue that lines the inner wall of the abdomen and covers most of the abdominal organs). As a result, the service reviewed the pathways they used for patients who were planned for or were undergoing peritoneal dialysis. The outcome of this audit was to make significant changes to the pathways from referral, access and long-term management. Further audits had been planned and changes to the patient training programme in relation to infection control had already been made. Senior staff had visited another NHS renal service where they had better infection rates to look at the system they used.
To meet national guidance by The Renal Association, renal services monitored peritoneal infection rates yearly. This was still ongoing at the time of our inspection for this year. A senior member of staff told us their last results were in line with the guidance.

Audits in other areas of the renal services included renal vascular access, this was monitoring infections in central venous lines used for haemodialysis. These took place monthly.

The Hospital Standard Mortality Rate (HSMR) for renal services for patients with a main speciality of nephrology from November 2017 to October 2018 was 119, which was within expected limits.

The peritoneal dialysis service was given key performance indicators from their provider of fluids used for this service. One indicator was for the prescriptions for each patient to be completed in full. Senior staff told us they were at 100% compliance, which resulted in them receiving discounts on the fluids they ordered.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. Staff had the right skills and knowledge to provide safe and effective care and treatment for patients. Nursing staff had the right qualifications and some staff had obtained renal nursing qualifications. Some healthcare assistants had also undertaken additional training and were able to carry out additional tasks.

Staff had to complete their competency assessments prior to their appraisal to get their pay increments. We were shown a copy of an appraisal form which was based on the trust’s values. Staff had to complete their section prior to the meeting and then their appraiser would complete their section following the meeting.

**Staff were supported to deliver effective care and treatment.** When new staff started in any of the dialysis units they were given an induction programme to follow. New staff were supernumerary for a period of four to six weeks. They worked with a clinical practice facilitator who supported them to meet the competencies required to carry out their role. Once the induction period was completed, new staff were then allocated a mentor who supported them. New staff told us they felt well supported by the staff on the units in which they worked. New staff on Creedy ward and in the community teams also had an induction programme and were supported by a mentor.

We were shown one of the competency booklets staff had to complete on the dialysis units. This included the management of fistulas, grafts and central venous catheters and dialysis equipment. This was under review at the time of our inspection. Staff at Heavitree and Wonford units were undergoing or had completed training on new dialysis machines and competency booklets had been set up for these machines. Staff confirmed they had to be assessed as being competent before being able to use the new machine alone. We were told training records were maintained as evidence staff were competent for the use of dialysis equipment. We were shown a copy of these at Honiton haemodialysis unit. Staff in the community teams and Creedy ward also had to complete competency assessments but we did not ask to see any of their booklets as we were shown copies of competency assessments at Honiton dialysis unit. Staff confirmed they had to complete these.

Rotational posts for band five qualified nurses between Heavitree and Wonford dialysis units and Creedy ward were offered to enable these members of staff to gain greater knowledge and skills.

Each dialysis unit and Creedy ward had link nurses, for example in infection control and moving and handling. They provided support and guidance to other staff on the units. At one of the dialysis units, a band four staff member held the role of being a trainer for other staff for vascular access. They
also linked in with other specialist nurses in renal services and undertook auditing of central venous catheters.

Some qualified staff had additional qualifications in renal nursing. At Heavitree they had two nurses who had additional qualifications in renal nursing. At Honiton they had four nurses with this qualification and one undertaking this qualification. At the Wonford dialysis unit they had six qualified nurses and one undertaking this course. In the community services, the majority of the qualified nurses had completed this qualification or had plans to start the course shortly. Nurses could apply to undertake this course.

The community teams had access to clinical supervision each month, which was mostly patient focused. Staff also had monthly access to a clinical psychologist to help support them emotionally.

Volunteers were recruited at some of the dialysis units. At Honiton there were four volunteers who visited the unit regularly. Senior staff told us they were part of the team and patients enjoyed having extra people to talk to during their treatment.

The trust had a system for managing poor or variable staff performance. Staff were supported to improve. There were processes and support systems for senior staff to follow when a member of staff’s performance was under investigation. Where possible, this would be carried out informally within each unit. A senior member of staff told us they could get support from their human resources team when they had to address issues with behaviour.

Appraisal rates

Most staff had completed an appraisal in line with the trust’s target of 80%. By December 2018, 91.7% of staff at Wonford dialysis unit had completed an appraisal. The renal day case unit was at 80% and Creedy ward was at 93.6%. The Honiton dialysis unit had exceeded the trust’s target at 92.3%, but Heavitree was just below the target at 73.1%.

Revalidation for consultants took place every five years and all were up-to-date. Some consultants were due to go through the revalidation process later in the year.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. Staff, teams and services were committed to working collaboratively to deliver more joined-up care to patients who used services.

On Creedy ward there was a ‘board round’ every weekday morning, which was attended by all members of the multi-disciplinary team. These included nurses, physiotherapists, occupational therapists and dietitians, consultants, junior doctors and registrars. All patients on the ward and renal patients that were on other wards were discussed. We observed a board round during our inspection and found all staff participated in the meeting.

Renal services met with other specialities, for example x-ray, urology and diabetes to discuss their service provision and to discuss any patients with complex needs.

All relevant staff, including those working in different teams, were involved in assessing, planning and delivering care and treatment. There were clear decisions about who was responsible for patients’ care. Staff knew who the consultant in charge of the care for their patients was.

There was a team of specialist community renal nurses who visited patients with renal failure. They visited patients at their own home to discuss treatment options with them and their family/carers. They also ran clinics and education sessions for patients at locations around their catchment areas.
The specialist community renal nurses liaised with community nurses, learning disability specialist nurses, ward staff, recovery and anaesthetics teams to organise the best possible experience for patients with a learning disability needing blood tests and operations. This team also worked with community nurses, GPs and hospices when the patients were coming to the end of their life. They gave them advice about medicines suitable for patients with renal failure.

Each dialysis unit had a monthly quality review meeting where each patient was discussed with their consultant, a senior nurse from the unit and dietitians. Patients’ treatment and care was discussed along with their latest blood results. Following the meeting, letters were sent to patients’ GPs detailing any changes to treatment or requests, for example for non-renal investigations. Outcomes from this meeting were recorded in the patients’ records and shared with staff. Dietitians would review all patients as part of this meeting and would visit them if required to provide advice and support.

Patients could be referred to the renal social worker for an appointment, but as they were based in Exeter it meant patients needed to be able to get to Exeter.

**Seven-day services**

*Acute renal services were available seven days a week and this included haemodialysis.* Patients receiving planned haemodialysis could access the service six days a week. Morning, afternoon and twilight sessions were held to help patients fit them in around their lifestyle.

If a dialysis patient was acutely unwell they could be admitted to the Royal Devon and Exeter Hospital (Wonford) for treatment and could access dialysis treatment on Creedy ward out of hours if required. Once admitted as an inpatient, they could access all services from the hospital.

Consultant cover was available out of hours. There was an on-call rota. Ward rounds took place every day, led by a renal consultant. All patients were reviewed, including those not on Creedy ward as required. Staff confirmed they could contact a consultant out of hours if needed. Junior doctor and registrar cover was provided as part of the medical out of hours rota.

Patients using peritoneal dialysis could contact Creedy ward out of hours for advice, especially if they felt they had an infection. Staff would direct them on the action they needed to take, for example coming to the hospital.

**Health Promotion**

*Staff supported patients to be involved in monitoring their health.* Patients were identified when staff felt they may require extra support. For example, if a patient was in the last 12 months of their life, a specialist end of life nurse could offer them support and advice. Specialist renal nurses could support patients and provide them with education about how to monitor their condition.

We observed many patients weighing themselves before and after dialysis. Other patients told us they liked to know their blood results each month, so they could keep up to date with their progress.

A clinical specialist in renal young adult/transition nurse whose role was to support younger adults to monitor their own health. This role was funded by a kidney charity who worked closely with the trust. This role encouraged younger adults to meet up as a group which was supported by this specialist nurse to discuss how they monitored their health and lived with diagnosis. This had included the use of smartphone applications (‘apps’) to help patients, for example by reminding them to take medicines. The specialist nurse told us about one patient who was struggling with their diagnosis and had become depressed. This patient joined in with the social activities organised by this specialist nurse and went away on their weekend trip set up with the charity. The weekend trip was to encourage younger adults to bond as a group and discuss how to manage their diagnosis to...
fit in with their life style. It was also about having fun and about leading a normal life whilst managing their condition. On their return, the patient felt better and had learned from meeting others in the same situation. They planned to monitor their health to remain healthy and to take their medicines. We saw in the newsletter evidence of this weekend trip away and feedback from young adults was very positive.

Diabetic patients monitored their own blood glucose levels at home and told the staff if they were worried about them during their dialysis sessions.

To help improve patient fitness levels, bed-based cycles had been purchased for use during dialysis sessions. We observed several patients using these at the Heavitree unit.

There were many leaflets available to patients and their relatives containing information about health promotion, especially about renal care. We also observed posters about renal and diabetic diets at the Honiton unit.

Patients who used the home haemodialysis service were supported to monitor their health and maintain their independence. Patients were offered a training programme at one of the units and then they could start haemodialysis at home with support from the community team. We spoke with one patient who told us they could have their haemodialysis at home when it suited them.

Patients undergoing peritoneal dialysis had to complete a training programme with emphasis on infection control and hand washing. Advice was also given to patients about oral fluid management and diets.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff followed the trust’s policies and procedures when a patient could not give consent. Staff understood their responsibilities in relation to consent. We observed staff asking patients for their consent when undertaking any care activities, for example monitoring vital observations. We observed staff informing patients about tasks and awaiting either verbal or implied consent. This practice was clearly embedded among all staff in renal services.

We did not see any written consent forms in patients' notes regarding the treatment for haemodialysis. For peritoneal dialysis, the care plan was an agreement from the patient to undertake the tasks required to make sure they remained safe and infection free during treatment. We saw written consent forms for staff to share patient information with other health care professionals. We found only one of these had not been signed in all the patient records we examined.

When patients lacked the mental capacity to make a decision, staff ensured best interests decisions were made in accordance with legislation. Staff on Creedy ward explained the process they needed to follow if they felt a patient lacked capacity to make a decision. We saw several patients had best interest meetings booked following our inspection. Staff told us all relevant professionals would attend, along with a representative for the patient. We did not see any records about this as the meetings had not yet taken place.

Staff understood the requirements and guidance and received training about the Mental Capacity Act 2005. Senior staff at the dialysis units told us they were not treating any patients who lacked the capacity to consent to treatment at the time of our inspection. They did provide treatment for patients who were not able to communicate verbally, but staff were aware of non-verbal body language and would stop if the patient was becoming distressed or agitated during dialysis treatment. They told us they could use other communication aids for example, picture boards.
Staff in the renal services were aware of patients who had a ‘do not attempt cardiopulmonary resuscitation’ (DNACPR) order. A copy of this was stored in the patient’s records. The patient held the main copy unless they were on Creedy ward, in which case the main copy was stored in their medical records until discharge. We saw several forms and all had been completed in full and signed by the consultant or senior doctor. Patients had been assessed as having capacity to make DNACPR decisions. This was recorded in patients’ medical records if they were on Creedy ward. We were not able to check this for patients who were having haemodialysis as some orders had been completed by their GPs.

No patients at the time of inspection were subject to a Deprivation of Liberty Safeguard. Staff on Creedy ward were aware of the process to follow if they needed to apply for a Deprivation on Liberty safeguard. Staff on all the dialysis units were aware of this as it was part of their training but it did not apply to patients using this service.

Mental Capacity Act and Deprivation of Liberty training completion
Latest trust figures for training for all staff working in renal services exceeded the target of 75%.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients and those who were close to them was continually positive about the way staff treated them. Staff took the time to interact with patients and those close to them in a respectful and considerate way. We observed staff encouraging patients to talk about their condition and how it affected their life. Staff were compassionate and engaged in regular conversation with patients. This helped staff to build up a rapport with patients to improve the patient’s experience. Patients from the dialysis units told us the staff became their friends as they got to know them very well because they saw them so often.

Some patients had been having dialysis for 10 years. They told us: “staff go the extra mile”. We were given an example of this when several patients were not able to get home in the snow last year. Staff stayed overnight in one of the units with them to make sure they were cared for.

There was a strong, visible patient-centred culture. Staff demonstrated sensitive and supportive attitudes towards patients. Staff took the time to listen to patients and could empathise with them. We saw staff taking the time to listen to patients and offer support and advice.

Staff gave time to patients and their relatives and they were not hurried for responses. On Creedy ward we saw staff making specific efforts to ensure patients and their relatives understood the care their loved ones were receiving. For complex or sensitive discussions, staff took relatives to private spaces away from the risk of being overheard and where they could be comforted by staff if it was needed. We saw in patients records when staff had spoken with patients about their care. This included where patients had been asked for their input.

Staff used a specific indicator on their patient board to indicate patients who were very close to the end of their life. This was to inform staff that the patient and their relatives/carers may need extra support and care from them.

Staff were motivated to offer care which promoted people’s dignity. Staff made sure patients’ privacy and dignity needs were understood and respected, including during any examinations. Curtains were used around each station, at each bed space on the ward and in the side rooms for the viewing windows and at the window on the doors.
During our inspection, we spoke with 11 patients and one carer to seek their views of the service provided to them. They were extremely positive about the care and treatment they had received. Comments made included: “we have received very good care here”, “all the nurses have been lovely and looked after me well” and “the nurses are excellent, cannot fault the care I have received”.

We received 24 comments cards, 14 for Heavitree and 10 for Honiton. Examples of the feedback we received from these included: “the service is excellent and the staff are as considerate and caring as is humanly possible, and nothing needs improving”, “I have a very good relationship with all the staff, I am treated with respect and I am always listened to” and “5 star rating for the staff and treatment.” Other patients told us: “I receive exceptional service”, “the service provided by all members of the staff is exemplary” and “the service I have received while coming to this unit is superb”.

**Emotional support**

**Staff provided emotional support to patients to minimise their distress.** Staff recognised the broader emotional wellbeing of the patients under their care. Some patients told us how it could be hard and tiring managing with renal failure and having dialysis. They told us staff had taken the time to speak to them and provide them with support when they were feeling low, which they greatly appreciated.

One patient told us how they were new to dialysis following a decline with their renal function. The patient told us how the staff kindness, consideration and friendliness had helped them come to terms with their condition. We observed their treatment, which was problematic and increased the patient’s anxiety. We observed staff offering reassurance and support. The staff remained calm, which helped the patient’s anxiety.

Staff on Creedy ward offered support to patients and their families. We observed a family who had been told distressing news about their relative who was at the end of their life. Staff were compassionate towards the family and allowed them time to ask questions. This was done in a private room away from the main ward area for privacy. This patient was moved to a side-room so their family could stay with them and visit as often as they wanted.

**Staff understood the impact on a patient’s condition, care and treatment and how this affected their family and relatives.** One patient told us their family were struggling with their diagnosis and change in their overall medical condition. The support from the staff at the dialysis unit had really helped.

**Staff could signpost patients to additional support about their condition.** We saw all the dialysis units and Creedy ward details of support networks for patients and their relatives and/or carers. This included organisations such as the Kidney Patients’ Association who held social events and had support networks for patients and their relatives and/or carers, and newsletters provided by kidney charities. Staff told us patients could be referred to a psychologist if needed to help them come to terms with their diagnosis.

On Creedy ward one patient had an assistance dog and they could bring them into hospital with them. They were given a side room to enable them to privacy and have their dog with them.

**Understanding and involvement of patients and those close to them**

**Staff involved patients and those close to them as active partners in making decisions about their care and treatment.** Staff communicated with patients so they understood their care, treatment, condition and any advice given. We observed staff discuss with patients their treatment options or changes to their dialysis regime. They checked the patient understood what they told them and spoke in a way they understood, by not using medical jargon.
Patients told us they felt comfortable to ask questions about their care and treatment to the staff and this was also confirmed in the feedback cards we received.

Staff understood the importance of involving family members and close relatives as partners in patients’ care. We spoke with a relative of one patient who said the staff always kept them up to date on how their relative was progressing and discussed any changes in their treatment plans.

Staff provided patients with the details of support networks to enable them to feel empowered and supported. All patients were informed of any social events provided by support networks, so they could make an informed choice about attending.

Staff told us about the support and advice that was given to new patients attending haemodialysis for the first time. We also spoke with staff from the wider team who told us how they met and supported patients with their diagnosis and treatment. We spoke with a patient who had recently started haemodialysis following a decline in their renal function. They told us they had visited a dialysis unit where they were able to speak with other patients about the treatment and what to expect. They told us they could speak with staff and ask any questions about their treatment and vascular access. Whilst they were nervous about their first session, they felt staff put them at ease by explaining everything to them.

Patients felt listened to and included in their care and treatment. Patients’ feedback included: “I am always listened to and the staff respond with the right care and treatment”, “staff have offered me helpful advice and listened to my requests for information and supplied helpful answers”, “staff always happy to answer questions relating to my treatment and never seem irritated even when busy”, “staff always respond to my questions in a professional manner” and “I am always listened to and all my needs are met fully”.

We spoke with a clinical specialist nurse who told us one of their roles was to support young adults aged from 17-30 years understand their condition and treatment options. This involved one to one sessions and group activities where young adults could meet others in their situation and to help them come to terms with their diagnosis.

**Staff supported people who used the service to find additional information and link with support networks.** Patients told us they were given verbal and written information about their condition and treatment options. For haemodialysis and peritoneal dialysis patients, this was about access into their body for treatment and how this would impact on their life. Haemodialysis patients were made aware of how to care for their fistula or other vascular access and what they could and could not do, and how it would impact on their life. For example, they must never have blood taken out of their arms and blood pressure must never be taken on the side with vascular access. One patient told us this had caused them a few problems at their GP surgery but staff, once aware, respected these boundaries.

Patients told us they were involved in their care and were told about their blood test results. One patient told us they communicated directly with the consultant about their blood test results and change of medicines. They felt this enabled them to maintain their lifestyle and stay in control of their medical condition.

When decisions were made to withdraw treatment from a patient at the end of their life, the end of life care nurse who worked in the renal services was informed. They could support the patient, their relatives and staff. They assisted with the planning of the next step which could be to move the patient to another environment or home depending on their assessed needs. Relatives and their patient could ask questions and be actively involved in any decision making.
Is the service responsive?

Service delivery to meet the needs of local people

The needs of local people were central to the planning and delivery of tailored services within the renal care. The Royal Devon and Exeter NHS Foundation Trust provided renal services to patients across Devon and parts of Somerset. Patients’ individual needs were central to the planning and delivery of tailored services. Haemodialysis was provided to patients in several locations close to where they lived, including Honiton, Heavitree and Torbay. The trust also commissioned private providers to provide haemodialysis to patients in Taunton and North Devon (Barnstaple). These were called satellite locations. The trust also had a dialysis unit at Royal Devon and Exeter Hospital (Wonford). There were plans to build a new dialysis unit in Somerset to meet the demands of the service.

The renal services had developed a chronic kidney disease specialist nurse role. This meant patients who were referred to the renal service were triaged to see either a consultant or specialist nurse. When patients were referred to the specialist nurse they could choose a location near to them, based on the sites offered. Patients were reviewed and assessed by the specialist nurses who provided advice and education about their treatment. Renal services found this had reduced their waiting times and improved relationships with local GPs and practice nurses as they could provide them with advice and support. This service was not offered in any other NHS trust across the country.

The service reflected the needs of the population served and provided flexibility and choice for patient care. Patients using peritoneal dialysis were supported at home by specialist community renal nurses who were allocated an area within Devon and parts of Somerset. The Assisted Peritoneal Dialysis service also covered all of Devon and parts of Somerset to meet the needs of patients. These services helped patients to maintain their lifestyle in their own homes and prevented them from travelling three times a week to a haemodialysis unit.

Patients could access dialysis units six days a week and had the choice of either the morning or afternoon session to receive their treatment. The units also provided six twilight (evening) sessions a week to allow flexibility for patients who worked. This enabled patients to maintain a good quality of life and incorporate dialysis at a time to best suit them.

The chronic kidney disease service provided clinics at locations around Devon to help patients reduce their travel time to attend treatment sessions.

Services were planned to account for the needs of different people. All the dialysis units, the renal day case unit (Sid ward) and Creedy ward had side rooms which were allocated to patients who may need isolating, for example due to infection. Some patients on haemodialysis also preferred their treatment in a side room.

Designated parking and disabled parking was available next to the dialysis units for patients who travelled independently for treatment. There was convenient and safe access to the dialysis units for walking and disabled patients.

There was not a transport user group and/or any transport surveys for patients receiving haemodialysis. However, staff told us they always completed an incident form if there was an issue with patient transport. Following a change in transport provider, some patients told us they had seen an improvement in their transport, for example being picked up from home and collected from hospital on time. We did observe one issue with transport where the transport provider was not able to collect one of the patients and alternative arrangements had to be made. Senior staff told us
transport arrangements varied between local councils, who had different commissioning arrangements. They collated feedback and incident forms and fed this back to the commissioners regularly.

**Meeting people’s individual needs**

The service took account of patients’ individual needs and their preferences were central to the delivery of tailored services. Patients could receive their treatment at a time which suited them. One patient told us the staff at the unit often changed their dialysis times to suit them, so they could continue to work full time. Without this the patient would have not been able to continue with their employment.

The haemodialysis units had provisions to ensure patient comfort. Patients were able to use the toilet prior to commencing dialysis at the units. The toilet facilities also enabled disabled access and were spacious enough to accommodate a wheelchair. Other provisions included dialysis chairs, pressure relieving aids, and hospital beds. Some patients told us they preferred a hospital bed as they were more comfortable. Other patients felt the dialysis chairs were very comfortable. Blankets and pillows were provided as necessary for patients at their request.

**Patients were treated without discrimination.** All staff in the renal services had completed equality and diversity training. We were told about a transgender patient and how staff cared for them. They were offered the choice of side room for their own privacy, which they accepted, and staff told us they were treated with dignity and privacy as any other patient would have been.

**Renal services used technology and equipment to enhance the delivery of effective care and to support patients to be independent.** Patients could access haemodialysis away from the normal unit. There was a system to support patients to find and book treatment at another dialysis centre when they were away and not able to attend their usual unit for treatment. Staff told us they knew the process to follow and how this needed to be done in a timely way as information needed to be sent from the dialysis unit well in advance of a patient attending the other unit. We observed this taking place during our inspection.

The renal services ran a home haemodialysis service. At the Heavitree unit, a comprehensive training programme was provided for patients who wanted to undertake this treatment at home. Once assessed as being safe to undertake this treatment at home, community staff from the renal services supported them at their home. At regular intervals patients were invited back to the unit for staff to observe their technique to make sure they were safe to continue. We spoke with a patient who said doing this at home meant they could continue with their normal life and fit their dialysis into their daily life. This patient also told us they felt very well in themselves from using this service.

Patients receiving peritoneal dialysis could choose from two systems: Continuous Ambulatory Peritoneal Dialysis (CAPD) or Automated Peritoneal Dialysis (APD), based on their needs and assessment. For example, some patients used the Assisted Peritoneal Dialysis where community staff came to patients’ homes to help them set up the machines. Training programmes were provided and patients were supported by specialist community renal nurses. If patients used the Assisted Peritoneal Dialysis service, they received support from the designated community team.

Patients had access to entertainment or activities during their haemodialysis session. Each station had its own individual television, integrated handsets and a call bell to get the nurse’s attention. Patients also had access to Wi-Fi at the units to access the internet via laptops and other personal electronic devices.

Heavitree dialysis unit had a set of bike pedals for patients who wanted to carry out some light exercise during their treatment session. We observed these being used during our inspection.
Technology was also used for ‘virtual clinics’ for patients to help cut down on their travelling to hospital or clinics. A virtual clinic is a planned contact by the healthcare professional responsible for the patient with the purposes of clinical consultation, advice and treatment planning. It may also be referred to as a telephone contact, telemedicine, teleconference or video link.

Services were planned to consider the needs of different patients to enable them to access care and treatment. Admission criteria was set out for the satellite dialysis units, so all patients irrespective of age, gender, race, religion, belief or sexual orientation could access the services. Patients were required to be haemodynamically stable, have established fistula or central venous catheter access and reside in the local area. For patients who were new to haemodialysis, they started treatment at the Wonford site until they were assessed as being stable. Once they were stable, they were referred to a satellite unit close to where they lived.

There was a process to introduce new patients to the service which enabled individual concerns and needs to be addressed. Once the patient had been reviewed by a renal consultant, they were referred to the team of specialist nurses who would visit them and their family and/or carers at their home to discuss the treatment options available.

If the decision was to start haemodialysis, new patients were welcome to visit one of the dialysis units. During this visit, they would meet staff and could speak with patients who had already been attending long term to discuss what it felt like and ask any questions. We spoke with a new patient who felt this was very beneficial.

Patients who were new to haemodialysis were provided with written information to ensure their understanding of the nature and purpose of the treatment, the effects, the risks and benefits and any post procedure instructions. The information included how haemodialysis worked, coping with fluid restriction, diet, understanding blood results, and vascular access. Information was set out clearly and simply for patients to follow.

The dietitians had a programme for weight management for patients undergoing haemodialysis, which involved dietary advice and exercise to meet patients’ specific needs. Staff told us this programme was showing good results. We did not meet any patients during our inspection that were on this programme to ask them about their experience.

Patients were provided with support once they had booked their treatment at a dialysis centre at their holiday destination. Staff completed all the paperwork required by the chosen treatment centre to ensure a seamless transition into the haemodialysis unit for the patient going on holiday. We saw a folder at one of the units where staff made sure all the information needed for patients going on holiday was provided in plenty of time. There was a designated telephone number for patients out of the area wanting to arrange dialysis at one of the units in Devon or Somerset.

To meet the needs of younger adult patients, one of the clinical specialist renal young adults/transition nurse supported them with their ongoing treatment. This included one to one sessions and group sessions where they could meet other patients with the same medical condition. They also planned weekend trips away on a yearly basis, which was supported by the Kidney Patient Association. They had set up a social media group for younger adults to contact each other and ask for advice and support. The specialist nurse had access to this and could provide advice and support to the group. Social gatherings were also arranged. Applications for mobile phones had been created to support younger adults, for example by providing reminders to take medicines. In the newsletter for the charity that funded this post we saw photographs and feedback from younger adults who attended the weekend away and it was all very positive.

Renal services had access to translation services if required. Staff told us they could use symbols to show patients what was going to happen during their treatment. Some staff on the ward and
Dialysis units could speak different languages, which also helped. Some staff on the haemodialysis units told us they used members of the patient’s family to translate if needed, however this is not best practice.

There was a proactive approach to understanding the needs of different groups of people to deliver care in a way which met their needs. There were arrangements to provide treatment for patients with complex needs or learning disability. The renal services had experience of managing patients with complex needs and staff told us they worked closely with families and carers to ensure the needs of the individual were accommodated. At one of the dialysis units a patient was accompanied by their carer during each haemodialysis session and were allocated a side room for their comfort. The carer told us the staff were very good at looking after the patient and knew how to meet their individual needs.

The renal services provided care and treatment for patients with learning disabilities. The specialist community renal nurses told us that over the years they had completed large amounts of work with patients with learning disabilities and their carers to make sure they were preparing them and providing them with the right treatment. They had looked after patients with a wide range of abilities and provided all modalities of renal replacement therapy as well as conservative management. This process involved complex meetings with the patient, their carers, their parents and wider family. The specialist community renal nurses gave us an example of this. A patient had moved to a new house because their health needs could not be met at their original address. They then moved many times before they moved to this area, which was distressing and disorientating for them. The community specialist renal nurses had to respond quickly to train and support new staff teams and provide the patient with reassurance and continuity for their dialysis. They had been involved in best interest meetings and provided evidence for continuing care meetings regarding the patient’s funding.

The specialist community renal nurses had supported patients receiving dialysis. They had prepared patients for peritoneal dialysis, haemodialysis and transplantation using different methods and tools, including hospital visits, pictures and photographs, cuddly toys to demonstrate dialysis and forming supportive relationship with patients. The specialist community renal nurses told us identifying the most effective way to communicate with patients with learning disability was essential, as was taking the time to get to know the patient, their abilities and preferences. At the time of our inspection they were supporting a patient with challenging behavioural needs who had been on peritoneal dialysis for more than seven years. The team of specialist community renal nurses provided ongoing training for the patient’s care team, created procedures and documentation for them, and had regular meetings with them to keep their skills up to date and to discuss their concerns and fears for the future.

Access and flow

People could access the service when they needed it. Waiting times from referral to treatment exceeded the target. Patients could access renal services when needed. Patients undergoing haemodialysis were booked in on a planned basis. Patients who had undergone a renal transplant were referred back to the trust after their operation for follow-up. Patients were given information about how many times they needed to attend and where to go. Emergency admissions for renal services were admitted to Creedy ward (beds allowing) for review and treatment.

Creedy wards had a list of patients that required repatriation to them from other NHS locations. These were managed by the registrars who liaised with the ward when beds were available to enable patients to be transferred. Renal patients who were on other wards were also reviewed daily and the most urgent patients were transferred to Creedy ward as soon as a bed became available.
Renal services monitored it capacity for haemodialysis weekly. This was to enable them to monitor if the haemodialysis units were working to their funded staffing capacity and where if any they had any spare sessions. All patients who required haemodialysis did not have to wait for this treatment but they may not be able to have haemodialysis at a unit close to their home. All new patients started their haemodialysis at the Wonford site until staff were certain they were medically stable before referring them on to a satellite unit closer to their home. There were waiting lists at each of the haemodialysis units for patients waiting to move to a unit closer to their home. The largest was in Somerset at 13 patients and plans had been devised with the local Clinical Commissioning Group to address this lack of capacity.

All dialysis units had a list of patients who were due for dialysis each day. At the Wonford dialysis unit they also took inpatients who had been admitted to hospital or were already in hospital. This varied each day and was managed by the patient flow member of staff. They liaised with the wards and the unit throughout the day. We observed several inpatients being transferred to this unit for dialysis during our inspection.

Once new patients on dialysis were assessed as being stable at the Wonford unit, they were then referred to a unit closer to where they lived. The timescale for this depended on the waiting list and if there were any free sessions suitable for the patient.

Patient appointments with the other healthcare professionals, for example the dietitian, were scheduled for the same day as the patient’s haemodialysis sessions to prevent multiple attendances at the centre where possible.

The referral to treatment times (RTT) for incomplete pathways for nephrology from January to December 2018 were exceeded the target of 92%. Performance ran above 97% across the year, and for four months it was at 100%.

There were regular trust-wide patient level audits of patients staying over seven days. Renal services monitored the length of stay by running ad hoc reports on inpatients at regular intervals. The data for Creedy ward showed from January 2016 to January 2019 that the figures were variable, with no pattern.

The trust monitored their weekend discharge rates for 2018. The data covered inpatients admitted as an emergency and discharged. Creedy ward discharged the highest percentage of patients on weekends compared to any of the other medical wards.

**Services ran on time.** On arrival at the dialysis units’ patients were allocated a station and staff collected them from the waiting room. Some patients told us they did not have to wait long to be set up on the machines. Staff told us they tried to get all patients set up quickly once they had arrived. We received one feedback card in relation to the Heavitree unit which said on the day of our inspection it was the first time the patient had received their dialysis on time and their transport did not have to wait until they had finished. We received no other complaints of waiting times from other patients.

Patients with the most urgent needs had their care and treatment prioritised. Renal services had a process to prioritise care and treatment for patients with the most urgent needs. For example, if one of the dialysis units had a partial or total loss of water or electricity they would try to move patients to other dialysis units. They would review all patients and find the patients who needed dialysis more urgently and move those to other units. During the snow in 2018 each unit had to review each patient and cut short some of their treatment times to make sure they could all get home safely.

If a patient using renal services was admitted as an emergency to the Royal Devon and Exeter Hospital (Wonford) they would go to Creedy ward (beds allowing) for a review and treatment.
Emergency haemodialysis or peritoneal could be provided. Patients who had undergone a transplant who were experiencing problems could also be admitted there for medical review. Information was given to all renal patients about who to contact in an emergency.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. Patients and their relatives and/or carers could access information easily about how to make a complaint or raise a concern. We observed information leaflets and posters on notice boards in the units informing people how to do this. However, patients told us they had no complaints about the service.

There was a comprehensive complaints policy and procedure to ensure all complaints were handled effectively and confidently, although complaints were not always responded to in time. The procedure ensured complainants received a timely response (acknowledgement within three working days and a full response in 45 working days).

The trust’s website contained information on raising concerns and making complaints. Patients could contact the Patient Advise and Liaison Service (PALS) to assist them in making a formal complaint. The website also had an easy read version of their complaints policy using words and pictures to help patients with communication difficulties understand how to make a complaint.

Summary of complaints

The trust told us they had received three complaints and seven concerns involving renal services in the last 12 months. Only two were responded to within the trust’s target of 45 days. The third was a complex case because it involved other services and took more time to coordinate. A senior member of staff told us about one complaint they had received in September 2018. It related to communication. Whilst the member of staff involved had handled the situation correctly, there had been some shared learning about communication.

Number of compliments made to the trust

The trust was not able to give us exact figures but told us they were encouraging their staff to record this information in a more structured way to enable them to have exact figures.

During our inspection of renal services, we received very positive feedback about staff and the services they provided.

Is the service well-led?

Leadership

Managers at divisional and unit level had the right skills and abilities to run a service providing high-quality sustainable care. Renal services had a management team consisting of a senior nurse, the cluster manager and the lead consultant in renal care. They were part of the medical directorate. Matrons led each of the dialysis units and Creedy ward and they were supported by nurses. The lead for the renal day case (Sid ward) was one of the specialist nurses. Matrons all had additional qualifications in renal nursing. There was dedicated and experienced leadership within renal services. The senior staff we met were well informed of the pressures and challenges that existed. For example, on Creedy ward they had pressure with their beds due to the demand on the services for the whole which meant at times renal patients were cared for on other wards.
The senior leaders demonstrated enthusiasm for their roles and a commitment to improving the quality of the service. They were passionate about improving the service and positively engaging staff. For example, all staff were invited to their weekly learning and teaching sessions where they discussed any feedback or audit results. Staff from all areas within renal services spoke about the great support they received from the senior managers. They said they were available to them, spent time in their departments and identified and tackled any issues or challenges.

Service leads were visible and encouraged supportive relationships among staff. Staff were aware of their line managers and who they were accountable to. Staff told us they felt confident about raising issues with their line managers. There were clear lines of responsibility from renal services to the executive board. Managers, including the senior leadership team, were visible and approachable. Staff told us they knew who members of the executive team were but were not sure if they had visited their department.

Vision and strategy

Renal services had a vision for what it wanted to achieve and workable plans to turn it into action. The vision had been developed with involvement from staff, patients, and key groups representing the local community. The trust had a clear vision and set of values. The values were fairness, honesty, openness and integrity, respect and dignity and inclusion and collaboration. Staff were aware of the values. The senior management team for renal services told us they had developed the strategy based on the trust’s overall strategy and how they wanted to move forward with improving services for patients.

The strategy for renal services was aligned to local plans in the wider health and social care economy, and services have been planned to meet the needs of the population. The trust’s renal service was a specialist tertiary service that provided care and treatment across Devon and Somerset. One the goals of the service’s strategy was to provide what they called “fairness” across all services. This meant that all patients for renal services would have the same access to treatment across Devon and Somerset. In East Devon, patients had access to ‘low clearance clinical services’. The low clearance clinic looked after patients with chronic kidney disease at a stage where kidneys were working at a low rate. At these clinics patients were provided with information about renal replacement therapy (RRT). Patients could meet several specialist consultants and nurses to discuss their treatment. Other areas of the strategy were to improve the access to home haemodialysis, and expand the in-centre dialysis services to include a new unit in Somerset to meet demand.

Culture

Managers across the renal services promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. The culture centred on the needs and experiences of patients. Senior managers told us they were most proud of the culture and attitude of staff. They said all staff engaged well with the trust, met the needs of the patients and they felt the trust’s values were well embedded.

There was a culture of openness and honesty amongst staff. Staff we met said they liked working at the units and wards. They felt they worked in supportive teams and were supported by their line managers. Many staff had been working for the service for long periods. Senior staff told us retention of staff was good and turnover rates were below the trust target except for Wonford dialysis unit which was just above. We spoke with new members staff who told us they were made to feel welcome by staff and felt supported by them.
Staff felt supported, respected and valued by their managers and colleagues. All staff felt they worked well together as teams and supported each other, especially when they were busy. Staff felt respected and valued by their managers and colleagues and enjoyed working in the dialysis units, renal day case unit (Sid ward) and Creedy ward.

Senior staff told us about one of the extended members of staff who was awarded the ‘Extraordinary People Awards’ at this trust for going above and beyond their role. This was where visitors and staff could nominate a member of staff who they felt had gone the extra mile.

Staff told us they were aware of who their Freedom to Speak up Guardians were and how to contact them if they felt they could not speak with their line managers. We also saw posters informing staff who they were and how to contact them. Freedom to Speak up Guardians were employees who worked alongside the trust leadership teams to support employees to raise concerns. They worked to ensure all staff were actively encouraged and enabled to speak up safely and without the fear of retribution.

Measures were taken to protect the safety of staff who worked alone and in the community.
Renal services had developed their own lone working policy, which was used by the whole trust. There was a lone working risk assessment and competency form which was completed for each member of staff working in the community setting. This was reviewed at their annual appraisal. The lone working policy was accessible to staff through the intranet. The policy outlined the role and responsibilities of staff when lone working. Each Friday a list of visits for the Assisted Peritoneal Dialysis APD team was given to Creedy ward so staff on the ward knew where each member of community staff was in case of any issues.

There were mechanisms for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations. At their appraisals staff could identify their learning and development needs with their line manager. Staff told us there was a culture to support and develop their knowledge and skills to provide quality care to patients.

Action was taken to address behaviour and performance that was inconsistent with the trust’s vision and values. There were processes and support systems for senior staff to follow when a member of staff’s performance was under investigation. Where possible this was carried out informally within each department. A senior member of staff told us they could get support from their human resources team when they had to address issues with behaviour.

Governance

Renal services used a systematic approach to continually improve the quality of its services and safeguarded high standards of care by creating an environment in which excellence in clinical care would flourish. There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. There was a straightforward governance structure. The renal services were part of the medical division and had their own governance arrangements, which fed into the medical division.

Minutes from the renal governance group meetings were consistent with regards to the quality and depth of discussions around safety quality and performance. We reviewed three sets of minutes from July, September and November 2018. The meetings looked at information such as quality and safety, risk, audit, learning and development and complaints. The minutes contained details of discussions held and evidenced a good level of scrutiny of the issues raised. Standard agenda items included discussion around escalation of issues, incidents, complaints and risk. Items were escalated to the medical divisional governance meetings as required. The clinical director for
planned care was a renal consultant and could feed information from renal services and back to them.

Capacity meetings were held monthly or more frequently, dependent on the demand for their services. Minutes for these meetings were not taken, but the weekly capacity report fed into these meetings.

**All levels of governance and management functioned effectively and interact with each other appropriately.** Staff from all areas within renal services attended meetings that fed into the main governance for renal services.

Nurse management meetings took place every two months for band seven staff. Meetings for band six and band seven staff also took place two monthly. We were shown minutes of these meetings. Each had a set agenda. The rolling agenda items included staffing and nurse education. Any issues from these meetings were then fed into the renal governance group.

Staff meetings at the dialysis units and Creedy ward took place every few months, but we did not ask to see any minutes to evidence this.

Senior staff for the community teams told us they met with qualified staff each month who were band five and above. These meetings were to discuss any issues the teams were having and to review performance. They also had the opportunity to have guest speakers from other services to help keep staff up to date.

Other meetings which fed into the governance arrangements included a senior staff meeting one morning a week, a multi-disciplinary (MDT) meeting every two weeks, and a clinical MDT meeting once a week. The MDT meeting once every two weeks was used to discuss policy changes, urgent issues and any updates. The clinical MDT meeting discussed all patients, and this was also attended by the microbiology team to discuss infection control. Budget meetings took place every other month to monitor finances and were attended by senior staff.

Mortality and morbidity meetings took place every three to four months with the renal consultants in attendance and, where possible, the renal supportive care nurse. A list of all renal patient deaths was taken from the computer system and circulated to the consultants. They selected for discussion any deaths that were unexpected, complex or deemed to have learning points or concerns. The full notes were made available for the meeting and the case discussed. Any outstanding issues were taken forward for further discussion with colleagues as appropriate. Written outcome sheets were completed by the doctors at the time and typed up and saved by the secretarial staff. We were shown some of the outcome sheets. These showed where the patients had died, the circumstances around their deaths and any further information they required or if other specialities’ input was required.

**Management of risk, issues and performance**

Renal services had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. There were arrangements for identifying, recording and managing risks, issues and mitigating actions. We saw evidence of risks being recorded on risk registers, which were reviewed regularly. We did not see the issues with patients’ records not being stored securely on the risk register, despite it being discussed at governance meetings.

Issues identified for the local risk register were scored between one and 16. Items scoring higher than 16 were escalated to the trust’s corporate risk register. All renal risks scoring between 12 and 15 needed signing off by the medical division for inclusion on the medical risk register. All risk
register items were included in the governance meetings for review. These were then fed to the board via the governance committee meeting for the medical division.

The main risk register for the renal services had four risks included, but it was documented on the risk register that other low-level risks were going to be added. It did not say what these were or where else they were recorded. There was one risk with a score of 10 and another with a score of 12. One was the ongoing replacement of dialysis machines and the other was the computer system used for renal patients. Both had been on the risk register for many years. Actions were planned, but these were not included in the risk register we saw. During discussions with the senior management team for renal services we heard about other risks, for example medical staffing (registrars were covering nights for the medical unit and this had impacted on the renal service). Also, the number of junior doctors coming through the training had reduced. Other areas of risk included the reduction in the number of vascular surgeons, which had an impact on vascular access. However, this was due to improve in March 2019 with more vascular surgeons being available.

**There was a systematic programme of clinical and internal audit to monitor quality, operational and financial processes.** We saw evidence the renal services took part in clinical audits both locally and nationally. Actions to address any areas of improvement were identified as previously mentioned in the report. The findings of these were shared at their weekly education meeting.

The senior management team for renal services told us about their contingency arrangements in the event of bad weather. This included writing to all patients about capacity arrangements and looking to move patients to haemodialysis units closer to their home. Senior staff told us how they managed in the snow in March 2018. Some patients got stuck at Heavitree dialysis unit during this time and staff stayed overnight with them. They praised their staff for their support during this period.

**Information management**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. There was an understanding of performance, which integrated information on quality, safety and operational performance.

Information was shared effectively with staff. There were handovers throughout the day on the ward and the haemodialysis units where they discussed their patients and any operational issues.

Information stored electronically was secure. Computer access was password protected and we observed staff logging out of computer systems or the hand-held devices when they had completed tasks.

Daily board rounds took place, which involved a multi-disciplinary team discussion at the white board on Creedy ward. The whiteboards provided information for staff regarding each patient on the ward and was referred to when staff discussed their care needs and treatment plans. The whiteboard on Creedy ward was located behind one the nursing stations, which meant information could be viewed by patients and visitors to the ward. Information recorded on the board was limited to protect patients’ confidentiality and included the patient name, admission and discharge dates, and when they had been reviewed by other healthcare professionals. Symbols were used to identify certain characteristics or information, which staff understood but other patients and/or visitors would not. During the board rounds each morning all the doors to the bays were closed to prevent other patients and visitors hearing what was being said.

There was a paper record system in use. There were no records audits taking place in renal services. Records were not stored securely to ensure patient confidentiality. None of the trolleys used to store patient records could be locked. This was highlighted in the governance meeting in
November 2018 where plans to look at short term solutions were discussed because the trust had plans for electronic records to be implemented within the next two years.

When patients were discharged or any changes were made to their treatment following clinics or quality review meetings, letters were sent to the patient’s GP to make sure they were kept up to date.

**Staff received training on information governance as part of their mandatory training.** This was part of staff mandatory training and most staff were compliant with this.

Information technology systems were used effectively to monitor and improve quality of care. Staff had their own trust email account and received updates on training courses they could attend and could view when their mandatory training was due or had expired.

**There were effective arrangements to ensure data or notifications were submitted to external bodies as required.** Data was submitted regularly to the renal registry. There were systems to ensure notifications of serious incidents causing harm to patients were reported in line with national requirements.

**Engagement**

Renal services engaged with patients, staff, the public and local organisations to plan and manage services, and collaborated with partner organisations effectively. Renal services worked with other providers who ran services with their support, for example satellite dialysis units. They also worked with other Clinical Commissioning Groups (CCG’s) and NHS trusts both in Devon and Somerset in providing renal services for patients.

Open days were held at the Royal Devon and Exeter Wonford hospital site to inform staff and members of the public about the services on offer from the renal team. We saw evidence of one of these in one of the newsletters which was also advertising dates for further planned events.

Renal services worked with local charities. For example, the Exeter and District Kidney Patients Association (EDKPA) one of the consultants was the president for this charity. We saw copies of their newsletters which detailed how they supported people with chronic kidney failure. A website was also available for patients to access for information and advice.

**Patients’ views and experiences had been gathered with plans to act on them to shape and improve the services and culture at the time of our inspection.** The renal services had encouraged patients to take part in the national patient reported experience survey (PREM), which was a collaboration between Kidney Care UK and the UK Renal Registry in 2018. The results from this were very positive, as reported in the effective section of this report. However, they had only just been released at the time of our inspection so any areas where they felt improvement was needed had not been actioned.

There was no trust-led survey for, and limited feedback from patients using renal services. Staff told us they asked patients to complete feedback forms, but often these were not being done. Patients told us they shared their views with staff about the services, but all said they had no issues or concerns.

Newsletters were devised for both patients and staff to keep them informed of any changes. We saw the newsletters from the trust for staff which included details for example, about staffing coming and goings, important updates and any courses for staff. These were issued several times a year. For patients, staff and members of the public the EDKPA issued newsletters. This provided
information about any social gathering planned or that had taken place and details about how to access support.

Staff told us they could share their feedback on services with their line managers and at their team meetings. We did not see any minutes of team meetings to evidence this.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system. The renal services worked well external providers, for example the Kidney Patients Association who funded a post for one of their specialist nurses to help younger adults come to terms with diagnosis and treatment. They had also funded a selection of snacks for patients to have during their dialysis treatment at the Wonford site. They also worked with Clinical Commissioning Groups (CCG’s) to look at providing more services in Somerset especially haemodialysis and progress had been made on this to build a new unit. The renal services worked with other NHS trusts when providing renal services. For example, consultant and registrars could provide advice and support to other medical staff caring for patients with renal failure. Royal Devon and Exeter renal services were looking to make sure all patients in Devon and Somerset had access to the same services. They were working with CCG’s across these areas to promote this.

Renal services worked with other providers of haemodialysis services as the consultants were responsible for the patients attending these services in Devon and Somerset.

Learning, continuous improvement and innovation

Renal services were committed to improving services by promoting training, research and innovation. There was a fully embedded and systematic approach to improvement with renal services participating in national and local audits to improve the service they offered to patients. We saw evidence of changes to practice following the identification of areas of concern following investigations. For example, in the peritoneal dialysis service they noticed an increase in the number of infections patients were experiencing and they implemented a study to review the potential causes. From this study they made changes to their practice and training programme for patients which had shown improvements.

Leaders and staff strived for continuous learning, improvement and innovation. This included participating in research projects and recognised accreditation schemes. Creedy ward had obtained the Gold Standard Framework for End of Life Care for the second time. Renal services took part in many research and audits projects for all aspects of their service, including haemodialysis, peritoneal dialysis and renal transplant. Examples of these have been listed in the effective section of this report. A member of senior staff told us they had worked with the National Institute for Health and Care Excellence (NICE) in setting up some guidance around Chronic Kidney Disease in 2014 and they had been requested to help again. Some staff had their research work published, for example in renal nursing journals. Other renal services had visited the trust as part of peer review to help improve their service provision.

Some of the trust’s renal services were the first in the country. For example, the chronic kidney disease (CKD) service where patients were triaged and then if suitable were referred to specialist nurses. This had resulted in patients being seen quicker and had reduced their waiting times.

The renal services were only the third trust in the country to provide an assisted peritoneal dialysis service. They had also found following research and audit that by fitting peritoneal dialysis catheters earlier and burying them under the skin had improved outcomes for patients. This had meant that if patients were ready to start their peritoneal dialysis they were all set ready to go without having to
wait for the catheter to be fitted. This had been peer reviewed by another renal service to see if they could provide this. This was presented regionally and nationally to other renal services.

**Staff could regularly take time out of work to attend training.** Every Thursday, renal services had lunchtime training sessions and all staff could attend if able. We saw the timetable for these for the next year. Different specialities could attend to update on their service provision as well as the renal services feeding back on developments in their service.

Qualified nurses could apply to attend accredited additional training in renal care. A non-medical prescribing course had been completed by some of the community specialist nurses and another was in the process of completing it. Nurses could apply to attend renal conference and meetings.

**The leadership had ensured there was a programme of phased replacement of older haemodialysis machines.** One of the models of machine was not going to have replacement parts manufactured in the future. We saw new machines at two of the units and staff had completed, or were completing their competencies in using them. The trust provided evidence they had plans to purchase more new machines on a rolling programme.
Outpatients

Facts and data about this service

The Royal Devon and Exeter NHS Foundation Trust outpatient services are provided at Wonford and Heavitree hospital, the two hospital sites. Some outpatient services are also delivered at other locations in the county. Axminster hospital, Crediton hospital, Tiverton and District, hospital Exmouth hospital, Honiton hospital, Okehampton community hospital, Ottery St Mary hospital, Seaton hospital and Victoria hospital site in Sidmouth; these were not visited during this inspection.

During our inspection, we visited the main outpatient’s department at the Wonford site. This included ophthalmology, trauma and orthopaedics including fracture clinic, cardiology, oncology, haematology and gynaecology. Also, the diabetes and endocrinology centre, ear nose and throat, oral and maxilla-facial, general surgery including urology and breast clinic and medical records. We visited the therapies department, including physiotherapy and dietetics. We also visited the Heavitree hospital site which included dermatology and the pain management clinic. We did not inspect children’s outpatient services.

The trust has experienced a significant increase in demand for outpatient services for 2018/19 compared to previous years.

We spoke with five patients and two relatives, 58 members of staff including administration staff, managers, matrons, senior nurse, nurses, healthcare assistants, allied health professionals, consultants and doctors. We looked at six sets of medical records, none of which were computerised.

The trust also provided the following outpatients clinics in community hospitals:

<table>
<thead>
<tr>
<th>Location</th>
<th>Specialty</th>
<th>Opening hours</th>
<th>Number of clinics per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axminster</td>
<td>General medicine / surgery</td>
<td>08.00 - 18.00</td>
<td>44</td>
</tr>
<tr>
<td>Crediton</td>
<td>General medicine</td>
<td>08.00 – 17.00</td>
<td>3</td>
</tr>
<tr>
<td>Exeter</td>
<td>General medicine / paediatrics</td>
<td>08.00 - 17.00</td>
<td>4</td>
</tr>
<tr>
<td>Exmouth</td>
<td>General medicine / surgery</td>
<td>08.00 - 18.00</td>
<td>25</td>
</tr>
<tr>
<td>Honiton</td>
<td>General medicine / surgery</td>
<td>08.00 - 18.00</td>
<td>18</td>
</tr>
<tr>
<td>Okehampton</td>
<td>General medicine / surgery</td>
<td>08.00 - 18.00</td>
<td>10</td>
</tr>
<tr>
<td>Ottery St Mary</td>
<td>General medicine</td>
<td>09.00 - 17.00</td>
<td>20</td>
</tr>
<tr>
<td>Seaton</td>
<td>General medicine</td>
<td>09.00 - 17.00</td>
<td>2</td>
</tr>
<tr>
<td>Victoria hospital site in Sidmouth and District</td>
<td>General medicine / surgery</td>
<td>08.00 - 18.00</td>
<td>20</td>
</tr>
</tbody>
</table>

The trust’s outpatients service includes traditional consultation, admissions avoidance clinics, ambulatory clinics and one stop clinics. Fast track appointments are available for all patients with suspected cancer. However, ambulatory services have been inspected under the medical care core.
service. The trust also provides telephone and virtual clinics. Additional out-of-hours and Saturday clinics are provided in response to variable increase in demand.

The trust provided a number of specialty community clinics at Community Hospitals in Axminster, Exmouth, Okehampton, Sidmouth and Tiverton. Hospital consultants provided a range of outpatient services to both north Devon and south Devon hospitals.

(Sources: Routine Provider Information Request (RPIR) Sites tab; Acute RPIR Context acute tab)

**Total number of first and follow up appointments compared to England**

The trust had 639,379 first and follow up outpatient appointments from August 2017 to July 2018. The graph below represents how this compares to other trusts.

(Source: Hospital Episode Statistics - HES Outpatients)

**Number of appointments by site**

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from August 2017 to July 2018.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Devon &amp; Exeter Hospital (Wonford)</td>
<td>588,208</td>
</tr>
<tr>
<td>Royal Devon &amp; Exeter Hospital (Heavitree)</td>
<td>121,862</td>
</tr>
<tr>
<td>Newcourt House</td>
<td>60,711</td>
</tr>
<tr>
<td>Exmouth Hospital</td>
<td>20,656</td>
</tr>
<tr>
<td>Tiverton District Hospital</td>
<td>19,024</td>
</tr>
<tr>
<td><strong>This Trust</strong></td>
<td><strong>899,878</strong></td>
</tr>
<tr>
<td><strong>England</strong></td>
<td><strong>107,320,812</strong></td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

**Type of appointments**

The chart below shows the percentage breakdown of the type of outpatient appointments from August 2017 to July 2018. The percentage of these appointments by type can be found in the chart below:
Number of appointments at Royal Devon and Exeter NHS Foundation Trust from August 2017 to July 2018 by site and type of appointment.

![DNA First Follow up Hospital cancelled Patient cancelled](chart)

(Source: Hospital Episode Statistics)

**Is the service safe?**

**Mandatory training**

The service provided mandatory training in key skills to all staff assigned to outpatient areas. However, these figures were linked with those of inpatient services. Managers and individuals were informed through email when mandatory training was due to be updated.

**Mandatory training completion rates**

The trust was unable to provide separate training data for qualified nursing staff and most medical staff in outpatients. The training data supplied showed a single member of medical staff and some additional clinical services staff. The one member of medical staff shown in the trust’s mandatory training data had completed all the mandatory training modules for which they were eligible. These included dementia and delirium, falls slips and trips, manual handling and mental capacity. The trust clarified that most of their staff who worked in outpatients, worked across both inpatients and outpatients. Accordingly, in the trust’s human resources (HR) and training data, these staff were mapped to the relevant inpatient service. The trust supplied further training data for manual handling in outpatients which showed most areas achieved better than the trust target of 75%. Okehampton, Crediton and Tiverton outpatients only achieved 66%. However only three members of staff were involved and one had not updated their training.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**All outpatient department (OPD) staff received training in dementia and delirium.** Training regarding specific mental health problems and learning disability was available from the psychiatric and learning disabilities liaison if requested. Staff described being supported to book and attend planned sessions. This meant staff were prepared and knew how to manage their needs in the outpatients setting. Oversight of mandatory training, for example, within the surgical outpatients’ department was gained through the electronic staff record which was overseen by two band six
nurses. Staff told us they rarely had issues being released for face to face training, and often had time to complete e-training during normal working hours.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had received training on how to recognise and report abuse and they knew how to apply it. Staff gave us several examples of when they had raised safeguarding concerns.

There were arrangements to keep both adults and children safe from abuse that was reflective of relevant legislation. The trust’s safeguarding policies described the definition of abuse and who might be at risk, the rationale of assumed capacity, and the responsibilities of individuals. The policies were linked with the provisions of the Mental Capacity Act (MCA) 2005 in relation to deciding if a person was also vulnerable, due to their lack of mental capacity to make their own decisions. All staff had MCA training and staff could talk about the MCA and how it may be applied. These policies were easily accessible on the trust’s intranet pages. along with information provided by the trust’s safeguarding team (including contact details and phone numbers).

Staff could identify children who might be at risk of potential harm and we were given examples where they had done so. The outpatient departments had a safeguarding lead. Staff could tell us who this was and how they would contact them. There were posters about safeguarding issues displayed in most outpatient areas. We also saw a ‘Quick reference guide for children who are not brought in for a hospital appointment’. This described the process for staff to follow if a child was not brought to attend an appointment on two occasions, and how to escalate concerns to the safeguarding team. Staff in medical outpatients, for example, told us they would also inform the child’s GP. This was shown in a flow chart on display in all consulting rooms we looked at. In addition, staff in the pain clinic could access help and support directly from the safeguarding team, and told us messages, advice and support was clear and consistent.

There were arrangements to safeguard women or children with, or at risk of, female genital mutilation (FGM). Staff in gynaecology outpatients were aware of and knew how to recognise the various types of FGM but had only experienced one case.

**Safeguarding training completion rates**

The trust was unable to provide separate training data for qualified nursing staff, therapy staff and most medical staff in outpatients. The training data supplied show a single member of medical staff and some additional clinical services staff.

The trust told us that most of their staff that worked in outpatients, worked across both inpatients and outpatients. Accordingly, in the trust’s HR and training data these staff were mapped to the relevant inpatient service.

The one member of medical staff in outpatients shown in the trust’s mandatory training data was not eligible for any safeguarding modules.

(Source: Routine Provider Information Request (RPIR) – Training tab)
Cleanliness, infection control and hygiene

Although there were systems and processes to prevent the spread of infection, they were not always used. Environmental cleaning audit results for all outpatient areas were generally good, and above the trust target of 85%. However, the dental/ear nose and throat OPD scored less than 85% twice in six months. Despite this, their average was still above the trust target of 90% at 90.3%. However, standards of cleanliness and hygiene were maintained in other areas through daily cleaning schedules, matrons’ visits, and the use of ‘I am clean’ stickers on equipment. We saw cleaning schedules for individual consulting rooms, waiting areas and some specialist pieces of equipment. All records we viewed were up to date and complete. Staff could explain how they would escalate concerns about cleaning standards if they needed to.

Not all outpatient areas participated in hand hygiene audits. Thirteen areas, including the clinics held in community hospitals should have submitted data for six months, from July to December 2018. The response rate was 83.3% (65 submissions from a possible total of 78). Hand hygiene results ranged from 29% (at Axminster Community Hospital in July 2018) to 100%. Only Fracture clinic, Orthopaedic, Haematology and Gynaecology one and two clinics submitted data every month. The Macleod centre for Diabetes and Endocrine, Surgical and Ear nose and throat outpatients only submitted three months of data. This meant the trust could not be assured that patients were not at risk from poor hand hygiene. Staff told us that results were discussed at the ‘Comm Cell’, a brief team meeting held most days. Actions to be taken following the results were also discussed at this meeting. Although some hand hygiene results were poor, there were no actions or plans displayed to remedy a poor score.

Outpatient areas we visited were visibly clean and uncluttered. All stock cupboards were well organised with all supplies stored up off the floor to enable effective cleaning. Clinics used green ‘I am clean’ stickers to show pieces of equipment were cleaned. In medical outpatients. we saw cleaning audit results on display. Results showed 97.6% compliance against audited standards, however these results were from August 2018.

Staff were bare below the elbow in line with trust policy. This promoted more effective hand washing and prevented long sleeves from touching patients, therefore reducing the risk of spreading infection. We saw staff washing their hands and using hand gel before and after patient contact. This was in line with the National Institute of Health and Care Excellence (NICE) Quality statement 61, (statement three). We also saw World Health Organisation (WHO) ‘five moments for hand hygiene’ posters displayed in most clinics we visited.

Staff were aware of the trusts decontamination policy for dealing with infection control in the department. They described when patients attended with infectious conditions, for example Flu, that these patients needed to be isolated and the deep cleaning requirements which would occur after their appointment.

In the phototherapy (a light source treatment) room in the dermatology clinic, the phototherapy UVA and B machines were cleaned after each patient use. There were cleaning schedules to demonstrate cleaning had happened. The patient and visitor toilets in all outpatient areas were visibly clean and had cleaning schedules completed.

In all outpatient areas we visited, disposable curtains were in use to prevent the spread of infections. These were dated and changed regularly according to trust policy. All curtains we checked were within the policy timeframe of being changed every three months.

The hospital managed and decontaminated reusable medical devices in line with national guidance, Health Technical Memorandum 01-06: Decontamination of flexible endoscopes
All qualified nurses undertook decontamination of scopes. We saw clear standard operating procedures and evidence of annual competency based training for all relevant staff.

There was an electronic system to track the cleaning, usage and decontamination of endoscopes used in the ear nose and throat clinic. This system allowed full traceability to each patient. If the electronic system failed, paper records were available to be used.

In the urology department, flexible cystoscopes (used for looking inside bladders) were used. We saw staff decontaminating scopes with a three-step system which was in line with trust policy. In addition, all scopes were sheathed prior to use. Serial numbers of scopes were recorded in the procedure notes to allow scopes to be traced to patients in the event of any infection concerns.

Environment and equipment

The service had suitable premises and equipment and looked after them well. The waiting areas for outpatients were appropriate and patient centred. We saw sufficient seating areas and most clinics had a quiet room for patient use. Chairs were provided for bariatric patients and areas for mobility scooters to park safely. There were arrangements for bariatric patients such as specialised bed/trolleys and weighing scales. Staff told us that further bariatric equipment was available if required.

Personal protective equipment (PPE) was provided, including protective eyewear for the laser clinic in ophthalmology. Staff used PPE, which included disposable gloves and aprons when necessary, to prevent the spread of infection. We found that cleaning products were locked away which was an improvement following the inspection in February 2016.

The maintenance and use of equipment generally kept people safe. We looked at a sample of eight pieces of equipment across all the outpatient departments we visited, and found they were within both service date and/or electrical safety test date. However, in medical outpatients, we found an electric thermometer which was outside of its service date which was last recorded in 2015.

Resuscitation equipment was not always checked correctly in outpatient clinics. Most resuscitation trolleys were checked both daily and weekly. However, in medical outpatients we found 12 days between October 2018 and January 2019 where daily checks had not taken place. In addition, we also found weekly checks were not always documented, with the longest gap between checks being 14 days between December 2018 and January 2019.

All trolleys we looked at had tamper evident tags on them, and all equipment and medications we looked at were in date. Where equipment or medications were due to expire, this was clearly recorded on the checklists and reported to the resuscitation department for replacement.

The hospital ensured specialised personal protective equipment was available for staff to use when needed. In departments where cytotoxic medicines (these contain chemicals toxic to cells and used to treat cancer) were administered, staff used gloves, aprons to protect themselves from exposure.

The arrangements for managing waste and clinical specimens kept people safe. In medical outpatients, we saw good segregation, labelling and storage of waste. Staff used colour coded
sharps bins, which were stored securely prior to collection for disposal. This was in line with trust policy and The Safe Management and Disposal of Healthcare Waste (Department of Health 2013) and EU Waste Directive 2008/98/EC. We also saw recent waste disposal audit data from December 2018. Results showed 100% compliance against the audited standards. However, in one open side room we saw staff stored patient samples including urine, in an open box on a worksurface, which was directly accessible to the waiting area.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary. Risk assessments were carried out for patients who used services in line with national guidance, for example nutritional assessments for new patients.

Outpatient departments who undertook invasive procedures followed the World Health Organisation safer surgery checklist. This was a tool used to ensure that surgical procedures were conducted safely. National safety standards for invasive procedures were embedded in the organisation. They provided a framework to produce local safety standards for invasive procedures. Dedicated checklists were used for invasive outpatient procedures such as taking biopsies, removing lesions and laser treatment for eyes.

Staff we spoke with could describe the processes involved when managing a deteriorating patient. They could give examples of when they had to quickly call for other members of staff or the crash team. The trust had a clear process for clinically unwell patients in outpatients to be admitted to hospital, the consultant contacted the bed management team to arrange admission. Oncology and haematology patients were given an information sheet with various contact details for different times of the day and night so they knew who to contact if they became unwell whilst at home. A helpline was available Monday-Friday 8am until 5pm where patients received advice or were asked to attend the hospital. Out of hours, the contact was with acute oncology nurses on a mobile number or the nurses on Yeo ward. At weekends the triage nurse was available on a mobile number.

Staff had access to mental health liaison and other specialist mental health support if they were concerned about risks associated with a patient’s mental health. Staff explained the process of how to make an urgent referral to them.

Nurse staffing

The service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment. There were no national standards or guidelines for staffing in outpatient departments. A manager told us that staffing requirements were determined by skill mix the workload of clinics.

The trust was unable to provide separate staffing data for qualified nursing staff and most medical staff in outpatients. The staffing data supplied showed a single member of medical staff and some additional clinical services staff. However, in urology, senior staff told us they had recently secured two additional healthcare assistant posts and two qualified nurses as a response to the increase in referrals they had experienced over the previous 12 months. The trust clarified that most of their staff that worked in outpatients, worked across both inpatients and outpatients. Accordingly, in the trust’s HR and training data these staff were mapped to the relevant inpatient service.
Arrangements for handovers and shift changes ensured that people were kept safe. In outpatients, at the start of every clinic, staff met in a safety huddle to discuss the clinic activity for the day. They also discussed staffing, safety updates and incidents, as well as any ‘flagged’ patients attending the clinic where they might need to provide additional support. If somebody with a known problem was due to come in this was also discussed. The matron in Orthopaedics was very proactive in making reasonable adjustments for people with special requirements coming into the department.

The only other staffing data supplied was a small amount of bank and agency usage data. This data is shown below.

(Source: Routine Provider Information Request (RPIR) – staffing tabs)

Bank and agency staff usage

The service had minimal use of bank staff and did not use agency staff.

It should be noted that:

- Data was provided from May 2017 to May 2018, excluding February 2018, to provide 12 months of data. The trust was unable to provide data for February 2018 due to the migration to a new computer system that occurred in that month. Bank and agency shifts booked in advance were entered on both systems, therefore due to the risk of double counting providing inaccurate data the trust decided to omit this month.

- The trust was only able to provide unfilled shifts for the period from May 2017 to January 2018. This was also due to issues related to the change to the new roster system in February 2018 leading to a risk of double-counting and inaccurate information being provided.

- The trust was unable to supply the total number of shifts worked by all permanent and temporary staff. Therefore, it was not possible to calculate the percentages of shifts worked by bank and agency staff and left unfilled.

- Due to the issue with providing separate staffing data for outpatients explained in the previous section, this data covered only a few specific areas of outpatients. These included dermatology outpatients at Heavitree Hospital, ENT outpatients, Fracture Clinic, Princess Elizabeth Orthopaedic Centre outpatients, and “Surgery 1” outpatients.

From May 2017 to May 2018, excluding February 2018, the trust reported that across the outpatient areas:

- Dermatology outpatients at Heavitree Hospital,
- Ear nose and throat outpatients,
- Fracture Clinic and Princess Elizabeth Orthopaedic Centre outpatients,
- “Surgery 1” outpatients.

There were 87 shifts were filled by bank qualified nurses, while 449 shifts were worked by bank nursing assistants. Over the same period, no shifts were covered by agency qualified nurses or agency nursing assistants.
In addition, over the shorter period from May 2017 to January 2018, two qualified nursing shifts and 187 nursing assistant shifts were not filled by bank or agency staff to cover staff absence. This data showed that 35% of shifts were unfilled. To cover this shortfall, managers told us that many outpatient staff worked extra shifts to cover clinics. Many clinics had bank staff that only worked in specific clinics because they had the knowledge and experience to do so. This meant that not every clinic was fully staffed. Between April – December 2018 0.7% of appointments were cancelled due to nursing shortages. This equated to 512 appointments.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Unfilled*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nurses</td>
<td>87</td>
<td>2</td>
</tr>
<tr>
<td>Nursing assistants</td>
<td>449</td>
<td>187</td>
</tr>
<tr>
<td>Total</td>
<td>536</td>
<td>189</td>
</tr>
</tbody>
</table>

* May 2017 to January 2018

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

The service did not always have enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

The trust was unable to provide separate staffing data for medical staff in outpatients. The staffing data supplied show a single member of medical staff and some additional clinical services staff.

The trust clarified that the most of their staff that worked in outpatients, work across both inpatients and outpatients. Accordingly, in the trust’s HR and training data these staff are mapped to the relevant inpatient service.

(Source: Routine Provider Information Request (RPIR) – staffing tabs)

The trust told us that they had experienced a reduced number of surgical consultants due to long term sickness and vacancies. There had also had an increase in demand in OPD referrals and capacity issues. The effect of not having enough medical staff and the time lag associated with recruitment created severe delays in seeing patients, especially for gastro-intestinal illnesses. The trust had addressed these shortfalls by creating 14.5 whole time equivalent additional consultant posts in various specialities to alleviate the problem. The trust was in the process of actively recruiting consultants. Between April – December 2018 4% of outpatient appointments were cancelled due to medical staff shortages. This equated to 2830 appointments.

Vacancy rates

From February 2017 to May 2018, the trust reported a staffing surplus of 48.5% across the two clinics for which data was available (the fracture and pain clinics).

Over these 12 months the number of medical staff in post in the fracture clinic was 0.2 whole time
equivalent (WTEs) in February, July and October 2017, and two WTEs across all other months. As the establishment was set at 0.2 WTEs for the whole 12 months, this resulted in a large staffing surplus. The trust reported that no medical staff left fracture clinic over these 12 months. The above data may result from changes in how the trust allocated medical staff to reporting units in its staffing data, rather than from real staffing changes.

There were 2.5 WTE medical staff in post in the pain clinic every month, which was consistently in line with establishment.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From February 2017 to May 2018, the trust reported that no medical staff left either its fracture or pain clinics. The turnover rate was therefore zero. The Trust’s turnover rate target is between 10% to 12%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From February 2017 to May 2018, the trust reported a sickness rate of 1.3% for medical staff in its outpatient fracture and pain clinics. This was lower than the trust’s target of 4.0%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

It should be noted that the trust was unable to calculate bank medical staff usage due to deficiencies with their data. In addition, the trust provided no bank medical staff usage data for outpatients.

(Source: Routine Provider Information Request (RPIR) – Medical locum agency tab)

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care. We reviewed six sets of paper records and found them to be complete and legible, and we could find information easily. Records were clear, up-to-date and available to all staff providing care. No medical records were yet computerised. The trust was planning to introduce an electronic notes system called “My Care” in June 2020. This was to be a ‘real time’ information system that could be accessed by healthcare professionals and patients alike. Every aspect of a person’s care, which included relevant history, current medications and latest test results was to be available at any time to be viewed and on any device. The trust hoped that this system would standardise the way to manage all aspects of care and involve the patient.

There was a system to ensure medical records were available for clinics. The trust audited the percentage of notes available for outpatient clinics. Between December 2017 and December 2018, the trust prepared 333,630 sets of medical notes for outpatient clinics. Of these, 215 (0.06%) were temporary notes. This meant an average of 99% of original notes were available for outpatient
clinics. The electronic patient system allowed letters and results to be printed off for temporary notes. The temporary notes were linked to the original notes but tracked separately. All notes could be tracked and the temporary notes could be filed in the original notes once no longer required. Patients' clinic appointments were not cancelled and they were not seen without notes.

**Patients' individual care records were managed in a way that kept their information safe.** Patient records were stored securely in all outpatient clinics we visited. This was an improvement since the last inspection in February 2016.

**Records contained details of patients' varied needs.** The trust had an accessible information and communication needs policy for staff members, to help and support communication needs of patients and carers associated with a disability. Medical records contained details of patients' mental health needs, learning disability needs, autism and dementia needs alongside their physical health needs such as hearing difficulties and mobility issues. Staff explained the process of how they obtained advice from mental health liaison and how they documented when a patient attempted to discharge themselves or refused treatment.

**Medicines**

**The service did not always follow best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.** Medicines were mostly stored securely behind locked doors with access restricted to appropriate staff. There were suitable systems for the ordering and disposal of medicines. In ophthalmology, medicines were stored in locked trolleys which were locked away when the unit was closed. They were put into each clinical room when the department opened. As part of the morning checklist in ophthalmology, expiry dates of medicines were checked and topped up from the ward stock by a pharmacy technician. We found one clinic room (room 11) was unlocked and near a patient waiting area with medicated eyedrops on the desk. This area was not always manned. When we made the staff aware, the medication was locked away.

**Medicines were not always prescribed, administered and/or supplied to patients in line with relevant legislation for patient group directions (PGDs) (these allow some registered health professionals to supply and/or administer specific medicines to a pre-defined group of patients).** Nurses were trained and assessed to ensure they were competent to administer medicines under PGDs. Drugs administered under a PGD were recorded in patients' notes. We found PGDs in ophthalmology clinics had been signed and authorised. However, in respiratory clinics PGDs had not been signed by staff.

**Medicines and medicine-related stationery, such as prescriptions pads, were managed in a way that generally kept people safe.** Medicine refrigerators were locked when not in use and within the correct temperature range. Refrigerator temperatures were monitored correctly to ensure medicines were stored at appropriate temperatures. We saw evidence of daily checks in all outpatient clinics we visited. We checked a random sample of medications and controlled drugs and found them all to be in date and accounted for. Drug cupboards were locked and the registered nurse coordinating the clinics we visited held the keys.

Staff in medical outpatients had identified that doctors from one specialty were taking generic onsite pharmacy prescriptions away with them in error at the end of their clinic sessions. A registered nurse
signed out a set number of prescriptions to the doctors at the beginning of the clinic, and doctors filled out a sheet to indicate how many they had used and who for. Nurses then counted the remaining prescriptions back in at the end of the clinic. Staff told us of two occasions where doctors from the same specialty had taken blank prescriptions away from the clinic in error. As a result, nursing staff had been reminded to chase doctors for their remaining prescriptions before they left the clinic.

**Patients received specific advice about their medicines in line with current national guidance.** All patients told us they had received information about the medications they were given, including whom to call if they were concerned about anything. One patient said they received good and timely information around medicines and information as to whether they needed to stop taking them prior to the appointment.

**There were satisfactory arrangements to ensure safety of controlled drugs and chemotherapy given in outpatients.** All chemotherapy was prescribed, dispensed and administered on a named patient basis.

In medical outpatients, the room temperature of the treatment room was not being monitored. When we visited, the temperature was 25 degrees. The trust medicines policy stated that it was not mandatory that the room temperature should be taken unless there were concerns, in which case monitoring should be undertaken. Some medicines should not be stored in extremes of temperature as it may have affected their effectiveness. This was brought to the attention of the nurse in charge.

**Incidents**

**The service managed patient safety incidents well.** Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

**Staff understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and to report them internally and externally, where appropriate.** Staff told us they had a good understanding of incidents and felt confident to report them. Staff received feedback when they had reported an incident and it had been investigated. They all understood their responsibility to raise concerns, report patient safety incidents and near misses. Staff showed us the electronic incident reporting system and gave examples of when they had used it.

Lessons were learned and shared through various means. There was discussion at the “Comm Cell” meeting before the start of clinics. For example, a patient developed a pressure ulcer under a plaster cast that had been applied in theatre. The learning from this incident was an improved training session in plaster casting techniques for medical staff. To disseminate learning further, the trust produced a ‘learning from trust-wide incidents’ newsletter for staff. We saw evidence that incidents and learning was discussed and monitored at speciality governance group meetings. We saw minutes of meetings from different division governance group meetings demonstrating they had oversight of clinical incidents.

**The trust had processes and training for staff to ensure they met the duty of candour.** Staff demonstrated their awareness of Regulation 20 of the Health and Social Care Act 2008 (Regulated
Activities) Regulations 2014, introduced in November 2014 regarding duty of candour. This Regulation requires the organisation to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. We saw letters sent to patients demonstrating that duty of candour took place following serious incidents.

Never Events

From October 2017 to December 2018, the trust reported one incident classified as a never events for outpatients. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Immediate learning had spread across the trust following the incident. This was wrong site laser surgery performed in Ophthalmology outpatient’s department (still under investigation). Staff told us they were aware of the wrong site surgery incident in Ophthalmology. They described the lessons learned and how they could be applied to their own speciality. For example, ensuring operation sites were marked with indelible pen.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from October 2017 to December 2018.

These SI's were the following types:

- Diagnostic incident including delay (including failure to act on test results). It took the trust almost two years, from the data of incident, to report this diagnostic incident SI to STEIS. This related to a patient who had not had the correct follow-up after a scan and had suffered harm as a result but was not realised until the patient presented with further symptom two years later. A comprehensive action plan addressed the issues highlighted.

- Diagnostic incident including delay (including failure to act on test results). There was a long delay between the date of the clinic visit (21 April 2016) and the typing of the letter (10 May 2016). The patient was harmed.

- Medication incident. Administration of chemotherapy in an outpatient setting and the patient was harmed (still under investigation).

(Source: Strategic Executive Information System (STEIS))

Staff told us learning from serious incidents was shared with them through a newsletter from the Incident Review Group.
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. All professional healthcare workers have a professional responsibility to keep themselves updated. Relevant best practice guidelines, such as National Institute for Health and Care Excellence (NICE) guidance, was distributed to staff through the regular “Comm Cell” meetings.

The trust contributed to national clinical audits within outpatients. The endocrinology department was feeding into a national initiative called ‘Getting it Right First Time.’ This benchmarked the trust’s performance at specialty and procedure level, using best clinical practice as the benchmarks. Results were not available for individual trusts who took part.

Patients care and treatment outcomes were monitored. The trust used an Outpatient Quality Assessment Tool (OQAT) to audit outcomes. All outpatient departments were to be graded gold, silver or bronze and the re-review time was according to results. These audits comprised of an;

- Observational audit, in which eight areas were looked at. These included food and nutrition, infection control, mental health, record keeping, respect and dignity, safe environment and self-care,
- Patient questionnaires,
- Staff satisfaction survey,
- Documentation audits.

The senior nurse for outpatients led the OQAT assessments which were completed by peers from another department.

The OQATs were suspended for a review of the tool and re-started December 2018. Since the OQAT assessments recommenced, two were completed in January 2019. The Macleod Diabetes and Endocrine Centre scored 84% and X-ray procedures 78%, both did not meet the trust target of 95%. Matron’s for the area were responsible for writing an action plan for improvement.

The trust ensured staff had the skills, knowledge and experience to deliver effective care and treatment. Staff told us of further training they had received to do their job.

There was evidence to show the trust ensured it identified and implemented relevant best practice and guidance, such as NICE guidance. This was identified and monitored at speciality governance group meetings.

Patients were told when they need to seek further help and advised what to do if their condition deteriorated. Patients who became unwell whilst at home were given an information sheet with various contact details for different times of the day and night.

Staff knew how to handle violence and aggression incidents. Teams had de-brief sessions to talk and reflect on incidents that occurred. However, staff said these types of incidents were not common.

Patients’ physical, mental health and social needs were assessed, and their care, treatment and support were delivered in line with legislation, standards and evidence-based guidance. In the diabetes centre, patients and their families or carers could access support facilities based in the centre. These facilities focussed on all aspects of diabetes management from diet control to blood glucose monitoring. In addition, the hospital has also developed its own inhouse course called ‘ERICA’ (Exeter recommendation Insulin Carbohydrate Adjustment) for newly diagnosed type-1 diabetics.
Staff told us how patients who were suspected to be experiencing depression could be referred for a mental health assessment.

The service ensured it identified and implemented relevant best practice and guidance, such as National Institute for Health and Care Excellence (NICE) guidance. When safety alerts were released, they were circulated to all staff by email. There was an expectation that all staff read the alert and signed a signatory sheet when an alert was released. The medical and surgical outpatient matrons followed up anyone who had not signed the sheet to ensure completion. Alerts were also discussed as part of service line in division governance group meetings and morning safety meetings and recorded in communication diaries.

**Outpatient procedures were carried out in line with professional guidance.** In urology, patients with suspected bladder cancer could access a one-stop clinic that involved a camera test to look at the inside of the bladder. This was in line with NICE guideline NG2 Bladder cancer: diagnosis and management. Outpatient procedures such as hysteroscopy / cystoscopy were carried out in line with professional guidance, by correctly trained staff.

There were protocols and standard operating procedures in most clinics we visited. In the Pain clinic we were shown laminated posters on the walls explaining post procedure observations for the different investigations and treatments performed. In addition, we also saw formal competency based checklists for nurses to care for patients who had received sedation. Staff explained this training was being developed by senior nurses and was due to go before the anaesthetics governance board prior to approval for use.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. There were cafes, the hospital restaurant and various snack bars available for patients and relatives to use. They offered meals, snacks and hot and cold drinks. This included snack bars in the Leukaemia and Oncology centres and the Princess Elizabeth orthopaedic outpatients centre. Food and drink vending machines were also situated throughout the hospital site. The hospital also had a shop where refreshments could be purchased. Many clinics also provided free tea, coffee and water for patients especially if they had a long wait.

**Patient’s nutritional needs were identified, monitored and met.** We saw evidence that new patients attending outpatients were nutritionally risk assessed in line with the NICE QS15 (Statement 10, physical and psychological needs) and results acted upon. Where relevant, patients were referred for specialist nutritional advice. All oncology patients attending outpatients had a nutritional risk assessment and their weight recorded at every visit.

The trust had a five-year Food and Drink Programme 2017-2022 to ensure the use of the Malnutrition Universal Screening Tool (MUST) and other nutritional screening tools in outpatients by March 2019. This action formed part of the Nutrition Steering Group workplan for 2018/19. This was audited through the Outpatient Quality Assessment Tool. However, the trust could not provide data for MUST specific assessments, as the audit performed was on generic outpatient documentation.

**Pain relief**
Patients’ had their pain assessed and managed and clinics used adapted tools for those patients who had difficulties communicating. For example, in various outpatient clinics, patients had their pain assessed using simple numerical pain scales and picture pain scales for people who had difficulty in communicating their pain levels verbally. In oncology, pain was routinely discussed at every appointment.

Staff used an appropriate tool to help assess the level of pain in patients who were non-verbal. For example, the Abbey Pain Scale for people with dementia was used routinely as part of assessments in the surgical outpatient department.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. In surgical outpatients, staff identified a group of patients who attended for regular cystoscopies as part of their treatment. Administrative staff used codes to determine the frequency of the follow up cystoscopies, however it had not been clear that for this group of patients, the follow up appointments were time critical. As a result, codes were changed so that this was clearly indicated on the booking computer system.

The main outpatient department and several other specialist service lines participated in relevant quality improvement initiatives such as local and national clinical audits. The outpatient service audited locally against national guidelines and we saw various audits that demonstrated this. The audits had elements of outpatient care. For example, British Association of Urological Surgeons audit for Cystectomy (removal of bladder) and Nephrectomy (removal of a kidney)

Most recently the outpatient service had been involved in a “Risky Behaviours” CQUIN (Commissioning for Quality and Innovation) target. New training had been introduced for staff to encourage them to ask every patient if they smoked and offer them referral to the smoking cessation advisor. Since November 2018, the service had referred 70 patients to the service.

Information about the outcomes of people's care and treatment (both physical and mental where appropriate) was routinely collected and monitored. In the pain clinic, staff recorded pre- and post-procedure pain scales on the national Joint Registry as a way of indicating the effectiveness of the treatment given to the patient.

Follow-up to new rate

Follow-up to new rate was the number of new referrals in comparison to the number of follow up appointments for people already in the system

From August 2017 to July 2018:

The follow-up to new rates for Royal Devon & Exeter Hospital (Wonford), Tiverton District Hospital and Exmouth Hospital were consistently lower than the England average.

The follow-up to new rate for Royal Devon & Exeter Hospital (Heavitree hospital) was consistently
higher than the England average.

The follow-up to new rate for Newcourt House was lower than the England average in eight out of 12 months. It should be noted that no clinics were held at Newcourt House. All podiatry appointments relating to community hospitals were booked centrally there.

**Follow-up to new rate, Royal Devon and Exeter NHS Foundation Trust.**

![Graph showing follow-up rates](image)

(Source: Hospital Episode Statistics)

The follow up to new rate is a calculation which showed how many new patients could access services compared to the number of patients already on a pathway.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. Staff had the skills, knowledge and experience to identify and manage issues arising from patients’ mental health conditions, learning disabilities or dementia. Staff in all the outpatient departments and diabetic services told us they had received training to help them identify and support patients who were living with dementia. There was a dedicated dementia link nurse they could contact for advice.

Staff told us of specific training they had undertaken as specialist nurses to deliver care in outpatient departments. The gynaecology clinical lead nurse specialist completed further training to undertake colposcopies (a gynaecological procedure) and ultrasound scans. In Ophthalmology, specialist nurses were trained to administer intra vitreal (eye) injections. This was previously only undertaken by medical staff. Staff told us there were University accredited courses and in-house training available with associated competencies for different procedures.

Staff were encouraged and given opportunities to develop. In surgical outpatients, we were given multiple examples of staff development. These included band two staff progressing to qualified nursing training, and enhanced roles for band four assistants who had received additional training to help assist with prostate specific antigen blood test monitoring in urology clinics. We were also
told of nursing staff in pain clinic receiving additional training to be able to give pain relieving patches. The training had been developed using manufacture and best practice guidance, and had been taken before the anaesthetic governance committee for approval.

**There were mixed arrangements for supporting and managing staff to deliver effective care and treatment.** It was identified at the last inspection in February 2016 that the trust had no formal clinical supervision policy for staff and did not routinely monitor or record clinical supervision. There was also no target rate to achieve. At this inspection we found there was still no formal system of clinical supervision. However, there was formal clinical supervision in specialist teams such as Clinical Specialist nurses in Cancer services who received supervision through a cancer charity. The Cystic Fibrosis team were supported from the psychology component of the multi-disciplinary team.

**The Trust had a professional development plan** (2018 – 2021) which outlined an approach for reflection as individuals and teams. We saw clinical supervision taking place at local levels. For example, in the diabetes service, all nurses had monthly one-to-one clinical supervision supported by weekly team meetings. In addition, specialist diabetic dieticians had supervision sessions with clinical psychologists. Staff had appraisals and access to Schwartz rounds (a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare) as part of supervision.

**Volunteers were recruited where required.** They were trained and supported for the role they undertook. In medical outpatients, volunteers escorted patients between the main waiting area and the sub waiting areas. This was to help patients, as the department was quite large and could be confusing to navigate unaided.

**Appraisal rates**

**There were inconsistent arrangements for supporting and managing staff through the appraisal process.** The trust was unable to provide separate appraisal data for qualified nursing staff and most medical staff in outpatients. The appraisals data supplied showed a single member of medical staff and some additional clinical services staff. The trust clarified that most of the staff who worked in outpatients, worked across both inpatient and outpatient services. Accordingly, in the trust’s HR and training data these staff were mapped to the relevant inpatient service.

The data that was supplied showed, that from February 2017 to May 2018, the one member of medical staff (who worked in the pain clinic) had received an appraisal. Over the same period one of the eight eligible additional clinical services staff (12.5%) had received an appraisal.

The trust’s 80% appraisal completion target was met for the medical staff member included in the data, but not met for the additional clinical services staff included.

*(Source: Routine Provider Information Request (RPIR) – Appraisal tab)*

The trust provided the latest appraisal data for staff identified as working exclusively in 15 outpatient departments. They did not specify whether this was nursing, medical, therapy or clerical staff. The trust completion target of 80% was met by seven of the 15 areas. The lowest compliance was in medical outpatients at 28.6% while three areas managed 100%. The average compliance rate was
76%. Staff felt that the new senior nurse in medical outpatients would improve the appraisal rate to ensure staff were supported and managed more appropriately.

The senior nurse responsible for community outpatient departments met staff every six weeks and held group meetings to provide clinical supervision support.

**Multidisciplinary working**

*Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.* Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. There was good evidence of multi-disciplinary working, including occupational therapists, medical staff and nurses. There was interagency working with a neighbouring mental health NHS trust liaison team.

In the pain clinic, patients could attend multi-disciplinary clinic appointments. In these clinics, patients could access physiotherapy, occupational therapy and had input from a team of clinical psychologists, as well as consultants and nurses.

**The trust used staff from different teams to assess, plan and deliver care and treatment.** Specialist nurses were utilised in the outpatient department to run some clinics. Many clinics around the hospital, such as in diabetes, endocrinology, breast, urology, ophthalmology and gynaecology were nurse-led with support from consultants if required. Escalation processes within these clinics were clear and nurses told us they could get advice and support from medical colleagues easily.

**There were one-stop clinics in many different specialties for outpatients.** For example, breast care, urology and cardiology. For example, a one stop breast clinic was run by radiographers. Patients would be sent from the surgical OPD. They could have a mammogram, ultrasound scan and biopsy completed in one visit. If the patient did not have a disease, they could be discharged. Results were recorded in real time and the radiographer or consultant could discuss the results with the patient. The clinic also placed guidewires for tumours prior to surgery. This was a one-day service which was beneficial to patients who lived a long way from the hospital. The multi-disciplinary team was made up of the breast clinical nurse specialist, radiologist, radiographic team, pathologist and oncologist.

**Seven-day services**

*Services were not always made available to support care to be delivered seven days a week.* Although many services were still traditionally five-day services, some service lines had set up weekend clinics as response to demand. Many specialties such as ophthalmology and urology ran extra Saturday morning clinics, but the bulk of patient appointments were held between 8 am and 6 p.m. Monday to Friday across most specialities. Evening clinics were also held routinely in both medical and surgical outpatients. In the diabetes centre, evening dietetics and retinal screening clinics had been put on to improve access for working patients and younger adults. In December 2018, the emergency gynaecology clinic held five extra clinics including, Saturday clinics, to prevent potential cancer patients breaching the two week wait before Christmas. The gynaecology nurse specialist told us patients were very grateful and relieved to be seen before the long Christmas holiday.
Health promotion

Patients were empowered and supported to manage their own health, care and wellbeing to maximise their independence. In the medical outpatient clinic, nurses directly referred patients to support programmes, such as smoking cessation. With permission, they also involved patients’ GPs in the ongoing management of the patient. We also saw in the pain clinic, psychologist led compassion based therapy sessions to help patients understand and manage emotions surrounding long term pain.

Patients were involved in regularly monitoring their own health. In the diabetes service, patients monitored and reported blood glucose readings by downloading them from their meters prior to attending clinics. In addition, many specialist education programmes had been established to help patients manage their diet and lifestyle. These included, carb counting and mood and food groups, to help patients understand the links between emotions and food.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent. Patients were supported to make decisions in line with relevant legislation and guidance. In urology, patients were encouraged to go home to think about treatment options following diagnosis. Staff and managers told us thinking time was factored into the patient’s pathway and staff made sure patients were given all the information about their treatment options to make an informed choice. For example, we saw patient information given out during appointments. Patients could ring the clinic to speak to staff with any questions during this time.

We observed consent to care and treatment was sought in line with legislation and guidance. Staff were aware of how to gain consent from children using Gillick competence (used in medical law to decide whether a child under 16 years of age could consent to his or her own medical treatment, without the need for parental permission or knowledge).

Mental Capacity Act and Deprivation of Liberty training completion

The trust was unable to provide separate training data for qualified nursing staff and most medical staff in outpatients. The training data supplied show a single member of medical staff and some additional clinical services staff.

The trust clarified that most staff that work in outpatients, worked across both inpatients and outpatients. Accordingly, in the trust's HR and training data these staff were mapped to the relevant inpatient service.

The training data the trust did supply showed that, as of May 2018, the one member of medical staff (who worked in the pain clinic) and all eight additional clinical services staff had completed this training module.

(Source: Routine Provider Information Request (RPIR) – Training tab)
Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was included in the trust’s safeguarding adults training module. Staff told us about the relevant consent and decision-making requirements of legislation and guidance. This included the Mental Capacity Act 2005 and the Children’s Acts 1989 and 2004 and trust policy. When patients lacked the mental capacity to make a decision, staff ensured that best interest decisions were made in accordance with relevant legislation. Staff were not routinely trained in the application of the Mental Health Act (1983). However, they were well supported by the site management team.

### Is the service caring?

#### Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. We saw staff interact with patients and relatives in a positive, respectful and compassionate manner. They introduced themselves to the patients in line with the NICE QS15 (Statement 1, patient experience in adult NHS services). Clinics displayed notices asking patients to stand back to allow privacy while booking in. We observed receptionists speaking to patients in an attentive and patient manner without being overheard.

Patients were not always able to speak to the receptionist without being overheard. In the general surgical outpatients, patients were booked in by two receptionists working side by side. This did not allow privacy for the patients. In Fracture clinic, the reception was open plan and patients could also be overheard. In the physiotherapy outpatient clinic, patients being treated could not see each other but could hear other patient’s consultations. This did not allow privacy whilst being treated. Privacy during consultations was identified at the last inspection in February 2016. While privacy had improved in Ophthalmology, it remained an issue in physiotherapy.

Staff members displayed understanding, a positive and non-judgemental attitude towards (or when talking about) patients who had mental health problems, learning disability, autism and dementia diagnoses. All language used was respectful and positive. We saw patients who were ‘fast tracked’ through clinics to minimise their fear, anxiety, and confusion.

In the Oncology and Haematology clinics, we observed two patients from booking in and through their consultation. The patients were introduced to the healthcare professionals involved in their care. When the patients had to undress for examination, the assistant practitioner assisted the Consultant and ensured their privacy and dignity was maintained in line with NICE QS15 (Statement 3). We spoke to the patients who were very positive about their experiences in both clinics and praised staff for their ‘calming influence’ and ‘reassuring manner’.

Staff understood and respected the personal, cultural and social needs of patients and treated them with compassion and kindness. In the National Cancer Survey 2018, the trust performed well and was in the top 10 nationally. In two questions for outpatients:

- Was the patient able to discuss worries or fear with staff during the visit? The trust scored 80% against the national average of 71%
- The doctor had the right notes and documentation with him. The trust scored 98% against the national average of 96%
Staff showed sensitive and supportive attitudes towards patients and relatives. We saw staff in medical outpatients greet patients in waiting areas and enquire after their health and wellbeing whilst escorting them to clinic rooms. In pain clinic, compassion based therapy was used to help patients cope with chronic pain symptoms. Staff reported dramatic changes to some patients lives including some patients leaving abusive relationships. The course concluded with patients writing letters to themselves, which staff told us was very emotional for all involved, and many patients remained in contact with their groups for ongoing support.

Staff told us they would raise concerns about disrespectful or abusive behaviour or attitudes displayed by other staff, and explained this would not be in line with the trusts core values. These types of incidents were reported on the trust incident reporting system

Staff ensured that when intimate personal care and support was given by a member of the opposite sex, service users were offered the option on a chaperone. We saw posters offering chaperones in the clinics we visited. Staff understood the importance of chaperones and provided them upon request and where possible offered same gender chaperones especially if intimate care or treatment was involved. Staff sought permission from patients to be present during their examinations and documented these conversations in the patients’ records.

Staff responded in a compassionate way when people experienced physical pain, discomfort or emotional distress. For example, in a consultation we attended, staff discussed the distressing side effects the patient was experiencing from chemotherapy and ways to remedy them.

In most clinics we visited, receptionists made every effort to ensure patients and relatives could speak to them without being overheard. Staff told us if patients indicated they wanted to speak in private, they would arrange this or let the nurse know for when the patient was taken through to the clinic.

We spoke to six patients and two relatives in the outpatients waiting areas. All were positive about the staff and hospital. Comments included “lovely service, staff are kind” and “clean hospital and caring staff”.

All clinical areas had access to picture boards and other communication aids. They used a variety of interpreting services. Clinical areas used the “This Is Me” document for people with dementia and the learning disability passport. If somebody did not have the documents the staff prompted family or carers to complete or would complete it with the person.

Emotional support

Staff provided emotional support to patients to minimise their distress. Patients told us they were given emotional support from all staff and were included in decision making regarding quality and quantity of life.

Patients were given appropriate and timely support and information to cope emotionally with their care, treatment or condition and advised how to find other support services. In all outpatient settings, patient information was freely available to explain conditions and treatment options. Patient information provided was a mixture of trust, national and local charities and local support groups. Information was relevant to the main trust site and satellite clinics in community hospitals.

A patient told us that they had received written information and that it had been invaluable as they “hadn’t taken in everything when I saw the doctor, it really helped having it written down”. Another
patient said staff had explained their treatment options and side effects “in a way I could understand. I felt they listened to me when I had doubts”.

We observed, following a consultation, a specialist nurse took a patient into a quiet room so that she could catch up on how the patient was feeling as he was newly diagnosed.

**Patients (and their families) who received life-changing diagnoses were given appropriate emotional support, and had access further support services.** In the oncology outpatients, a Macmillan representative attended the unit on a regular basis to provide practical support to help patients cope with the financial impact their diagnosis might have on their life. Clinical nurse specialists also offered support within specialities.

**People who needed extra support were identified, and the different clinics directed patients to appropriate support groups.** For example, patients (and their families) who received life-changing diagnoses were given information about support groups such as North Devon Laryngectomy Group, Exeter Laryngectomy Group, group sessions for Acupuncture clinics and Head & Neck Recovery Group. Help was provided to access further support services both nationally and locally. Many long-term outpatients told us that the staff were ‘like family to us, they understand what we are going through’.

We saw that during consultations we observed that doctors discussed different treatment options with patients and they were encouraged to be part of the decision-making process.

**Staff identified how they would respond to somebody in distress to help preserve their privacy and dignity.** They would achieve this by using side rooms and patient lounges. Fracture and Orthopaedic clinics brought patients in at the start of a clinic to assist with this if they were pre-warned. Staff also told us if a patient became distressed in an open environment such as a waiting area, they could take them to sit in a consultation room. In the clinic environment, most had a ‘quiet room’ which could be used to maintain their privacy and dignity. Patients were offered refreshments, tissues and time to gather their thoughts and staff would stay with them, before leaving the clinic. Specialist nurses could be called upon to offer support patients in clinics including learning disability, mental health and dementia.

**Understanding and involvement of patients and those close to them**

**Staff involved patients and those close to them in decisions about their care and treatment.** Following their appointment, we saw how patients were told when they would receive test results / next appointment date. Many follow-up appointments were booked in the clinic (especially for long term patients) and patients received a letter informing them of the details. Patients were also told how long to wait before contacting the hospital if they had not heard about their next appointment.

We saw in medical notes that patients received copies of letters sent between the hospital and their GP. Patients were given information about who to contact if they were worried about their condition or treatment after they left hospital. Oncology patients were given a patient held record book which contained contact details of health professionals, symptoms to be aware of, when to contact someone, blood results and pages for them to write in.

Information regarding safeguarding from abuse (including domestic abuse) was displayed where patients and relatives could see it. We saw posters in the outpatient waiting areas and in the patient toilets.
Staff communicated with people so that they understood their care and treatment. We saw staff actively checking patients had understood conversations and leaflets they had been given. Staff made sure that people who used services and those close to them could find further information, including community and advocacy services, or ask questions about their care and treatment. Nurses and doctors told us clinic appointments especially first appointments, considered extra time for questions or further tests. This ensured patients left feeling informed about their condition and the plans for treatment moving forward.

People were empowered and supported where necessary, to use and link with support networks so that it had a positive impact on their health and wellbeing. We saw information displayed in pain clinic for specific support groups and staff told us the service also benefited from clinical psychologist support. Staff told us they understood the impact that chronic pain could have on a whole family, not just the patients, and always involved relatives and carers in as many aspects of care as they could.

Staff routinely involved people who used services and those close to them in planning and making shared decisions about their care and treatment. Patients and relatives told us they felt listened to, respected and had their views considered. For example, when we sat in on a consultation, the doctor asked the patient then the relative was there was anything they wanted to question or discuss further about the planned treatment.

Patient’s carers, advocates and representatives including family members and friends, were identified by staff and were greeted in the same way patients were. We spoke with eight relatives and carers who told us they felt involved in decisions about their loved one’s care or treatment. We spoke to six patients who told us that following their appointments, staff were always clear about when they would receive test results or follow up appointments. Patients said their GPs had received copies of their clinic letters, and some told us the clinic doctors had explained what would be in the letter before it was sent. This included changes to medications and the reasons for this.

When patients became distressed, staff knew how to assist them to maintain their privacy and dignity. The provision of private spaces for people in distress varied. However, all staff could identify how they would respond to somebody in distress to help preserve their privacy and dignity using side rooms, quiet rooms and patient lounges.

Most patients told us if their consultant was away when they came for their appointment, they were told of the change.

Staff had access to communication aids to help patients become partners in their care and treatment. For example, staff told us picture and easy read materials were available to use in clinics to help patients remain at the centre of decisions about their care and treatment. All clinical areas had access to picture boards and other communication aids. They used a variety of interpreting services.

Is the service responsive?

Service delivery to meet the needs of local people
The trust planned and provided services in a way that usually met the needs of local people. The environment was appropriate and patient centred to wait for appointments. Waiting areas were comfortable with sufficient seating. Toilets were clean and catered for disabilities. There were magazines, drinks machines and separate play areas for children in an adult clinic.

There was not always sufficient car parking available on site. The trust operated two park and ride facilities and public transport stopped outside both hospital sites. Car parking for all patients was at a variety of car parks on the site. There were disabled spaces outside most outpatient entrances with dropped curbs allowing easy wheelchair access. Patients and relatives complained about the price of parking and the lack of car parking spaces including disabled spaces. However, there were many bus routes and a park and ride system served the hospital. Patients in medical outpatients were given paper slips to reduce the parking to a minimal charge regardless of how long they were attending. This reduced patient anxiety about parking costs. Staff told us they were aware of the parking pressures faced by patients. If the patient contacted the clinic they were attending to say they were held up due to parking issues, the patients were still seen. Also, if a patient was delayed in clinic, staff could extend their parking free of charge. This also reduced patient anxiety about parking costs.

From January until December 2018 the trust received 24 complaints related to parking for outpatient appointments. Of these, two complainants reported they were late for their appointment and two had missed their appointment. The trust was unable to provide data about how long patients were kept waiting for their appointment once they arrived in the department. The electronic patient administration system was unable to capture this. However, the trust told us the introduction of a new electronic patient administration system to be introduced in June 2020 would remedy this. Patients we spoke to did not have cause to complain about waiting for their appointment, as they had not experienced long delays.

The clinic environments were not planned to be responsive to patient’s needs in breast care. It was identified at the last inspection in February 2016 that the breast care team and services were not co-located. This resulted in patients having to walk down a long public corridor following mammograms, ultrasounds, and biopsies before they had been informed of their results. The situation had not changed at this inspection due to space issues.

The trust had an accessible information and communication needs policy for staff members to help and support communication needs of patients and carers associated with a disability.

For example, sight loss, hearing loss or learning disabilities. The policy had five key objectives known as “Identify, Record, Flag, Share, Act”. It addressed three areas of communication and information. These included supporting direct communication whilst a patient is in hospital, communication by post or other means when a patient was offered an appointment or sent information after an appointment and provision of patient information leaflets in relevant formats tailored to their disability. For example, braille, easy read and large print. These were known as ‘special requirements’. With the patient’s consent, a yellow sticker was attached to the medical notes denoting their special requirements. For example, a flower for dementia, a wheelchair for mobility issues and clasped hands for learning disability. These identified needs were also entered on the electronic patient system for future reference.

All outpatient departments were clearly signposted although there were no environmental adaptations of signage for patients with special requirements. However, most clinics, such as oncology and medicine, had volunteers to help guide and direct all patients.
We saw information which had been provided to patients in accessible formats before appointments included contact details, a hospital map and directions and the consultant name.

**Services provided reflected the needs of the population served and tried to offer flexibility, choice and continuity of care.** In the surgical outpatients, specialist urology nurses held weekly interstitial bladder treatment clinics where patients attended for catheter-based therapy. The aim of the treatment was to improve overall quality of life, by allowing the patient to keep the use of their bladder. The service was planning to extend the therapy offered by adding another weekly nurse led clinic.

The trust had a team called Healthcare at Home to coordinate and deliver oral chemotherapy to patients at home. This prevented unnecessary patient journeys to the hospital. The team ensured prescriptions were completed and delivered to patients.

In the surgical outpatients, specialist urology nurses held weekly interstitial bladder treatment clinics where patients attended for catheter-based therapy. The aim of the treatment was to improve overall quality of life, by allowing the patient to keep the use of their bladder. The service was planning to extend the therapy offered by adding another weekly nurse led clinic.

In the pain clinic, work had begun to streamline some pathways. This had occurred due to the identification that complex patients often received multiple diagnoses which could often lead to mixed messages from different specialist staff. Work had begun around an integrated medical service pathway to improve education of staff to clarify simplify messages being given to patients on the pathway. For example, the local Clinical Commissioning Group (CCG) had recently approved a trial of a cognitive functional pathway to improve overall information being given to patients seeing multiple healthcare professionals.

**Same day / next day appointments were available if needed.** For example, the breast one stop clinic had ‘hot slots’ (immediate appointments) for patients in need.

**Where patients' needs and choices were not being met, this was identified and used to inform how services were improved and developed.** In medical outpatients, in particular cardiology outpatients, a new appointment system had been introduced to improve flow through the clinic. Patients were seen for a variety of reasons in the clinic. These included timed appointments for diagnostic tests. Previously, staff had seen patients in order of when they arrived, however this often-meant patients with timed appointments experienced delays. Staff now had implemented a coloured card system, so that patients with timed appointments held orange cards, and patients for specialist clinics, held blue cards. Staff alternated calling patients according to card colour and reported the flow through clinic had been improved as a result with fewer informal complaints around waiting times. At the time of our inspection, the system had been running for a month and an evaluation by the medical outpatient’s senior nurse was planned to assess its impact formally.

**There was use of telephone appointments as an alternative to face-to-face appointments in some clinics.** Senior staff understood the importance of supporting GPs and primary care services to manage some patients’ conditions in the community. A service for diabetic patients had been set up. This service included consultant holding virtual clinics in GP surgeries to review notes with the primary care team, without the need to bring the patient to the surgery. In addition, staff in the diabetes service had developed plans to start skype clinics for younger patients, where did not attend (DNA) rates were higher. Staff explained that these clinics were already well established in several other large hospitals, and the plans were waiting approval form clinical leads.

**There were specialist clinics for the local population which involved multi-disciplinary support.** The pain clinic supported the women’s health physiotherapists at Royal Devon and Exeter Hospital to understand the reason behind some of the conditions they were treating. For example, physiotherapists used invasive techniques to treat some intimate problems, but had little knowledge of underlying psychological issues behind the physical problems. Clinical psychologists supported physiotherapists to explore these reasons, and met with them on a six-weekly basis to discuss and share learning from individual cases.
To streamline emergency care, ophthalmology had developed specialist clinics involving the multi-disciplinary team;

- Nurse Practitioner and/or Prescriber led service within the eye emergency department.
- Telephone triage referral advice and guidance for community health care practitioners and patients (9 am-5 pm, Monday to Friday).
- Access to ‘pre-booked’ and ‘on the day’ slots for sub/acute problems staffed by an Ophthalmologist or Nurse Practitioner.
- Nurse Practitioner led review sessions in the Ophthalmology Unit.

Outpatients had the expertise to ensure the needs of patients in clinical areas had access to psychiatric liaison or the on-call psychiatrist every day. The Learning Disability liaison service was available during office hours and they were involved in facilitating outpatient appointments.

Gynaecology had noticed a drop in the number of women attending for routine cervical screening. To improve screening figures, funding was secured from the National Screening Programme for a three-month pilot to hold a drop-in clinic from 6 pm to 8 pm once a week and Wednesday afternoon in school time. This was aimed at capturing younger women and it was open to all staff at the trust. The service was advertised in GP surgeries, on the trust Facebook site, posters around the hospital, local gymnasiums and on toilet doors in local nightclubs. The service attracted 27 patients in two weeks. A gynaecological consultant was going to present this concept to the British Gynaecological Society and publish an abstract to share good practice.

Did not attend rate

From August 2017 to July 2018:

- The ‘did not attend’ rates for Royal Devon & Exeter (Wonford) and Royal Devon & Exeter (Heavitree) Hospitals were consistently lower than the England average.
- The ‘did not attend’ rate for Exmouth Hospital was consistently higher than the England average.
- The ‘did not attend’ rate for Podiatry booked through Newcourt House was higher than the England average in six months, and lower than or very similar to the England average in the remaining six months.
- The ‘did not attend’ rate for Tiverton District Hospital was higher than the England average in 10 out of 12 months.

The chart below shows the ‘did not attend’ rates over time.

Proportion of patients who did not attend appointment, Royal Devon and Exeter NHS Foundation Trust. (Source: Hospital Episode Statistics)
Meeting people’s individual needs

The service took account of patients’ individual needs. The service ensured appointments for patients were tailored to their needs, allowing time for patients to ask questions and have follow up tests. For example, fracture clinic had appointments for 10, 15 or 20 minutes and double slots could be booked if required. In the physiotherapy hand clinic, patients with special requirements were given more time for their appointments.

The diabetes centre had a nurse on call seven days a week from 9 am to 8 pm, which could be accessed by other healthcare professionals such as GPs and paramedics. For example, paramedics had attended a call for a patient experiencing a hypoglycaemic episode. Through contacting the on-call nurse, the patient could have their treatment options reviewed and avoided an admission to hospital. Ear, nose and throat clinic provided a 24-hour nursing advice for patients known to the service.

We found most outpatient waiting areas had separate areas for children to wait with toys and books provided. Cleaning schedules for the toys were evident.

Patients received care tailored to their needs which had a significant impact on their experience and quality of life. The specialist nurses for breast care were using the national initiative from NHS England “Living with and beyond cancer” programme. This meant asking patients if they would prefer patient motivated follow up. This was available to patients considered low risk and who wanted to manage their own follow up care. The breast care service also invited patients to health and wellbeing clinics. There were presentations from a local cancer charity, the Lymphoedema (swelling commonly experienced by cancer patients) nurse, dietician and radiotherapists. The clinical nurse specialist told us that these were well received by patients and their comments shaped the way the clinic was run.

In Dermatology patients were offered sample sizes of emollient creams to try for their skin condition. Patients could then express a preference for their treatment before larger volumes of emollients were prescribed for them. Also, a pathologist worked in Dermatology to provide real time analysis of biopsy specimens. This meant the doctors and nurses performing the surgery knew they had removed a skin lesion completely and could prescribe further treatment without the patient having to come back to the clinic for results.

The service identified and met the information and communication needs of people with disabilities or sensory loss. Patients with specific needs were identified by using a specific
requirement form detailing their needs. With the patient’s permission, a yellow sticker was attached to their medical notes to denote, for example; a hearing problem, visual impairment, learning disability, mobility issues, a high risk of falling or a dementia diagnosis. This information was entered onto the electronic patient information system to alert all staff. In ophthalmology, there was a movement activated voice to guide patients when using the toilets. Also, eye clinic liaison officers in ophthalmology supported patients with vision problems.

**Outpatient services considered the individual needs of patients with complex needs, learning disabilities and dementia.** Staff we spoke with said that patients with learning disabilities were identified by the patient’s records before they attended the clinic. Staff said there was easy access to the learning disabilities team and they would either give advice or attend an appointment if requested. In addition, we saw multiple paper forms in use including a learning disabilities passport, communication preferences form and an easy read record of clinic discussions which patients could take away with them for their own records. The learning disability liaison team were very proactive in facilitating admissions for people with a learning disability. They would contact the person and their carers prior to admission, organising a site visit if required. They would liaise with the admitting service to ensure adjustments had been made and would accompany the individual if required. They were on hand to offer support and advice to staff looking after the individual. The team also provided a link with community learning disability services.

Clinical areas used the “This is me” document for people with dementia and the learning disability passport. If somebody did not have the documents the staff prompted family or carers to complete or would complete it with the person.

**There were appropriate arrangements for people with complex health and social care needs which took account of lifestyles.** In the diabetes service, a specialist transition nurse was in post to oversee the transition of children to adult services. The nurse communicated with patients via text message, as DNA rates for this group of patients were higher than trust targets. Staff had found using text messages had improved attendance rates.

**Access and flow**

**People did not always have timely access to initial assessment, test results, diagnosis or treatment.** In 2016, the trust reported a serious incident of a patient who was referred to cardiology then neurology for review. There was a long delay between the date of the clinic visit (21 April 2016) and the typing of the letter (10 May 2016). The patient died waiting for tests to be carried out. Substantial backlog for typing remained for cardiology and neurology clinics. The cardiology clinic backlog of 38 clinics dated back to 31 October 2018 and 33 administration and results tapes dated back to 5 November 2018. The trust had taken on three new cardiology consultants but recruiting administrative staff remained a problem. The neurology clinic backlog of 44 clinics dated back to 5 November 2018 and 20 administration and results tapes dated back to 7 November 2018. There was a risk of harm because there was no communication with GPs, follow-up appointments were not being booked, results were not being obtained and the requirements for further tests were not being recognised and actioned.

The trust reported on the backlog of typing for clinic letters. The trust standard was for routine letters to be typed within five working days. Most departments achieved this standard, however cardiology, neurology and respiratory were not. The trust attributed much of the backlog to long term sickness
and vacancies within the administration team for which the trust was actively recruiting. Bank staff were being used in the meantime.

**There was not a reliable trust-wide triage system for reviewing patients who were not able to book an appointment.** The trust had seen a significant increase in demand in referrals of 6% during 2018/19, compared to 1.5% during the previous two years. In January 2019, the trust discovered 1,302 referrals that had not been reviewed by a clinician (known as appointment slot issues). Of these, 1,226 were graded by GPs as routine but 74 were graded as urgent. Of the 74 urgent referrals, 39 patients had been waiting longer than one week, with the longest wait for an appointment since August 2018. There was a risk some patients may have been harmed because they had not been triaged and seen by a clinician in a timely manner.

The trust acted to deal with the situation and there was an immediate clinical review of all referral letters. The weekly appointment slot issue report was amended to include detail on any referral letters which had not been printed. The report was to be reviewed by the Monthly Access meeting and the data added to the monthly divisional Performance Assurance Framework, providing overview of this issue. The trust instigated further actions to prevent future recurrence. This included an investigation to identify and investigate what actions were required to prevent recurrence; revision of the process to ensure triage of appointment slot issues was electronically recorded; reviewed the access policy to ensure it covered clinical triage of appointment slot issues in detail. Also, the November board papers reported in terms of overall performance, 120 patients were waiting longer than 52 weeks at the end of October 2018.

However, it was too early to determine any patient harm. The trust acted to deal with the immediate situation and was taking further actions to prevent future recurrence. Divisions were asked to provide assurance that:

- booking staff were following the correct procedure,
- appointment slot triage backlogs were being cleared, and
- the system was followed to ensure timely triage of all referrals.

A detailed action plan was written to track the progress of all appointment slot issues and the triage process. This was to be discussed with divisions at the monthly access meeting. An additional report was to be made at the monthly divisional performance assurance framework meetings.

**Despite making improvements since the last inspection, it had been identified by senior trust management that there was a clear disparity between the clinics’ capacity to see patients, and the demand for services.** Although conversations around recovery plans following winter pressures and adverse weather were ongoing with commissioners, some specialities were struggling to meet demand. The average wait for a first outpatient appointment in orthopaedics was seven weeks, in ophthalmology it was nine weeks and in Cardiology it was 25 weeks. The maximum waiting time for non-urgent consultant-led treatments should be 18 weeks from the day the appointment was booked through the NHS e-Referral Service, or when the hospital or service received the referral letter. Therefore, the trust was failing to meet this for Cardiology. The trust had formulated action plans to manage this and progress was discussed at divisional governance meetings and up to board level. The urology service had experienced a significant increase in demand (25.4% increase) and managers expressed concerns over the sudden and sustained rise in new referrals into the service.
Appointments were cancelled or delayed. The trust told us that 71.4% of hospital initiated outpatient appointments were cancelled within six weeks of appointment from April – December 2018. The reasons were:
- Appointment moved 32%
- Clinical decision to cancel (not specified why) 24%
- Clerical error 16%
- Doctor on leave or on call 13%
- Clinic cancelled or reduced (reasons not specified) 6%
- Medical staff shortage 4%
- Cancellation reason not recorded 1%
- Nursing shortage 0.7%

The trust was unable to report on how long patients waited to be seen in outpatients. The trust did not record the numbers of patients who waited over 30 minutes to be seen after arrival at a location for an outpatient appointment. The electronic patient administration system did not capture time of arrival of patients, or the time seen. The trust was planning to introduce a new electronic patient record in June 2020, which was planned to capture this data. Waiting times for appointments were usually communicated to patients. For example, in oncology staff notified patients if the wait was over 30 minutes.

Since 2015, the trust had been consistently below (better than) the national median for patients not attending outpatient appointments. From October to December 2018, the ‘did not attend’ (DNA) data showed the trust had an overall DNA rate of 6% which was better than the national median. Specialties with issues with DNA rates addressed them in divisional work programmes. However, the trust took actions to reduce the overall number of DNAs.

Waiting times from referral to treatment were usually in line with good practice. The waiting time for outpatients who did not require admission to hospital was measured through the non-admitted pathway. Patients have a legal right under the NHS constitution to access services within
maximum referral to treatment waiting times (NHS England, 2017). The referral to treatment time (RTT) is the length of time that a patient waits from referral to a service to the start of treatment. The figure also included referred patients who have not yet commenced treatment and remain waiting to be seen. All the following information refers to outpatients only.

**Referral to treatment (percentage within 18 weeks) – non-admitted pathways**

From October 2017 to September 2018 the trust’s referral to treatment time (RTT) for non-admitted pathways was consistently better than the England average. The latest figures for September 2018 showed that 90.7% of patients were treated within 18 weeks, against the England average of 86.7%.

**Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Royal Devon and Exeter NHS Foundation Trust.**

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty**

Eleven specialties were above the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>99.7%</td>
<td>95.4%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>98.8%</td>
<td>89.1%</td>
</tr>
<tr>
<td>Other</td>
<td>96.6%</td>
<td>90.9%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>96.4%</td>
<td>88.0%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>96.3%</td>
<td>89.1%</td>
</tr>
<tr>
<td>General medicine</td>
<td>95.6%</td>
<td>91.1%</td>
</tr>
<tr>
<td>Urology</td>
<td>95.1%</td>
<td>86.9%</td>
</tr>
<tr>
<td>Ear, nose &amp; throat (ENT)</td>
<td>94.2%</td>
<td>85.5%</td>
</tr>
<tr>
<td>Neurology</td>
<td>93.6%</td>
<td>79.3%</td>
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<tr>
<td>Plastic surgery</td>
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</tr>
<tr>
<td>Gastroenterology</td>
<td>90.3%</td>
<td>83.4%</td>
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</table>
Five specialties were below the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
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<tr>
<td>General surgery</td>
<td>88.1%</td>
<td>88.8%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>83.4%</td>
<td>86.1%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>82.0%</td>
<td>86.7%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>80.1%</td>
<td>83.0%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>73.2%</td>
<td>86.1%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

The term ‘incomplete pathway’ refers to the number of patients who are waiting to be seen. From October 2017 to September 2018 the trust’s referral to treatment time (RTT) for incomplete pathways was consistently worse than both the 92% standard and the England overall performance. The latest figures for September 2018 showed 83.6% of patients were treated within 18 weeks, against the England average of 86.2%.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Royal Devon and Exeter NHS Foundation Trust.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Thirteen specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>98.6%</td>
<td>96.0%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>97.9%</td>
<td>88.0%</td>
</tr>
<tr>
<td>General medicine</td>
<td>97.7%</td>
<td>92.6%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>95.6%</td>
<td>92.5%</td>
</tr>
<tr>
<td>Neurology</td>
<td>95.6%</td>
<td>87.2%</td>
</tr>
<tr>
<td>Specialty grouping</td>
<td>Result</td>
<td>England average</td>
</tr>
<tr>
<td>----------------------------</td>
<td>--------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>81.3%</td>
<td>88.6%</td>
</tr>
<tr>
<td>General surgery</td>
<td>78.0%</td>
<td>84.1%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>72.9%</td>
<td>89.6%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>69.3%</td>
<td>81.8%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

The trust reported in October 2018 that, in total, referrals were 12.9% higher than planned for. Some specialities were facing very high demand, such as Urology at 27.6%, Neurology at 22.9% and Cardiology at 17.1%. This presented problems with an increase in appointment slot issues and demand outstripping capacity. To manage this, where possible, extra clinics were held. The trust hired a mobile cardiac catheter laboratory, fully staffed, to help clear the backlog in cardiology which was estimated to take five to six months.

The trust developed detailed recovery plans for referral to treatment times for each speciality, for example trauma and orthopaedics, general surgery, urology and ophthalmology. The recovery plans were overseen and discussed at the weekly referral to treatment recovery meeting chaired by the deputy chief operating officer. The trust board monitored performance recovery plans although it was too early to evaluate.

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers) The NHS Constitution (2013) states that patients should be seen by a cancer specialist within two weeks from GP referral where cancer is suspected.

From quarter four 2017/18 to quarter two 2018/19 the trust performed worse than the 93% operational standard for people being seen within two weeks of an urgent GP referral. There was a deterioration in the trust’s performance from quarter three 2017/18 to quarter one 2018/19. The performance over time is shown in the graph below.

Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Royal Devon and Exeter NHS Foundation Trust
The trust experienced a high volume of two-week wait breaches within gastro-intestinal (GI) surgery. This was due in part to the backlog of endoscopy patients. The backlog in endoscopy had been resolved as the trust ran additional clinics in October 2019 to manage this. However, this had impacted the two-week wait for GI surgery. From April to November 2018, neither upper nor lower GI surgery achieved the target for the two-week cancer wait. In September 2018, only 4.2% of patients were seen within two weeks. Urology only met the target for three months of the same time period.

The issues around cancer wait times were identified at our last inspection in February 2016. While the trust has worked at sustaining delivery of services in accordance with the ‘cancer wait’ targets set by NHS England, they continued to not meet the national standard.

Some patients were experiencing delays for their treatment. There was a national set of waiting time performance measures that were used to hold trusts to account for the length of time patients with cancer waited to have treatment. These included the following ‘pathways’:

- A maximum two-week wait to see a specialist for all patients referred with suspected cancer symptoms and for all patients referred for investigation of breast symptoms, even if cancer is not initially suspected.
- A maximum 31-day wait from the date a decision to treat was made to the first treatment for all cancers.
- A maximum 31-day wait for subsequent treatment such as surgery; radiotherapy or anti-cancer medicines (three separate pathways).
- A maximum 62-day wait for the first treatment from the date of referral from an NHS cancer screening service, from urgent referral for suspected cancer or from a consultant’s decision to upgrade the priority of the patient.

Failure to achieve the two-week wait meant that for some patients, their diagnosis and treatment was delayed.

**Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (all cancers), Royal Devon and Exeter NHS Foundation Trust**

The performance target was a maximum 31-day wait from the date a decision to treat was made,
to the first definitive treatment for all cancers.

From quarter three 2017/18 to quarter one 2018/19 the trust met the 96% operational standard for patients waiting less than 31 days before receiving their first definitive treatment following a diagnosis (decision to treat). However, in quarter two 2018/19 the standard was narrowly missed, with 95.4% of patients having waited less than 31 days.

The performance over time is shown in the graph below.

(Source: NHS England – Cancer Waits)

The trust reported that urology was the area with the highest number of 31-day breaches due to increased demand. This had been managed by additional weekend surgery, which provided extra capacity. The trust planned to conduct an in-depth investigation on cancer performance to be presented at the board.

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment. The performance target for patients beginning their first treatment for cancer was within 62 days following an urgent GP referral for suspected cancer.

Cancer patients were not seen in a timely enough manner. This was attributed to a sustained increase in two-week wait referrals across multiple specialties in 2018/19. April to November 2018 saw a 14.4% increase in referrals, which was more than 250 additional two week wait referrals per month.

In some specialties, such as urology, lower gastro-intestinal, and upper gastro-intestinal, patients who required treatment for cancer waited longer than others. The trust was not consistently meeting these performance measures for all patients with cancer. This was identified at our last inspection in February 2016 and had not improved. In December 2018 the trust developed a comprehensive cancer action plan to address the issues of the two-week and 62-day GP referral to treatment standard.

From quarter three 2017/18 to quarter two 2018/19 the trust consistently failed to meet the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive
Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them, learned lessons from the results, and shared these with all staff. Patient’s told us they felt it was easy to make a complaint or raise concerns. There were Patient Advice and Liaison Service (PALS) leaflets in the outpatient departments, detailing how to make a complaint. Managers told us they preferred to speak to patients about complaints and resolve them as soon as possible. For example, a patient complained that a member of staff was rough in their manner. The manager spoke to the member of staff involved and provided further training and support to them.

Staff told us complaints were discussed at the daily ‘Comms Cell’ to ensure information and feedback was provided to teams about complaints and the learning from them. We saw evidence that complaints were monitored at division governance group meetings.

Summary of complaints

From February 2017 to May 2018 there were 87 complaints about outpatients. For the 75 complaints that had been closed at the time of data submission, the trust took an average of 35.7 working days to investigate and close these complaints. This was in line with the trust’s complaints policy, which states complaints should be responded to within 45 working days.

The 12 complaints that had not yet been closed had been open for an average of 52.0 working days at the time of data submission. This was not in line with the policy statement that complaints should be responded to within 45 working days.

The breakdown by subject can be seen in the table below.

<table>
<thead>
<tr>
<th>Subject</th>
<th>No. of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications</td>
<td>19</td>
</tr>
<tr>
<td>Clinical treatment</td>
<td>17</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>16</td>
</tr>
<tr>
<td>Appointments</td>
<td>12</td>
</tr>
</tbody>
</table>
### Values & behaviours (staff)

<table>
<thead>
<tr>
<th>Category</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting times</td>
<td>8</td>
</tr>
<tr>
<td>Prescribing</td>
<td>3</td>
</tr>
<tr>
<td>Patient Care</td>
<td>1</td>
</tr>
<tr>
<td>Facilities</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>87</strong></td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Complaints tab)*

The trust provided more up-to-date information about complaints. Currently, 27 complaints for outpatients remained open past 45 days.

### Number of compliments made to the trust

From February 2017 to May 2018 the trust received 70 compliments about outpatients. The breakdown for the 10 highest reporting clinics and specialties is shown in the table below.

<table>
<thead>
<tr>
<th>Clinic or specialty</th>
<th>No. of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical outpatient’s department</td>
<td>11</td>
</tr>
<tr>
<td>MacLeod diabetes endocrine centre</td>
<td>7</td>
</tr>
<tr>
<td>Dermatology</td>
<td>7</td>
</tr>
<tr>
<td>Fracture clinic</td>
<td>6</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>6</td>
</tr>
<tr>
<td>PEOC outpatients</td>
<td>6</td>
</tr>
<tr>
<td>Endoscopy</td>
<td>5</td>
</tr>
<tr>
<td>WEEU out patient’s department</td>
<td>5</td>
</tr>
<tr>
<td>Pain management department</td>
<td>3</td>
</tr>
<tr>
<td>Oncology out patient’s department</td>
<td>3</td>
</tr>
</tbody>
</table>

The trust did not provide a breakdown by subject for compliments received.

*(Source: Routine Provider Information Request (RPIR) – Compliments tab)*

Patient feedback cards were displayed on noticeboards for patients and staff to see, and shared with staff at team meetings.

### Is the service well-led?

#### Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care. Leaders had the experience, knowledge and skills to manage the various outpatients’ services and had attended in-house and external leadership courses. For example, a nursing sister had recently completed a leadership course at the Institute of Leadership and Management.
Leaders were visible and approachable. It had been identified at our last inspection in February 2016 that the leadership and accountability structure of the medical outpatient service was lacking. Leadership had been strengthened by the appointment of a senior nurse for outpatients. Several staff in medical outpatients told us they felt this appointment had improved senior leadership and helped build better relationships with other outpatient areas, such as surgical outpatients. Previously, when short staffed, medical outpatients staff had not felt able to approach the surgical outpatients staff for support. Since the new senior nurse had begun, staff reported better utilisation of clinics and better relationships. This was because both surgical and medical clinics were held in the opposite outpatient department when space and capacity allowed. Outpatient clinic staff reported seeing board members, including the chief executive and medical director, carrying out walkabouts in the outpatient departments.

Leaders understood the challenges to quality and sustainability in outpatients. This included the deputy chief operating officer, senior nurse, deputy medical director and programme director, who demonstrated good understanding of the challenges that faced outpatients. For example, appointment slot issues and poor referral to treatment times.

The trust had a comprehensive mental health strategy. This was driven by the trust’s medical director. The board annually approved the mental health strategy, however the director had an aspiration to move away from having a separate mental health strategy in favour of mental health being present within the strategy for all clinical areas.

The trust was working closely with the neighbouring mental health trust and they had jointly enrolled onto a national quality improvement programme. The national programme involved looking to develop and clinically lead the redesign of healthcare pathways to improve patient flow through outpatients.

Managers ensured there was a plan which developed local safety standards for invasive procedures using the national safety standards for invasive procedures. Outpatient departments which undertook invasive procedures followed the World Health Organisation safer surgery checklist. National Safety Standards provided a framework to produce Local Safety Standards for Invasive Procedures. These were embedded in the organisation and had recently been reviewed.

The trust had clear priorities for succession planning. The trust had a talent management process that was included in the ongoing re-design of the performance and development review. Leaders could develop local succession plans using the trust’s talent approach.

Vision and strategy

The trust was planning a strategic vision for outpatients and what it wanted to achieve. Following our last inspection in February 2016, a trust-wide Outpatients Redesign Project was carried out in 2017. Prior to the outpatient programme and Outpatients Redesign Project, there had been several outpatient projects which had led to some improvement. However, this had not been consistent or sustained. Recommendations from the Outpatients Redesign Project and CQC inspection report 2016 were taken forward by the trust-wide outpatient team. They looked at the transformation and long-term plans within outpatients, led by the deputy medical director of
operations and strategy. Part of their remit was to develop an overarching vision and strategy specific to the outpatient service. This project was in its infancy. At inspection, the trust provided an aspirational programme brief with the programme’s objectives, vision, scope, governance structure, resource requirements and terms of reference for the programme. The outpatient programme group was to report to the operations board, strategic delivery group and up to the trust board.

Staff knew and understood what the trust’s vision, values and strategy were, and their role in achieving them. Staff told us they were involved in the development of the trust’s vision which was to provide safe, high quality, seamless services delivered with courtesy and respect. The vision was underpinned by a set of behaviours expected from staff of fairness, honesty, openness and integrity, respect and dignity and inclusion and collaboration.

Surgical outpatients had their own vision and staff were aware of it. Their vision was to offer ‘a high quality accessible service which meets the expectations of out patients’. Ophthalmology were working on their vision for the department.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff told us they felt very positive and proud to work for the trust and felt supported, valued and respected. This was reflected in the most recently published staff survey. Staff told us action had been taken to address the behaviour and performance of a senior member of staff in outpatients that was inconsistent with the vision and values.

There was a positive culture within outpatient services. Staff talked proudly of their work and contribution to patient care. Staff told us they would be happy for their families or themselves to be treated in outpatients. Staff felt supported by their line managers to raise concerns and challenge peers.

There was a strong emphasis on the safety and well-being of staff. The trust had a ‘People Strategy 2018-2021’. Part of this strategy was to “increase the delivery of outpatient and same day services close to where they are needed”. However, it also looked at staffing, recruitment, retention of staff and career development. This was a work in progress and had not yet been evaluated.

Governance

The board and other levels of governance in the organisation functioned effectively. Leaders and managers at all levels of the organisation were clear about roles and responsibilities to deliver safe services. We saw there were comprehensive and clear structures of accountability from speciality/divisions to trust board level. Performance issues were escalated appropriately through clear structures and processes. Information was shared through a variety of methods, including emails, team meetings, and morning ‘Comms Cells’. The ‘Comms Cells’ were used to ensure the day ran smoothly, any potential delays or concerns were raised and solutions sought in advance.

Concerns or issues from the ‘Comms Cells’ were escalated to the divisional governance meetings. Divisional governance meetings used the same meeting template to ensure all divisions were discussing the same things such as incidents, complaints, risks, audit programmes and guidance from the National Institute for Health and Care Excellence.
From division, concerns and issues were escalated to wider trust committees, such as the operations board, and up to the board.

At our last inspection in February 2016, the trust had a detailed plan to address the delays for cancer treatment. The trust had maintained close oversight of all delays for cancer treatment with a system for monitoring the risk to those patients waiting. The trust had also identified some challenges in the administrative processes within cardiology and had a detailed plan to address these. The trust continued to experience cancer treatment delays, due in part to increased referrals.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Outpatients did not have its own risk register as their risks were identified and recorded on the speciality and divisional risk register, for example the lack of administrative staff in cardiology. We saw evidence that risks and actions to mitigate them were discussed at divisional governance group meetings. Most of the risks had been updated within the past six months, although two risks had not been updated since July (Orthopaedics) and October 2017 (Oral and Maxillo-facial) respectively. Senior staff knew what was on their own risk register, for example administrative capacity within dermatology.

There were assurance systems and performance issues were escalated appropriately. Each speciality had risks on their individual divisional risk register. There were clear structures and processes within each speciality and division and evidence to show they were regularly reviewed and improved. For example, a risk in ophthalmology was upgraded and entered on the corporate risk register. Integrated performance reports were produced monthly and discussed at performance meetings with the chief operating officer. These reports were then discussed at monthly operations meetings, which then fed into the strategic delivery group chaired by the Chief Executive.

Referral to treatment times were monitored at divisional level for the medicine, surgery and specialist services divisions. Each division had an action ‘Comms Cell’ on a particular day of the week. From the ‘Comms cell’, issues were escalated to the referral to treatment programme and diagnostics board who met weekly, chaired by the deputy chief operating officer. This was a cross directorate task force working group. In turn, they reported to the monthly access meeting, which included cancer monitoring review. This was fed into the divisional performance assurance meeting and operation board which reported to the monthly strategic delivery group and up to the trust board for the integrated performance review. In-depth investigations called ‘deep dives’ were undertaken for waiting times including cancer and reported to the trust board. The referral to treatment time was discussed at board meetings in February, April and September 2018.

We saw evidence that antimicrobial stewardship was monitored at speciality governance group meetings as required by National Institute for Health and Care Excellence Quality Statement 121 Statement 5.

There was a systematic programme of national clinical audit within outpatients. Each outpatient department was under a speciality within a division. There was a programme of national mandatory audits, which included an element of outpatients. These included the national bowel cancer audit, national audit of breast cancer in older people, national clinical audit for rheumatoid and early inflammatory arthritis, national lung cancer audit and national oesophago-gastric cancer audit.
Patients continued to wait too long for their treatment for cancer and remained at risk of deteriorating health because of the delay. The trust had given careful and comprehensive consideration to reducing this risk. Despite the trust governance system maintaining a clear oversight of the delays in treatment, the situation had not improved since the last inspection in February 2016.

**Information management**

There were arrangements to ensure the availability, integrity and confidentiality of identifiable data. This included records management and electronic information. Computer screens were locked when not in use and records were safely stored. This was an improvement from our last inspection in February 2016.

There was an understanding and monitoring of performance that was used for assurance and improvement. Information was used as part of decision-making and to monitor performance. Each division had a performance assurance framework which had been developed to provide an overview of service provision and to monitor potential issues. This included finance, safety and quality, complaints, performance (including cancer waiting times for different surgical specialities), workforce and staff engagement. The performance assurance framework was discussed at monthly divisional performance review meetings. We saw evidence within governance meetings across outpatient services that the information was used to inform discussion and decisions.

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. Information regarding waiting lists was accessed through the electronic patient record system and validated by administrative teams to ensure it accurately depicted the number of patients requiring outpatient services. We saw evidence within governance meetings across outpatient services that the information was used to inform discussion and decisions.

**Engagement**

The trust engaged well with patients, staff, the public to plan and manage appropriate services effectively. The trust conducted patient and staff surveys using the outpatient quality assessment tool. However, use of the tool had been suspended for some months for review, so there were no meaningful results available.

We spoke with patients who attended clinics frequently. They said they felt engaged with clinics as staff listened to their issues and tried to resolve them. For example, ensuring multiple appointments were on the same day to prevent unnecessary travel into the hospital.

Staff felt engaged and their views were reflected in the planning and delivery of services and in shaping the culture. A staff survey was part of the outpatient quality assessment tool. We asked the trust for results but it was too early to provide the information following the recent review of the tool. However, staff we spoke with felt their views were listened to.

Staff were encouraged to think about their actions and the impact on other staff and patients. The Freedom to Speak-up Guardian (all NHS trusts have to nominate a Freedom to Speak-up Guardian to ensure staff can raise concerns safely) was available for confidential help. Posters displayed their contact details in the departments.
Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation. The trust displayed posters for patients to inform them of research the trust was involved in, including diabetes and respiratory diseases. This was part of the trust's commitment to continuous improvement and innovation.

The trust was also in the process of introducing a new way to deliver care in the form of a new electronic system, planned for introduction in June 2020. It was planned that real-time information of every aspect of a person's care, which included medical history, current medicines and latest test results, would be available for patients to view anytime, anywhere, on any device. It would also mean patients, or their nominated carer or relative, would be able to communicate directly with their care team to get answers to questions or concerns. This would positively impact on outpatients as multiple letters, duplicated appointments, and travelling numerous times to hospital for appointments would no longer be an issue. It was planned to enable more effective and visible treatment plans for healthcare professionals and patients alike. A dedicated team had been set up and issued newsletters to update staff on progress and staff were encouraged to be involved.

At our last inspection in February 2016, the ophthalmology outpatients’ team recognised improvement was required in the clinical environment for testing of visual fields. The clinic had received new electronic tablet devices which had eased the pressures on clinic space to test vision.

The trust made a joint application with a local mental health trust to join the National Flow Coaching Academy (FCA) programme that had been set up in the UK in 2018. The FCA would coach representatives from the trust to clinically lead redesign of healthcare pathways to improve patient flow. For outpatients this could mean reduced waiting times, calmer clinics, improved productivity and safer patient care. This was a work in progress and had not started yet.
Community health services

Community health services for adults

Facts and data about this service

The trust provides community nursing and Allied Healthcare Professional outpatients (musculo-skeletal physiotherapy and podiatry) from the following community hospitals:

- Axminster Hospital (Chard Rd, Axminster)
- Crediton Hospital (Western Rd, Crediton)
- Exeter Hospital (Hospital Lane Exeter)
- Exmouth Hospital (Claremont Rd, Exmouth)
- Honiton Hospital (Marlpits Rd, Honiton)
- Moretonhampstead Hospital (Ford St, Moretonhampstead)
- Okehampton Hospital (Cavell Way, Okehampton)
- Ottery St Mary Hospital (Keegan Close, Ottery St Mary)
- Seaton Hospital (Valley View, Seaton)
- Sidmouth Victoria Hospital (All Saints Rd, Sidmouth)
- Tiverton and District Hospital (Kennedy Way, Tiverton)

(Source: Routine Provider Information Request (RPIR) – Sites tab; Trust website)

Royal Devon and Exeter Hospital took over the management of community services in Exeter, east Devon and mid-Devon (collectively known as eastern Devon) on 1 October 2016. Community adult services are provided to a core population of over 450,000 people.

Community adult services are delivered through six locality teams working across eastern Devon. Throughout the report these locality teams will be referred to as clusters. Community services taken on by the trust include community nursing services, therapy services and some specialist services including Parkinson’s disease and podiatry services. Each team is made up of health and social care professionals working closely with GPs and other partners in mental health and the voluntary sector. The teams also focus on reablement and rehabilitation to help people regain or keep their independence for as long as possible.

The services work with colleagues from partner organisations to identify people who are frail or becoming frail to ensure there is an agreed plan to support them if their health deteriorates. Care coordination is facilitated by a weekly core group meeting which provides a multi-agency and multidisciplinary forum to review and coordinate care for people with the most complex needs.

In March 2017, the trust launched Community Connect which includes two functions:

The single point of access

- One telephone number for health and social care professionals, including GPs, to refer into the service.
Clinical conversations at the point of making a referral to agree the course of action focused on the patient’s need.

Urgent community response

- The multidisciplinary teams can respond quickly to support people at home, avoiding an unnecessary hospital admission, or be supported to return to their community from hospital.
- Assessment of a person’s needs take place in a person’s home environment as this is the most appropriate place to identify, with the person/their carer, what care and support they need.

(Source: Acute Provider Information Request – Context acute tab)

During this inspection we spoke with around 82 members of staff including senior managers for the community services, community nurses, therapists, and support workers. We reviewed 29 sets of patient records and observed the care and treatment of 33 patients in a clinic setting and in patients’ homes. We also looked at and analysed data about the organisation, and information provided to us by the trust. Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and most staff were compliant with the majority of mandatory training. We reviewed training records for staff and found most staff across therapy and community nursing were compliant with the majority of mandatory training courses. Mandatory training is important to ensure staff are updated in any change to practice and to act as refresher to current practices.

A breakdown of mandatory training levels can be found below:

### Mandatory training completion

#### Qualified nursing staff

The trust set a target of 75% for completion of mandatory training. A breakdown of compliance for mandatory training courses as at November 2018 for qualified nursing staff in community services for adults is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As at May 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Waste management</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>283</td>
<td>290</td>
<td>97.6%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution (level 1)</td>
<td>280</td>
<td>290</td>
<td>96.6%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia and delirium</td>
<td>279</td>
<td>290</td>
<td>96.2%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>242</td>
<td>290</td>
<td>83.5%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling</td>
<td>255</td>
<td>290</td>
<td>87.9%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Pressure ulcer classification</td>
<td>256</td>
<td>269</td>
<td>95.2%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Domestic abuse</td>
<td>257</td>
<td>282</td>
<td>91.1%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Food safety awareness</td>
<td>201</td>
<td>219</td>
<td>91.8%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention &amp; control (including hand hygiene)</td>
<td>230</td>
<td>290</td>
<td>79.3%</td>
<td>75%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
In community services for adults the target was met for 13 of the 14 mandatory training modules for which qualified nursing staff were eligible.

### Allied health professionals

A breakdown of compliance for mandatory training courses as at November 2018 for qualified allied health professionals in community services for adults is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As at May 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Basic life support</td>
<td>164</td>
<td>268</td>
<td>61.2%</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>242</td>
<td>243</td>
<td>99.5%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution (level 1)</td>
<td>240</td>
<td>243</td>
<td>98.7%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Waste management</td>
<td>27</td>
<td>28</td>
<td>96.4%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling</td>
<td>240</td>
<td>243</td>
<td>98.7%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia and delirium</td>
<td>235</td>
<td>243</td>
<td>96.7%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Domestic abuse</td>
<td>228</td>
<td>236</td>
<td>96.6%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>226</td>
<td>243</td>
<td>93.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Food safety awareness</td>
<td>90</td>
<td>97</td>
<td>92.7%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire competency</td>
<td>205</td>
<td>243</td>
<td>84.3%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention &amp; control (including hand hygiene)</td>
<td>173</td>
<td>243</td>
<td>71.1%</td>
<td>75%</td>
<td>No</td>
</tr>
</tbody>
</table>

In the community adults service, therapy staff met the target for 10 of the 12 mandatory training modules for which staff were eligible.

The organisation provided mandatory training on an annual basis to staff through face-to-face methods and e-learning. Staff felt training was informative and fulfilled their needs. Most staff reported they were given time to attend training as required. Some staff reported they often had to travel to the main hospital site in Exeter for training, which resulted in greater time away from their clinical duties. However, when requested, trainers attended the community hospitals to provide training. There were also opportunities for staff to access training from home. Part time staff could attend training on their days off and then either be paid for their time or claim the time back.

Responsibility for attending training was held by individual staff members and managers. Senior staff members could access team and individual training compliance, and would inform staff who were required to attend. Staff reported that compliance with training was also discussed during their appraisals and supervision sessions. Staff could also review their own compliance with mandatory training electronic records. These records highlighted their overall compliance and training which was overdue and required to be completed. However, at the time of our inspection, there was a
temporary issue where the electronic training system was not working and staff were unable to access online training. If required, staff were able to access the online training in paper format to ensure their compliance.

The service provided mandatory training in key skills to staff across a variety of courses relevant to their role. For example, as well as the usual range of mandatory training, community nurses carried out an additional session around pressure ulcer classification.

**Staff felt that mandatory training was aligned to community working.** We heard of examples where training had been adapted to suit the needs of the different community teams. For example, training in manual handling had been adapted and delivered locally to staff who were involved in supporting patients in some aspects of care, but were not involved in rolling or lifting patients. Staff also told us how infection, prevention and control training had been tailored to meet the needs of community staff.
Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. There were systems and processes reflecting relevant safeguarding legislation to safeguard adults and children from abuse. Staff had good knowledge of the systems and processes to keep patients safe from abuse.

The organisation had a policy for safeguarding adults which reflected current legislation and guidance. The policy was easily accessible and included the details for the relevant local authority to which staff could make a safeguarding referral. The policy outlined what safeguarding was and covered staff responsibilities with regards to raising safeguarding concerns and the procedure by which to report these. Female genital mutilation and PREVENT training were also covered in the policy. ‘PREVENT’ is training for the government counter terrorist strategy so people have due regard to the need to prevent people from being drawn into terrorism, identifying people who may be vulnerable to radicalisation and referring and reporting these individuals.

Staff understood their role and responsibilities to report safeguarding incidents and could give us examples of incidents they had reported. They had good knowledge of their roles and responsibilities in relation to this and were clearly able to describe the action they would take if they had a safeguarding concern. Staff reported that if they had any safeguarding concerns they would contact the local authority safeguarding teams directly. We heard of examples where staff had raised safeguarding concerns both about patients and their relatives. Staff reported that this system was responsive and they often contacted the local authority for advice and guidance. We saw information in the offices of various teams providing information and a telephone number for staff to use when raising safeguarding concerns.

Staff had received updated safeguarding training and were complaint with the trust’s target. We reviewed data for staff completion of safeguarding training against the trust target of 75% compliance. Data provided by the trust showed that as of November 2018, both community nursing and therapy staff were compliant with safeguarding and child protection level two training.

Safeguarding Training completion

Qualified nursing staff

The trust set a target of 75% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses as of November 2018 for qualified nursing staff in community services for adults is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As at May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>274</td>
</tr>
<tr>
<td>Child protection level two</td>
<td>262</td>
</tr>
</tbody>
</table>

In community services for adults the target was met for both safeguarding training modules for which nursing staff were eligible.

Allied health professionals

A breakdown of compliance for safeguarding training courses as at November 2018 for allied health professionals in community services for adults is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As at May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>230</td>
</tr>
<tr>
<td>Child protection level two</td>
<td>228</td>
</tr>
</tbody>
</table>

In community services for adults the target was met for both safeguarding training modules for which allied health professionals were eligible.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff ensured that where equipment was used, the area was clean and protective sheets were used to prevent equipment touching surfaces to minimise any infection control risks. We also saw that staff applied an aseptic non-touch technique when carrying out care interventions where this was required.

The departments and clinical areas we visited were visibly clean, well-organised and tidy. Furniture was clean and in good condition, fully wipeable and therefore compliant with the Health Building Note (HBN) 00-09: Infection control in the built environment.

**Staff managed infection control in patient’s homes and in clinic settings.** Infection control practice was adhered to across the six clusters. We observed staff to wear personal protective equipment, such as gloves and aprons where required when providing care or treatment to patients in their own homes or in clinics. Staff were also observed to be bare below the elbow. Being bare below the elbows is important in preventing the spread of infection. This is because bacteria can inhabit watch straps or pieces of clothing which cannot be cleaned with the normal disinfection and hand washing procedures. Clothing will also obstruct good handwashing practices.

**There was safe disposal of sharp instruments.** The service provided patients with safe sharp bins to dispose of sharp instruments in their own homes. We found these to be used to a safe level (not overfilled) both in the patient’s own home and in clinic areas.

**Clinical waste was managed safely and appropriately.** We visited clinics where clinical waste was separated from regular waste into the correct colour coded bags in separate bins. This prevented the spread of cross infection.

**There were systems to prevent and protect people from a healthcare-associated infection.** Hand gelling and hand washing facilities were available in the clinical areas we visited. Taps had long handles which meant they could be switched on and off using by elbow to avoid contact. There were posters on the walls in clinical areas to remind staff of the NHS ‘five moments of hand hygiene’. Staff members who cared for patients in their own homes, or outside clinical areas, had access to personal hand gel. These staff members would also, where possible, use the patient’s hand washing facilities prior to patient contact.

Clinic rooms we visited were equipped with hand washing sinks, paper towels, liquid soap and pedal bins were also available. Disinfectant wipes were used to clean equipment and plinths between patients in the clinic setting.

**Environment and equipment**

The service had suitable premises and equipment and looked after them well. Across the six clusters, the environment was well maintained and equipment was fit for purpose. The locations we visited in which community and therapy teams were based differed. Some of the buildings were more modern and well designed with lots of space, while others were older and not so well designed.
in terms of room design and space. Despite this, teams made the best of the environment they had. All the locations we visited were clean, well maintained and free from clutter.

The community nursing clinic was in a community hospital which was well-maintained and designed. Clinic rooms were spacious and free from clutter. Equipment was stored in a locked room accessible using a keypad. Equipment was stored in boxes, each labelled for the individual patient attending the clinic. Boxes were stored on shelves, off the floor, to enable effective cleaning of the area.

Staff across the community adults service had access to a range of basic equipment from their own stores. More specialist equipment was available from a local equipment company. This enabled staff to provide care and treatment in patient’s homes with the right equipment. Equipment was ordered electronically and staff could request basic equipment, such as walking frames to specialist hospital beds and pressure relieving mattresses. Staff could access equipment from the store urgently for patients to be delivered on the same day or the following day. There was also an option for the equipment store staff to set up equipment for patients. This ensured patients had timely access and use of the necessary equipment to keep them at home and avoid hospital admission.

Action had been taken to address issues with equipment availability. In the past there had been incidents where equipment had not arrived in time, or the wrong equipment had been delivered to a patient. A trend in the number of incidents reported by staff had been noted. Meetings and discussions were held with the equipment provider to rectify the problem. Staff reported this had improved over the last few months with fewer incidents being reported.

A stock of small equipment was held at each location where teams were based. This gave staff the opportunity to take equipment out with them, to meet the needs of the patients and avoid hospital admission. Available equipment included walking aids, such as frames and commodes. Equipment was stored tidily and in a locked area.

**Safe manual handling practice was carried out in patient’s homes** where items of equipment could be used to support the manual handling of patients. Manual handling risk assessment plans were completed for complex patients to reduce the risk of either a patient or a staff member becoming injured when managing a complex case, where manual handling equipment was required. We saw completed examples of detailed manual handling plans which included additional information to ensure safe operating procedures when managing a complex manual handling situation. We observed staff members reviewing patients’ and relatives’ use of equipment. Some patients had additional needs or required a review of the equipment and manual handling needs. In this case, staff could refer and book appointments for patients with the occupational therapists and/or physiotherapists within the team.

**Equipment was serviced and maintained to ensure it was safe for use.** We saw records of completed annual calibration of equipment such as blood pressure and blood glucose machines. Information was maintained to demonstrate regular maintenance was carried out. Staff were able to tell us what they would do if a piece of equipment failed in a patient’s home and how this would be reported and managed safely and efficiently.

Equipment was available for bariatric patients. Staff from different areas informed us they had access to some bariatric equipment stored on site at the community hospitals. This equipment included large chairs and mattresses. If additional equipment was required due to a lack of stock or the need for specialist equipment, staff could contact and order this through the equipment supplier used by the trust. Staff we spoke with reported if an order was placed, the equipment was received in a timely manner.

A nurse from the community nursing clinic was undertaking additional courses to gain qualifications to be able to prescribe and obtain equipment for patients, such as dressings, for their clinic
appointments. When the service launched several years ago, the requirement was that patients brought their own dressings and any other small equipment which may be required for their session at the clinic. The team noticed this was a challenge for some elderly patients who were coming to the clinic using public transport. Alternative arrangements were sought, which included the GP prescribing the equipment required. However, this had led to a number of errors and the team not having the right equipment for the treatment session. This meant the team could provide the right equipment was available for patients, which minimised the risk of error and wasted journeys and treatment sessions for patients.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient. Risk assessments, risk management plans and reviews were not being consistently completed by the community nursing teams across the six clusters.

We saw various compliance with the undertaking and completion of risk assessments within the patient records we reviewed. We reviewed one set of records, where a risk assessment for a patient’s pressure ulcer had been undertaken 22 times and risk assessments had been completed to varying standards. We also found no evidence of a malnutrition universal screening tool assessment being undertaken for this patient. Nutritional deprivation and insufficient dietary intake are the key risk factors for the development of pressure ulcers and impaired wound healing. We were therefore not assured that all risk assessments were undertaken and reviewed thoroughly to identify patient need and risk. However, we also saw examples of thoroughly completed risk assessments where there was clear evidence of regular reviews. We also saw evidence that audits were carried out to ensure compliance with MUST assessments. In November 2018, the trust were 93% compliant with this assessment in the community.

Community nursing teams service were not using any scoring system to detect the early deterioration of patients. The service was not using a national tool such as the national early warning score (NEWS) to identify a deteriorating adult patient. We were not assured that patients at risk of deterioration and sepsis would be detected and treatment given in a timely manner. However, at the time of our inspection, we were informed that the organisation was in the process of introducing the updated NEWS, NEWS2. This had been piloted in one of the community nursing teams over summer 2018. It was confirmed in the August 2018 divisional governance group minutes that roll out of the tool was to commence in March 2019 to all the community nursing teams. At the time of our inspection, the resuscitation team in the acute hospital were working in collaboration with community nurses to develop the correct process for escalation in the community. This needed to be correct to ensure that patients were not escalated unnecessarily to the acute hospital or the local GPs.

The urgent community response (UCR) teams were not using a NEWS score to monitor patients on their caseload for deterioration or sepsis. Nurses told us they did not routinely take a set of observations on each patient during each visit under the care of the urgent community response teams. The nature of some of the patients under the care of the urgent community response teams were usually patients who were unwell, where they had underlying infections. These were unwell patients the team were trying to clinically support at home and avoid hospital admission. Despite these patients being unwell, there was no standardised process for teams to routinely monitor a patient’s physiological observations. Also, there was no way to clearly record physiological observations to identify when a patient was deteriorating, or who may be at risk of sepsis. The August 2018, divisional governance minutes only stated that NEWS2 was to be rolled out to the community nursing teams, with no mention of the urgent community response teams.
The service was not screening patients for sepsis as recommended by National Institute of Health and Care Excellence, (NG51) Sepsis: recognition diagnosis and early management. Staff across the community adults service each carried a sepsis screening tool. However, they did not have access to and early warning score to monitor deterioration and signs of sepsis as recommended in the sepsis tool used by the service. This tool referred to a score of three or above in National Early Warning Score (NEWS) as a sign to detect a deterioration in the patient’s condition or sepsis. However, as the service was not using this tool, it was not clear how patient observations would be clearly recorded to identify deterioration, or this how this would be identified.

The sepsis screening tool also relied on staff undertaking baseline and routine observations from the patient to detect an increase in temperature or a deviation from their normal pulse. We asked staff how often they undertook baseline and routine observations. We were informed these were only undertaken when there was a clinical need, such as the patient feeling unwell. Staff told us they used their clinical knowledge and judgement and if they felt a patient had deteriorated, they would have a discussion with the patients GP. We were also told that the patient could be discussed at the community nursing patient safety handover.

Audits were carried out to review community nursing team’s compliance with carrying out baseline observations for patients, with results demonstrating an improving trend. However, at the time of our inspection there was no routine requirement for staff to carry out baseline observations on a patient. In July 2018, 64% of patients had their baseline observations completed, compared to 71% in October 2018. Work to improve the completion of baseline observations for all patients was part of the clinical effectiveness tool compliance for the community nursing teams, due to the proposed introduction of NEWS2 into the community setting in March 2019. Action to continue to improve performance in this area included ongoing work to pilot NEWS2 and how this would be used effectively in the community setting.

Staff were aware of the need to recognise and identify sepsis in a timely way. Training was being rolled out to ensure staff were competent to manage this issue. Some staff had received mandatory training on sepsis management. However, at the time of our inspection, we were informed this training was still being rolled out, and some staff were still awaiting training in sepsis management. Staff told us that they relied on their clinical knowledge, expertise and judgement to know when a patient was deteriorating and when there was a need to escalate patient care.

**There was a system to escalate concerns about a deteriorating patient.** Staff we spoke with reported that if they had concerns about a patient’s condition they could contact senior staff members, the patient’s GP, or would call 999 if needed. The policy used to support this process remained the one from the previous NHS trust providing this service. At the time of the inspection, work was ongoing to produce a policy for Royal Devon and Exeter, and align this to the implementation of NEWS2 for use in the communities.

Some of the urgent community response (UCR) teams were using a ‘red, amber, green system (a traffic light rating system to prioritise patients) to prioritise support worker care visits for patients if demand exceeded capacity for the service. This was required for additional pressures over the winter period and the issue of ‘backfill’ across the clusters. Backfill was when teams were completing care visits for patients as domiciliary care agencies did not have the capacity to support patients’ care needs. We saw examples of patients who had been assessed and their priority rated. We were told decisions were made as to the needs of the patient and the support they received dependent upon the assessed priority. For example, if the service came under pressure, some patients who had a daily shower with support from the urgent community response team would forgo their shower for a day if more urgent care was required for another patient.
Patients were given contact details if they had concerns about their condition both inside and outside of working hours. These contact details included that of the community nursing team. Messages could be left on answerphone which was reviewed at 9am, 12 noon and 4pm. Outside of these hours, patients could contact their GP, 111 or 999 if required.

**Nursing and allied healthcare professional staffing**

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. Despite some gaps in staffing due to vacancies and sickness, the teams we visited were safely managing their caseloads. Community service managers and nurse team managers spoke candidly about the challenges they had around recruitment, but how teams were managing this proactively.

The winter plan had addressed the challenge of increased demand for the urgent community response teams over the winter months and for future sustainability of the service. A review had been undertaken by the trust to determine the impact that winter and turnover had on staff and care levels. Following this review, in order to ensure teams maintained full establishment against the average turnover of 10%, a decision was taken to enable the clusters to over recruit to an additional 10%. Locally the teams had the flexibility to manage the skill mix employed within the team to best meet the needs of their population. For example, in the Honiton, Ottery St Mary locality, a further four fulltime support workers had been recruited. There had been the development of an urgent community response team leader role, to ensure better continuity of care for the service. Leaders reported that this had made it easier to maintain performance and ensure staffing levels met demand.

Although the staff were safely managing their caseloads, there were some systems and processes to match community nursing workforce with demand for the service and patient need, but no specific staff acuity tool was used. At the time of our inspection, there was no staffing tool in use to determine staffing needs of the service based on the dependency of patients. During a discussion with the senior leaders for the community adults service, we asked how they knew the establishment for the community adults nursing teams was correct to meet the needs of the patients. We were told that reviewing staffing establishment in the community setting was challenging. The senior team were awaiting guidance as how this was to be carried out and for guidance on the most appropriate tool to use for this piece of work.

A caseload weighting tool was used by the therapy teams ensured caseloads were equally distributed across the team and manageable for staff. The tool had been introduced by the occupational therapy professional leader. A caseload review was completed during the six weekly supervision sessions with staff. The aim was to have no more than a total of seven sessions per working day. A session was counted as a three if the case was complex. A session was counted as a two if there was a lot of work to do around equipment ordering and management, liaising with other professionals and sessions with the patient. A one was allocated for an administration task such as a discharge summary. For community nurses, there were discussions at their clinical supervision sessions to ensure their caseload was manageable.

Staff worked flexibly to support teams. The community nurse managers across the Exeter locality worked together to manage the staffing challenges. There was a daily staffing call which was also attended by senior leaders from the cluster to assess the daily staffing issues. Teams in the cluster were flexible to cover the shortages and in providing cross-cover between teams. There was also a peripatetic team (a team who would provide cover in any location) available in the Exeter cluster where nurses from the team went to work in the area which needed the most support.
Senior staff across the clusters all spoke of the challenges around recruitment in their clusters but spoke about how they were proactively managing this. Community service managers across all six clusters were thinking of innovative ways to recruit staff. The Exeter cluster was due to hold an open day in March 2019 to showcase the services provided by the teams. Community service managers from two other clusters we visited also told us how they had experienced success with recruitment when an advert was placed through social media. We were told they had received a lot of interest and had been successful at recruiting staff in this way. Staff were also looking at the skills within the teams and how best to use the variety of skills available to them.

**Turnover**

Turnover in the community adults team was average for the service. The table below shows the turnover of staff from the community adults service between January and October 2018.

A breakdown within community adults service teams by month is shown below.

<table>
<thead>
<tr>
<th>Month</th>
<th>Turnover rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2018</td>
<td>10.5%</td>
</tr>
<tr>
<td>February 2018</td>
<td>10.6%</td>
</tr>
<tr>
<td>March 2018</td>
<td>10.8%</td>
</tr>
<tr>
<td>April 2018</td>
<td>11.2%</td>
</tr>
<tr>
<td>May 2018</td>
<td>11.3%</td>
</tr>
<tr>
<td>June 2018</td>
<td>11.8%</td>
</tr>
<tr>
<td>July 2018</td>
<td>12.2%</td>
</tr>
<tr>
<td>August 2018</td>
<td>12.0%</td>
</tr>
<tr>
<td>September 2018</td>
<td>12.1%</td>
</tr>
<tr>
<td>October 2018</td>
<td>11.4%</td>
</tr>
</tbody>
</table>

**Sickness**

There were relatively typical levels of staff sickness which was slightly below the trust target. Between November 2017 and October 2018, on average, the community adults service was slightly below the trust’s sickness target of 4% with an average of 3.9%. The monthly detail is shown below:

<table>
<thead>
<tr>
<th>Month</th>
<th>Sickness Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2017</td>
<td>2.2%</td>
</tr>
<tr>
<td>December 2017</td>
<td>2.7%</td>
</tr>
<tr>
<td>January 2018</td>
<td>5.2%</td>
</tr>
<tr>
<td>February 2018</td>
<td>4.2%</td>
</tr>
<tr>
<td>March 2018</td>
<td>4.2%</td>
</tr>
<tr>
<td>April 2018</td>
<td>4.3%</td>
</tr>
<tr>
<td>May 2018</td>
<td>4.5%</td>
</tr>
<tr>
<td>June 2018</td>
<td>3.5%</td>
</tr>
<tr>
<td>July 2018</td>
<td>3.9%</td>
</tr>
<tr>
<td>August 2018</td>
<td>4.1%</td>
</tr>
<tr>
<td>September 2018</td>
<td>4.2%</td>
</tr>
<tr>
<td>October 2018</td>
<td>4.5%</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>3.9%</strong></td>
</tr>
</tbody>
</table>
Suspensions and supervisions

During the reporting period from May 2017 to May 2018, the trust reported that there were no cases where staff have been either suspended or placed under supervision within community services for adults.

(Source: Universal Routine Provider Information Request (RPIR) – Suspensions or Supervised)

Vacancies

Community adults service staffing

For allied health professionals, actual staffing levels compared well with planned staffing levels. Data provided by the trust showed that as of November 2018, community nursing teams were under established and had a vacancy rate of 19.09 WTE staff. However, data also showed that there was an over-establishment of occupational therapists across the community adults service.

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Contracted WTE</th>
<th>Funded WTE</th>
<th>Actual WTE</th>
<th>Vacancy WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Nurses</td>
<td>541.6</td>
<td>522.5</td>
<td>532.0</td>
<td>19.1</td>
</tr>
<tr>
<td>Senior Managers for the community adults service</td>
<td>18.7</td>
<td>18.0</td>
<td>18.1</td>
<td>0.7</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>74.3</td>
<td>79.4</td>
<td>80.6</td>
<td>-5.1</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>115.8</td>
<td>106.7</td>
<td>106.3</td>
<td>9.1</td>
</tr>
</tbody>
</table>

In April 2017 there were over 200 vacancies across the community adults service which had improved to just under 30 vacancies for both community nurses and allied healthcare professionals in December 2018.

Bank and Agency use – Community nurses

The service had minimal use of bank staff and did not use agency staff. We evaluated the data provided by the service for May to December 2018. This showed there was no agency staff used in that period. There was a small amount of bank staff used to fill vacant shifts. For example, between May and November 2018, the highest use of bank cover was provided to the urgent community response nursing team to cover 6.3% of shifts. The team with the lowest use of bank staff cover was the Crediton community nurse team with just 0.1% of shifts being cover by bank staff. The only anomaly was the urgent community response night sitters. These shifts were covered by support workers to provide cover for the backfill work which the service was supporting. As the night service provision was not a service provided by the community adults team, 100% of these shifts were covered by bank staff to support patients in need.

There was an inconsistent approach to some of the patient handover. There was a safety handover checklist, however, this was not being used consistently across the clusters. Daily safety huddles were undertaken involving the community nursing staff on duty that day. We attended two of these meetings and found an inconsistent approach. One handover we attended involved a clear review of all patients in the caseload who may be deteriorating, approaching the end of their life or at risk of pressure ulcers. However, another we attended only involved a discussion of those patients who had been seen that morning and the afternoon before. This meant some patients at risk might not be highlighted. We raised this during a conversation with the community adults service team leaders. During the discussion, they acknowledged they knew patient handovers were
inconsistent across the clusters. However, despite being aware, had not looked at how this could be improved to ensure a more thorough and consistent approach to the daily safety huddle.

Quality of records

Individual care records were not always fully integrated or consistently managed. Staff relied on paper-based records which were not above to be shared among different community staffing groups. For example, staff providing rehabilitation treatment were unable to access community nursing records or notes. This meant there was a risk that information about a patient’s medical health may be missed and teams were unaware of other interventions or services involved with the patient. However, at the time of our inspection, we were told that a new electronic record system was in the process of being set up, with a view to it being implemented in 2020.

The quality of patients’ care records was regularly audited. Audits of records were undertaken to check completion and action plans were devised to address identified areas of poor performance. These actions plans were specific for each locality which the community team covered. We reviewed action plans from November 2018 for each locality. They identified the section of records where completion was not adequate, the action required and further actions taken. For example, Honiton and Ottery St Mary and was deemed to be 60% compliant in the provision of evidence of a completed consent form. Training was given to staff, with re-audits undertaken and performance ranging from 70% in June 2018, 30% in September, and 80% in October.

Community therapy teams had their records audited regularly as part of the monthly clinical effectiveness tool use to monitor performance. In October 2018, across all the six clusters, the documentation of goal setting for patients was identified as any area requiring improvement across three of the six clusters. This was consistent with a review of therapy records which we carried out during the inspection. This issue was due to be discussed at the next managers’ meeting as to the benefit of carrying out a training session for therapy teams around the topic of patient goal setting. Another area identified as requiring improvement was the documentation of a clinical impression of the patient under the care of the Tiverton and Cullompton cluster. The team achieved 40% compliance with this. Action had been taken to address with the team the individual sets of notes which had been identified as non-compliant. The whole team met and a discussion was held as to the importance of documentation.

Medicines

The service followed best practice when prescribing, giving and recording medicines. Medicines were appropriately prescribed, administered and/or supplied to patients in line with the relevant legislation, current national guidance or best available evidence. Work was being done with the medical committee to introduce electronic patient specific directions. These are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.

At the time of our inspection, there was no formal update for staff regarding medicines training. Medicines training was completed at induction and when required following incidents/changes. The serviced planned to deliver face to face training for community nursing teams and ensure nurses completed a competency assessment regarding medicines every three years. At the time of the inspection, nurses could get support from the pharmacy team or the local GP regarding any medicines questions they may have.

Patients received specific advice about their medicines in line with current national guidance or evidence. An electronic application was available for staff to access which contained up-to-date medicine guidelines and formularies. This was particularly useful when there were shortages with
medicines and patients were prescribed alternative medicines. The pharmacy team provided support for people in their own homes around the management of medicines. Nurses told us they felt the pharmacy team were approachable and they felt supported with the advice and guidance they provided. Any information on changes to medicines or alerts given to teams by the pharmacy service.

**Medicines management arrangements were adapted where care was provided in patients’ homes.** The service made sure that patients received their medicines as intended. An assessment was completed as to how much support patients needed to manage their own medicines in their own home. There were three levels of assistance which were determined by the nurse and pharmacist following the patient’s assessment. If it was decided that a patient needed their medicines administered, then a medication administration record was created and left in the patient’s home for staff to use and complete.

The pharmacy team visited patients in their own home to support with medicines management. The team received referrals from community nurses, social workers and local GPs. Standard operating procedures had been developed to assign priorities to the referrals. However, most patients were seen within two or three days. The home visit involved developing a medicines chart for patients, checking compliance and completing medicine records. The team also checked supplies of medicines and assessed the need for compliance aids to enable patients to be more independent and safe with the management of their medicines. Follow-up visits were then completed after a few weeks to check the patient had no further issues.

**Medicines were reconciled in line with current national guidance when transferring between locations or changing levels of care.** Medicines reconciliation is the process of identifying the most accurate list of a patient’s current medicines, including the name, dosage, frequency, and route. Once this was completed by the pharmacist, it was compared to the current list, where any discrepancies would be recognised and managed. The pharmacy community team had a very close working relationship with local GP surgeries. The team had access to the local GP record systems. When medicines reconciliation work was completed, the team updated the patients records on the GPs’ system.

**There were minimal medicine errors and those reported in the last quarter had led to no harm to patients.** Compliance with medicines policies was audited. We reviewed data provided by the trust between October and December 2018 and found there had been 27 medicines errors reported. All were classified as near misses or no harm.

**Safety performance**

**The service used safety monitoring results well.** The community adults service used their own clinical effectiveness tool to monitor patient safety issues. Safety performance, which was assessing how many patients had been subject to avoidable harm, was monitored over time and improvements were made where identified as required. A recent decision had been taken to discontinue the use of the patient safety thermometer across the community adults service. The service was already collecting information around the same aspects of patient safety in the community, including falls, skin assessments and wound care. This information collected around patient safety provided the service with a more thorough understanding of patient safety issues across the service on an ongoing basis. This was preferred over the snapshot of patient safety over one day, as represented in the patient safety thermometer.

**Safety was monitored using a range of information.** The trust had identified aspects of care and treatment which could be improved to ensure patient safety. For example, omissions in documenting why a skin inspection had not been undertaken by community nursing teams had
been identified. Evidence of a skin infection correlated with pressure damage for a patient. Of the records reviewed in October 2018, only 48% had a documented reason why a skin inspection had not been carried out. Action was being taken to improve performance across the local teams. However, this improved to 74% by November 2018, increasing the average position from April 2018 to 63%.

Local action plans had been developed where pressure damage had occurred and learning had been identified. At the time of our inspection, the Exeter community pressure ulcer assessment was in the process of being rolled out across community nursing teams along with a supporting education session around its use. This was a specific pressure ulcer risk assessment tool developed specifically by the trust. The trust has a trajectory performance target for improvement, and were aiming for 100% compliance with assessments completed by January 2019.

There was a commissioning for quality and innovation (CQUIN) for improving the assessment of wounds in the community. This helped to improve patient safety in the community and to ensure better identification of wounds and action taken to manage these. A CQUIN is a system to make a proportion healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care. The tissue viability team nurses were leading this piece of work.

We reviewed the report following the outcome of a data review for July to September 2018. Data showed there had been an improvement in the full assessment of patients with chronic wounds from 61% to 66%. Data was also reviewed as to how many patients received a full wound assessment by the team when they were identified as having a chronic wound. Data showed 17 teams improved the percentage of overall assessments, with four remaining the same. The identification of teams where assessments were not completed, allowed targeted education and resource allocation to be specifically applied. This was intended to raise the overall standards of assessment in wound management. A target trajectory for improved compliance with the wound assessment had been set by the trust. This was to achieve 75% compliance. Improvements were being seen, and compliance for the month of October 2018 was 91%.

Following the analysis of the data, an action plan had been developed to identify actions which needed to be taken to improve compliance. The action plan outlined areas of non-compliance, action required, a named responsible lead and a timeframe for completion. For example, a review was required of the leg ulcer documentation and action was required to add it as additional section in the documentation. There was a named responsible person to ensure work was completed in January 2019, with a view to rolling out the new documentation across the teams in February 2019. The date for the next audit of the assessment of wounds in the community was March 2019.

Work was ongoing to improve performance in the use of a falls assessment tool - the falls risk and action tool. Action was being taken to improve compliance with the use of the tool. This included the physiotherapy professional lead for the service supporting the community teams to address the issues around assessment and use of the tool. A target trajectory for compliance had been set in July 2018 at 75%. The service had just exceeded the target in October 2018 by achieving 78% compliance.

There was a falls steering group which met regularly to review and develop falls interventions and policy for the service. We reviewed the minutes and action plan from the group. Work was ongoing around a community service post-falls assessment. This included a flow chart of how staff could signpost patients who had fallen to get the support they needed to reduce the likelihood of recurrence in the future. This work was all part of the prevention agenda and preventing unnecessary hospital admission.
Work was ongoing to review care and treatment interventions by the community nursing teams to reduce the need for unplanned catheter changes for patients. An audit of patients who received an unplanned catheter change was set up in July 2018. This was identified as necessary due to an increase in the number of unplanned catheter changes the out of hours nursing teams were carrying out. If an unplanned catheter change occurred, nurses had to complete a specific document identifying several different aspects of care and treatment. The forms were then reviewed in detail by the individual nursing teams to identify the contributory factors. The information was also fed to a central team to be collated to identify any trends and themes. At the time of our inspection this piece of work was ongoing and the results has not been collated.

Incident reporting, learning and improvement

Staff understood their responsibilities to raise concerns, record safety incidents and report them internally. There was an electronic incident reporting system. Staff told us the system was straightforward to use and they felt confident in using it. Staff said they were supported and encouraged to report incidents and there was a no blame culture within the service.

There was a policy around reporting incidents. This was available to staff on the trust intranet and staff knew how to find it. The policy outlined the procedure for reporting incidents and provided examples of what should be reported as an incident. The way incidents should be categorised in terms of their seriousness and the investigation process was also documented.

Staff could give us examples of learning from incidents which had from incidents they received. For example, we heard of an incident where by a piece of equipment was used incorrectly. Following this, the use of this equipment and the risks posed were discussed during training sessions.

Never events

The service reported no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2017 to September 2018, the trust reported no never events within community services for adults.

(Source: Strategic Executive Information System (STEIS))

Serious Incidents – data reported to STEIS

Trusts are required to report serious incidents to the NHS Strategic Executive Information System (STEIS). These include never events.

In accordance with the NHS Serious Incident Framework 2015, the trust reported four serious incidents in community services for adults which met the reporting criteria set by NHS England from October 2017 to September 2018. These were two grade four pressure ulcers and two grade three pressure ulcers.

Serious Incidents – Trust data

From June 2017 to May 2018, staff within community services for adults reported six serious incidents. Of these, none involved the unexpected death of a patient. All the incidents reported were pressure ulcers.

The number of the most severe incidents recorded by the trust incident reporting system is comparable with that reported to Strategic Executive Information System (STEIS). This gives us
more confidence in the validity of the data. It is important to note the different period between the two datasets.

<table>
<thead>
<tr>
<th>Incident Type</th>
<th>Number of Incidents</th>
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<tbody>
<tr>
<td>Pressure ulcer (grade four)</td>
<td>3</td>
</tr>
<tr>
<td>Pressure ulcer (grade three)</td>
<td>2</td>
</tr>
<tr>
<td>Pressure ulcer (grade unspecified)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6</strong></td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P29 Serious Incidents)

All serious incidents were subject to a thorough investigation and there was a systematic approach to reviewing and investigating these incidents. We reviewed three serious incidents regarding grade three and four pressure ulcers. All three incident reports were comprehensive and had been investigated thoroughly. There were clearly defined contributing factors and lessons learned with action plans to implement changes to practice. However, one incident report did not contain a clear root cause. Despite this, lessons had been clearly identified and action taken to address the contributing factors.

Serious incident reports also included updated action plans identifying the actions to be taken, a responsible individual and a timeframe in which the action needed to be completed. Of the three serious incident reports we reviewed, all the actions apart from two had been completed within the designated timeframe. There were just two actions ongoing which had a timeframe for completion in May and June 2018. There was no further information of a revised date for completion or an update as to the status of the action.

The duty of candour is a regulatory duty which relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

All three serious incidents we reviewed demonstrated the duty of candour had been invoked. In the letters to patients or families relating to the incidents, the letter demonstrated the patient received and apology and information about the actions the trust had taken and the lessons they had learned from the incident. We also saw evidence that patients had met with the investigators to discuss the findings of the incident report. This was also an opportunity for patients and their relatives to ask any further question they may have following the incident.

Prevention of Future Death Reports

The Chief Coroner’s Office published the local coroners Reports to Prevent Future Deaths. These contain a summary of Schedule 5 recommendations which had been made by the local coroner with the intention of learning lessons from the cause of death and preventing deaths.

The trust reported there had been no actions plans or outstanding actions resulting from any coroner’s inquests or prevention death reports within the last year.

(Source: Universal Routine Provider Information Request (RPIR) – P76 Prevention of future death reports)

**Is the service effective?**
Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Care and treatment was based on relevant evidence-based practice, national guidance and legislation. This included care plans, risk assessments, policies and assessment templates.

Relevant National Institute for Health and Care excellence (NICE) guidelines, quality standards, national service frameworks and other good-practice guidance were followed to provide effective care and treatment for patients. We heard of multiple examples of the NICE guidelines that different teams used. We were assured that any changes to guidelines or practice were reviewed by a trust-wide team, with the changes being provided to the appropriate teams though meetings and emails.

The community nurse teams had access to risk assessments based on current national guidance. For example, they were using the pressure ulcer risk assessment tool for adults (PURAT), for identifying pressure ulcer risk, and the malnutrition universal screening tool (MUST), which assessed the risk of malnutrition.

Community specialist services were based on current and evidence-based practice. We saw examples of this and staff were aware of the underpinning national guidance to support practice. For example, the Parkinson’s disease service followed evidence based guidelines to optimise care and treatment for patients. The service used the NICE guidance for Parkinson’s disease in adults (NG71). The team also met bi-monthly with other Parkinson’s disease nurses across the south west. During this meeting, staff would review any updates to evidence-based guidance and would have speakers come in to give a talk about a specific subject relating to Parkinson’s disease.

The musculoskeletal service used evidence-based pathways of care to provide effective and consistent care in conjunction with local GPs. Pathways of care existed for patients with hip, knee, shoulder and spinal problems. A pathway was in the process of development for foot and ankle problems.

Locally developed guidelines were based on national guidance and recommendations. The community nursing clinic were using a local guideline for urinary catheterisation in adults. The guidelines had been developed in conjunction with national guidance from the Royal College of Nursing catheter care guidelines and healthcare associated infections: prevention and control in primary and community care, (CG139) NICE 2017. The pressure ulcer prevention policy had been developed in conjunction with NICE 2014 (CG 179) Pressure ulcers: Prevention and management of pressure ulcers.

Patients had clear, personalised outcome goals. These goals were driven both by the patient’s condition and treatment and their personal wishes. We observed staff members having conversations with patients about their goals and what was important to them. For example, whether they would like their treatment and care to achieve walking to a specific place or being able to undertake a specific task like hanging out the washing. However, as we reported above, these were not always documented in the patients record.

Where appropriate, staff handovers and multidisciplinary team meetings referred to the psychological and emotional needs of patients, as well as their relatives/carers. We observed daily safety handovers/huddles where there was some general discussion about patients and how they were feeling emotionally. Some teams recognised anxiety among their patients and discussions were held as to how this could be effectively managed.

Following the transition of community services to the trust in October 2016, some policies were still going through a process to ensure they were redesigned and fit for purpose for use in the
community. On transition, some trust policies were immediately adopted by the community services, such as the safeguarding adult’s policy, lone working policy and incident reporting policy. As we have reported above, the community service was still using a policy from their previous trust: ‘Patient at Risk of Deterioration’. At the time of our inspection, work was ongoing to align the policies and to further develop the policy to include the implementation shortly of the national early warning score tool (NEWS2).

Staff were not aware of how the service evaluated the provision of care and treatment to check it was in line with evidence-based guidance and recommendations. During the inspection we asked teams how they monitored their care and treatment to check it was in line with recommendations they followed. Teams across the community adults service were not aware of a programme to monitor their service against best practice.

**Nutrition and hydration**

Where appropriate, patients care plans included a nutrition and hydration assessment and individualised management plans. Research has shown that malnutrition is common in some community settings and a routine assessment of height and weight in high risk patients in the community has been recommended. Staff used the malnutrition universal screening tool (MUST) to assess patients’ risk of malnutrition. Patients were given a score to indicate their level of risk.

Staff addressed the topic of nutrition and hydration with patients during treatment sessions. We observed a session with the Parkinson’s disease nurse. The nurse asked about the patients current nutritional and fluid intake and explained the importance of this. The nurse identified that the patient was not drinking enough fluid. A clear explanation as to the impact of this on symptoms relating to their condition was discussed and advice provided as to how the patient could manage an increase in their fluid intake.

**Pain relief**

Overall, staff assessed and monitored patients regularly to see if they were in pain. Staff across the community adults team assessed the level of pain patients experienced. This was carried out using a system with patients being asked to score their pain between one to ten, with one being little pain and ten being intolerable pain.

Patients felt their pain was well managed. Patients we spoke with reported pain relief was given where required. We observed staff acting when patients reported they were in pain. Staff discussed with patients the different options for pain relief. This included the use of pain skin patches which could be worn for varying durations.

Staff could escalate issues around pain management for patients, to ensure their care and treatment to optimise their pain was managed. Community therapy teams could speak to the patient’s GP to request a review of their pain medicine. We observed a physiotherapy session with a patient where a detailed discussion about the patient’s pain took place and the therapist provided advice around management options. The therapist also referred this patient to the pain management service for an in-depth review of their long-standing issues around pain, to see if this could be better managed in an alternative way.

However, we saw one example where the completion of pain assessments for a patient with a pressure ulcer was variable. Pressure ulcers are often associated with pain. This patient had been seen a number of times in relation to their pressure ulcer. In the notes we reviewed for this patient, pain was not consistently assessed during each visit. We saw some record entries containing no pain assessment and some records entries with a pain assessment completed, although, we did not see a record of a pain score or the frequency of the pain. However, the service monitored pain
assessments which were completed by the community teams. On average between April 2018 and February 2019 there was an 84% compliance with carrying out pain assessments.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. The service monitored patient outcomes and undertook a range of audits to promote best practice. Information about patients’ care and outcomes was collected and monitored by the trust. There was some internal audit work ongoing across the community adults service to look at the outcomes of care and treatment for patients and identify where improvements could be made to practice. Some teams also collected data for national audits.

The service monitored the quality of the care provided by the urgent community response (UCR) teams and the outcomes for patients receiving care and treatment. Data was captured to identify the demand for the urgent community response service and the average length of stay of patients on the urgent community response team caseloads. It included the number of patient contacts per week and the patient outcome on discharge from the urgent community response team. The outcome measured was whether the patient remained at home independently, with a long-term package of care or was readmitted to hospital. Performance was reviewed monthly for each locality. This was part of the performance assurance framework which was reviewed at local and divisional governance level meetings and communication meetings across each cluster.

One area not monitored were timeframes for urgent referrals. There was no auditing against the UCR performance in which category one patients had to be seen by the UCR teams within two hours. Staff told us they worked to a two-hour response time and there was currently no waiting list for the service. Each referral was clinically triaged for urgency with the appropriate action taken. The teams triaged the clinical need and prioritised/reprioritised work accordingly against the incoming demands against their caseload. We asked to see data collected by the teams to see if they met the two-hour target they set themselves, however, we were told data to represent this was not collected.

The service had participated in the 2013 national intermediate care audit (NICA) for the first time in 2018. The NICA is a national benchmarking audit which covers different models of intermediate care. These included intermediate care which was home based, bed based, crisis response and reablement. According to the NICA definitions for intermediate care, the trust met the stated criteria for crisis response.

The urgent community response service was performing better than the national average in some areas. These included, the crisis response team discharging 78% of patient’s home compared with 58% of patient nationally. The crisis response team converted 100% of referrals into patient assessments compared with 91% nationally. Only 8% of the trust’s crisis response patients were discharged to the acute hospital, compared to 22% of patients nationally. The NICA review demonstrated that despite the service being relatively new, it was performing well in keeping patients at home at the point of discharge, with fewer being admitted to the acute hospital. Results also showed the crisis response team received 42% of referrals from the trust’s acute wards compared with 12% nationally. The higher proportions of acute referrals into the crisis response service related to the close pathway working across the organisation since the acquisition of the community services to the trust.

There was a clear approach in the therapy service to monitoring and benchmarking the quality of the service and outcome for patients receiving treatment. The service was working to use the results of national audits to improve care and treatment for patients. The service had participated in the physiotherapy hip fracture sprint audit 2017. This was a national audit commissioned by the Chartered Society of Physiotherapy (CSP) and administered through the
Royal College of Physicians between May and October 2017. Teams representing community rehabilitation services, along with the acute service, participated in the audit. The audit had a focus on timeliness and levels of physiotherapy intervention post hip fracture. Following a review of the audit, the CSP developed specific standards for hip fracture rehabilitation. The trust submitted five cases to the audit from the community therapy teams. Results showed that the average days between a patient discharge from the acute trust and the start of therapy in the community was 19 days (CSP standard 72 hours) and the average time patients receiving therapy in the first week was 47 minutes (CSP standard two hours).

Following the results of the audit, community teams were committed to achieving the CSP standards including two hours of rehab per week. To do this, they had identified previous activity levels to ensure rehabilitation was focused on individual patient need, and ensuring patients were seen within 72 hours of referral. Action had been taken to review the triage process and intervention levels of home exercise packages for patients. This was due to be audited to review the outcome. Work was ongoing with the orthopaedic team to ensure the right rehabilitation was being provided. There was a drive to provide more rehabilitation for patients using the skills of the band four members of staff within teams. There was ongoing work to review and improve the discharge process for patients following a hip fracture and a review of the triage process for this patient group. The aim of this work was to meet the CSP standards and recommendations for care and treatment.

The pulmonary fibrosis group used outcome measures to monitor the progress of the patients attending the sessions. The BORG scale was used at each session to monitor individual patient outcomes on a session by session basis. The BORG scale is an outcome measure used to capture perceived exertion for an individual patient both at rest and during activity. Other patient outcomes were also used and completed at the start and end of the pulmonary fibrosis group programme. The measures used identified improvements in patient’s aerobic fitness levels following a period of rehabilitation by attending the course. These included the ‘20-meter shuttle test’.

The Parkinson’s disease service used a variety of outcome measures with their patients to monitor how the patient responded to care and treatment. Outcome measures used were mainly associated with movement. Other examples of outcome measures used included the restless legs syndrome rating scale. This measure looked at the patient’s symptoms due to restless legs, and a rating by the patient of the symptoms they experienced. This measure was completed when the problem was raised with the Parkinson’s Disease nurse. Advice and treatment was then provided to manage the issue of restless legs. The measure was completed again to see if there had been an improvement for the patient and a positive outcome following the intervention.

**Competent staff**

**Managers made sure they had staff with a range of skills needed to provide high quality care.** Staff had the skills, knowledge and experience to deliver effective care and treatment. Staff competencies within their area of expertise were appropriately assessed.

Support workers in the urgent community response teams completed nursing, occupational therapy and physiotherapy competencies on starting their role. This prepared them to provide care and treatment to patients within their limitations to patients during visits. Providing new skills for the support workers gave the opportunity for the best use of time to allow qualified healthcare professionals to see more complex patients. The support workers had also attended an advanced manual handling course to ensure they were skilled in managing the moving and handling care aspects of their role.

New support workers joining the urgent community response team were provided with a local induction programme on starting with the service. This intended for them to be competent to
undertake the variety of tasks which were asked of their role. The support workers spent a period of four to six weeks shadowing other support workers, physiotherapists and occupational therapists to develop an understanding of their roles. How long the shadow period covered was at the discretion of the support worker and their mentor. Once the support worker felt confident, they would start to take on tasks independently.

**There was a drive to increase skills of staff to provide effective care and treatment for patients.** For example, the urgent community response team nurse in the Sidmouth, Axminster and Seaton cluster had been encouraged to complete an advanced skills nursing course, with a view to completing the non-medical prescriber course. This would not only benefit the member of staff in the team, but the whole team and the patients due to their additional knowledge and skills they could bring to the service. The additional skill would also enable better management of acutely unwell patients in the community with a view to avoiding hospital admission, in line with the prevention agenda (an agenda looking at improving health and wellbeing and avoidance of unnecessary hospital admission).

Staff were encouraged to develop and to attend specialist courses to enhance their knowledge and skills in their area of specialism. The Parkinson's disease nurse was due to attend an advanced Parkinson's disease course in March and June 2019. This course would provide the nurse with additional skills to ensure care and treatment was optimised for this specific patient group.

Staff received training in caring for patients with different needs. This included training in dementia awareness. There were dementia champions to support this training and available for staff to contact if they had any concerns or questions in relation to caring for patients living with dementia.

**Clinical Supervision**

**There were arrangements for supporting and managing staff to deliver effective care and treatment.** Staff received regular supervision and one-to-one meetings with their line manager and clinical supervisor of the same profession. We were informed this should be undertaken monthly, however due to work pressures it was not always undertaken at this frequency.

Staff undergoing their professional revalidation could also access support from a band six clinician who would support staff in this process. Staff who had recently undergone revalidation reported that they felt prepared and supported in the revalidation process.

**Appraisal rates**

**The learning needs of staff were identified through appraisals (annual performance reviews) and staff across the community service were compliant with the trust’s target.** Data provided by the trust showed that as of October 2018, there was an 80.9% compliance against the trust target of 80%. Staff we spoke with reported they did receive regular annual appraisals, and said they were used as an opportunity to identify areas for development or progression.

**Multidisciplinary working and coordinated care pathways**

**Staff from different disciplines worked together as a team to benefit patients.** All necessary staff, including those in different teams and services were involved in assessing, planning and delivering care and treatment to meet the holistic needs of the patients. Teams worked together to provide effective care and treatment for patients. Where possible, they minimised the number of appointments patients needed to attend to see various healthcare professionals. Throughout our inspection, we saw strong examples of multidisciplinary team working, both internally between teams of professionals and externally, working with professionals from outside of the organisation.
The single point of access (SPOA) service coordinated care and treatment for patients receiving care under the community adults service. Referrals were made into the SPOA, triaged and then sent to the appropriate team to provide the most appropriate care pathway for patients. This was to either support their discharge from hospital or to support admission avoidance (preventing admission of patients into the acute hospital).

Staff with different skills worked together as a team to benefit patients. Staff delivered and reviewed care in a coordinated way. Staff felt confident in seeking support from members of the department and externally. We observed staff members contacting others for additional advice. Staff reported that since integrating with the trust in October 2016, there had been a positive improvement with multidisciplinary working due to the improved integration between the different teams across the community adults service. This helped to provide effective care and treatment for patients under the care of the service.

There was good multidisciplinary working across the systems for patients with Parkinson’s disease. The community nurses had a good relationship with the specialist nurse who worked in the acute trust. If a patient living with Parkinson’s disease was to attend the acute trust, the nurse at the acute site would inform the community specialist nurse. They would provide an update as to the patient’s care and treatment and information regarding the patient’s discharge. This meant the specialist nurse in the community could review the patient on discharge in a timely way. This relationship also worked in the opposite way, with the community specialist nurse informing the nurse at the acute site of a patient being admitted to the trust.

The specialist Parkinson’s nurses worked in conjunction with local care homes to improve their competency and ability to manage Parkinson’s disease patients living in the community. Improving skills of staff in the local care homes was also another way to help prevent unnecessary hospital admission for Parkinson’s disease patients. One of the Parkinson’s nurses had provided education sessions to staff at care homes around topics such as supporting with eating, nutrition and hydration. Furthermore, a therapist had provided some support to the care home staff when using specific manual handling techniques on a patient with Parkinson’s disease.

There were arrangements for working with social workers and social care providers to help plan and deliver care, treatment and other support to people in a holistic and joined up way. The service worked with other health and social care providers to plan to meet the needs of patients in the area, particularly those with complex needs, long-term conditions, or life-limiting conditions. Health and social care teams were based together in the same office to support good multidisciplinary working to benefit the patient.

The service worked well with local community services to ensure appropriate plans for patients when they required ongoing care and treatment in the community. Each locality held weekly wellbeing meetings in conjunction with their local GP surgery. At this meeting, complex patients would be discussed to identify the most appropriate and effective support to the patient to prevent an unnecessary admission to the acute hospital.

The community adults service was developing links with the local voluntary sector in each of the six clusters. In some clusters, a representative from the voluntary sector attended the weekly wellbeing multidisciplinary meeting to support the management of complex patients in the community. Other teams were looking to move to this way of working and were going through the relevant information governance processes to enable the voluntary sector representatives to attend this meeting. Attendance of a voluntary sector representative would provide another avenue of support for complex patients to enable better management of their needs in the community and prevent unnecessary hospital admission.
Some urgent community response teams had a social care assessor based in the team with them. This was to enable better coordinated and more timely intervention for patients under the care of the service. The role of the social care assessor was to identify and manage the patients social care needs in the community. Basing a social care assessor within the team supported joined-up working. It enabled better discussions to be held about the patient for improved planning of patient care, and more timely referrals.

Staff knew how to refer patients to appropriate internal and external services when they required additional support. Staff felt confident in referring patients to a variety of services that the trust provided. We observed staff discuss referring patients to internal services such as the physiotherapy team and external teams such as GPs. Staff felt they were quick to provide help and support and were responsive to patients’ needs.

Despite the urgent community response teams being made up of a multidisciplinary team of professionals, not all teams across the six clusters were co-located in one office. This was due to two reasons. One being the layout and the space within the building in which they were located. The other was historical ways of working with nurses being located with other nurses, and therapists being located with therapy teams. Staff told us this set up was useful because they had access to their own professional senior staff which they would use for support and advice with challenging and complex patients. We spoke with staff in the teams where they were not co-located. We saw staff going to speak with each other face to face when required. Staff told us this was not a problem and they did not feel the lack of co-location hindered their ability to work as a team in any way.

**Multidisciplinary working mostly supported effective care planning and delivery for adults with long term conditions and complex needs.** However, not all patients felt the care they received was joined up. In one situation where it was working well, we observed the care of a patient living with long-term conditions. The patient was receiving care from a variety of different sources to ensure they could stay at home with their family.

However, we also heard of situations where the number of different organisations involved resulted in confusion for patients. We spoke to three patients and their relatives about this. All of them reported it was often confusing to keep track of the appointments received and who was providing their care. They reported it was often difficult to find a healthcare professional who had an overarching view of their care and treatment and often the approach to their treatment was not coordinated. These patients felt there was a lack of any system to ensure there was a complete holistic approach to their care, with one clinician having overall oversight of the patient and their condition. They reported they found this to be confusing and stressful and increased the possibility that their care or treatment may be missed. This situation was likely to improve with the addition of the integrated electronic patient record system in 2020.

**Arrangements worked effectively when patients’ needs suddenly increased.** In instances where a patient may suddenly need additional care, the team could contact the urgent community response team. This team provided urgent care for patients for a period of seven days when needed. Also, staff reported they would contact other healthcare organisations for advice and support. This supported the staff to prevent unnecessary hospital admission for patients by accessing the right care in the community.

**On discharge, there were clear mechanisms for sharing appropriate information with the patient’s GP and other relevant care providers and healthcare professionals.** This ensured there was a plan for the patient’s next steps and further requirements for intervention and treatment, which all professionals were clear about. When patients were discharged from the community therapy teams, a discharge summary was sent to the patient’s GP. A copy was also maintained in
the patient’s record. The summary provided an overview of the patient’s problems, actions taken to address the issues, and further action which had been taken to support the patient. This meant there was a clear record and understanding about what had been provided for the patient. This information could also be reviewed and was available to support decision-making around care and treatment if a patient was to be re-referred to the service.

**Health promotion**

Patients who used the community adults service were empowered and supported to manage their own health, care and wellbeing and to maximise their independence. Staff encouraged patients and their relatives to undertake aspects of their own care where appropriate to do so. For example, we spoke with one relative who undertook a daily blood pressure and pulse reading for the patient. They reported they had been shown how to do this by the community matron along with advice about when to raise concerns. The relative informed us they felt confident in managing this and their support had helped the patient to remain in their own home.

The Parkinson’s disease service was launching a campaign in April 2019, during Parkinson’s awareness week. The aim of the campaign was to get patients to take notice and better manage their hydration and mobility. The campaign was going to be called Hydrate and Motivate. The service was working with an external charity and with the trust’s charity to set up the campaign. The campaign aimed to get patients to pledge to increase their fluid intake and/or their movement in a bid to improve their overall health and wellbeing.

**National priorities to improve the population’s health were supported by the community adults service.** For example, smoking cessation, obesity, drug and alcohol dependency, dementia and cancer. Some community teams had recently piloted and introduced a wellbeing coach. The role of this coach was not only to improve a patient’s connection with their community, but to also highlight and address areas within the overall community that needed support.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. They understand the importance of obtaining consent before providing care or treatment interventions and completed the associated documentation of the consent obtained to carry out care and treatment. We observed consent being gained and consent forms being completed with patients. Time was taken to explain the risks and impact which treatment might have.

Staff were compliant with the trust’s consent policy. The policy was accessible to staff through the intranet. It covered a definition of consent, the role and responsibilities of the staff, and the consent process. It outlined the procedures to be followed when patients lacked the mental capacity to provide valid informed consent. We saw examples of completed consent documentation across the community adults service. Staff explained if they had any concerns surrounding a patient’s mental capacity, they would raise these concerns during core group meetings with the local GPs.

**Through discussions with staff and inspection of records, it was clear staff understood the Mental Capacity Act 2005.** Staff knew about best interest decisions that had been made on behalf of a patient if they lacked the mental capacity to make a certain decision. We saw examples of the documentation which needed to be completed by staff when a patient lacked mental capacity.
Mental Capacity Act / Deprivation of Liberty Standards training was included in the mandatory training safeguarding adults’ training module. As we have reported above, both the community nurses and the therapy staff were compliant with safeguarding training.

**Deprivation of Liberty Safeguards**

Staff had knowledge of deprivation of liberty safeguards for when they visited patients in care and nursing homes subject to these restrictions. Staff we spoke with reported that if they had any concerns surrounding deprivation of liberty safeguards for patients living in the community, they would contact the local social services team. This team would undertake an assessment to determine if an application was required.

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**Is the service caring?**

**Compassionate care**

Staff treated patients with compassion and kindness. They respected patients’ privacy and dignity, and supported their individual needs. Staff took the time to interact with people who used the service and those close to them in a respectful and considerate way. We observed positive interactions between staff and the patients, with staff being courteous and polite.

Patients were complementary about the care and treatment they received from various teams. A quote from one patient included, “all the care had been way above the bar.” We also heard of examples where staff kindness, compassion and care went beyond normal duties. For example, we heard about a patient who was unable to go home as there was no social care provision. Due to this, and the fact the patient could not be transferred to hospital for a safe place to stay, the nurse cared for the patient throughout the night.

Staff respected the privacy and dignity of the patients under their care. For patients whose needs were of a more personal nature, staff were sensitive and delicate in the terminology they used.

Staff were respectful of the wishes of patients in their own home and in the community setting. We observed a visit with the urgent community response team. The therapist had recognised that the patient had become tired. Instead of continuing with the assessment, they supported the patient to get comfortable and rest, and arranged to contact the patient to continue the assessment at another time.

Staff interactions with patients were friendly and welcoming. Where patients agreed and had built relationships with staff, first names were used. We also saw staff knew the patient’s family when they were supporting them with treatment sessions. Staff engaged in relaxed day-to-day conversation with patients to make them feel at ease and less anxious about their care and treatment.

Staff took time to interact with patients in a respectful and considerate manner. We observed staff carrying out treatments with patients and gave them time and worked at the pace of the patient.

Staff showed an encouraging, sensitive and supportive attitude to people who used services and those close to them. We observed an assessment session between the Parkinson’s disease nurse, the patient and a relative. The patient and their relative had a number of questions about the condition and current treatment, which were sensitive topics due to the impact the condition had on the patient’s quality of life. The nurse showed compassion and empathy when discussing each issue in detail with the patient and the relative. They provided advice to demonstrate how they were there...
to support the patient, explaining how the patient could contact them if they had any questions or concerns prior to their next appointment.

**Emotional support**

*Staff considered the emotional needs of the patient alongside their physical needs.* Patients told us they felt supported emotionally. We observed patients talking to community staff about emotional, personal issues and saw how staff dealt with these sensitively and empathetically. Patients told us how they felt comfortable to talk to staff and felt they could raise any worries or concerns with them.

A member of staff in the pulmonary fibrosis group understood how a patient’s personal problems were impacting upon their condition and working life. The member of staff took the time to listen to the patient and provided support and reassurance. The member of staff also signposted the patient to where they could receive further support.

*Staff understood the impact that patient care, treatment or condition had on their wellbeing and on those close to them, both emotionally and socially.* For example, the Parkinson’s disease nurse had recognised that a patient and their relative were becoming anxious about attending a clinic at the local community hospital for their appointment. In order not to increase the stress or anxiety of the patient and their relative, the nurse carried out a visit in the patient’s home environment instead.

**Understanding and involvement of patients and those close to them**

*Staff involved patients and those close to them in decisions about their care and treatment.* Patients were routinely involved in planning and making decisions about their care and treatment. Patients and their relatives were involved as partners in their care. On all visits, we observed staff including patients in discussions about their care and treatment, and where applicable relatives and carers were also involved. Patients felt they were empowered to make decisions about their care.

Staff communicated with patients so they understood their care, treatment, condition and any advice given. During a consultation with a patient with Parkinson’s disease, the nurse gave the patient and their relative time to ask questions. Several questions about their condition and medicines were raised. Despite these being complex subjects, the nurse took the time to explain each element in a clear, simple way. Following the conversation, the nurse made sure the patient and their relative understood the information which had been explained to them to ensure they were clear as to why the patient was experiencing certain symptoms.

Staff clearly communicated with patients about their condition. We observed clinics and appointments with patients in their own home. Staff took the time to explain to patients what they felt the problem was, the treatment required and what they could expect from the treatment which they were going to carry out.

*Patients carers, advocates and representatives including family members and friends were identified, welcomed, and treated as important partners in the delivery of their care.* We observed a visit for a patient under the care of the urgent community response team. The needs of the patient’s spouse were discussed, as they were recognised by staff to play a key role in supporting the patient at home. Further advice and information was provided to the patient’s spouse as to where they could access help and support if they felt this was required later.

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**Is the service responsive?**
Planning and delivering services which meet people’s needs

People could access the service closest to their home when they needed it. Patients had access to timely care and treatment. The urgent community response team provided care and treatment from clinicians between the hours of 9am and 5pm. The support workers in this team provided the service between 7am and 10pm. Outside of the hours worked by the clinical team, patients would be connected to the single point of access service. This team would triage and either refer the patient onto the appropriate team, or manage the patient to ensure their safety overnight. This team was available to triage patients until 10pm. A referral alongside the action taken by the single point of access team was sent electronically to the urgent community response team cluster, where the patient would be seen the next working day. Between 10pm and 8am calls would be directed to the out of hours GP service who would then pass on any urgent nursing referrals to the Out of Hours Nursing Team who work from 2pm until 7.30am seven days a week.

The joint strategic needs assessment (JSNA) had been used to develop the community adults service. The JSNA looked at the current and future health and care needs of local populations to inform and guide the planning and commissioning (buying) of health, wellbeing and social care services within a local authority area. It had been used to develop the models of care provided differed across each of the six clusters. This helped to ensure the services provided met the needs of the individuals in the local populations.

Staff were clearly able to articulate in conversations the different demographics across each of the clusters. The community service leaders could tell us how the locality provided services which were best suited to manage admission avoidance and early supported discharge. For example, the Exeter locality was a large area split into four neighbourhoods. The community service manager told us in detail how in one neighbourhood there was a high prevalence of drugs, alcohol and homelessness, whereas another of the neighbourhoods was a high prevalence of an older people. The manager described how they were looking to best use the services available to provide care and treatment tailored to the needs of their local people.

The urgent community response teams were proactive in expediting patient discharge from hospital at the earliest opportunity. The identified patients from their locality who were an inpatient in the acute trust using an electronic system. This enabled the team to make telephone contact with the ward to support a rapid discharge for the patient. Also, in one locality we visited, once a week, the urgent community response nurse visited the acute trust to discuss patients coming up for discharge with the ward. This helped earlier discharge planning and getting the patient back into the community.

One of the urgent community response teams had developed a process to identify patients who were unwell in the community, to prevent them needing admission into the acute trust. Nurses in the team had access to the electronic system used by the local GPs. They could view the patients who had called the surgery to request a visit from the doctor. The nurses visited the surgery each morning if they identified a patient or patients who met the criteria for support from the urgent community response team. The nurse would then go out and visit these patients. They would then feedback to the GP the outcome of the visit and plan the next steps which were needed to manage the patient’s individual needs. This process ensured patients had access to the most appropriate service to meet their needs in a timely way.

The role of the single point of access clinicians and coordinators had developed in line with the place based care vision for the community services. Place based care aimed to better meet the needs of the local communities. To provide more continuity across each of the six clusters, a designated clinician located at the acute site was assigned to a specific cluster to support and facilitate the
discharge of patients back into the community. This enabled better working relationships to be built and more continuity of care across the clusters.

**Teams recognised when changes to their service delivery needed to be made to enable them to better manage the local population they served.** The Parkinson’s disease nurse had recognised that a large majority of their caseload was in a certain part of the patch. At the time, the nurse’s main base was at Tiverton Hospital. However, the decision was taken to move the nurse’s main base at Ottery St Mary Hospital, to enable them to be closer to most of their caseload. This would ensure more effective and efficient use of time and resource and easier access for patients who came to the clinic to see the nurse.

The single point of access team has identified how services could be improved for patients with closer working. Initially, the clinical team was based away from the acute hospital site. Staff were finding telephone triage challenging due to not getting the information they required and there being a difference in how acute and community clinicians viewed patients. The clinicians felt they could better provide constructive challenge to acute clinicians about patient discharge into the community if they were based in the acute trust. The clinicians were relocated to the acute site to help expedite the discharge of patients into the community.

There were plans to move the single point of access coordinators into the six clusters, to provide better local care for patients. This would also enable more continuity of care for patients as the coordinator would have a better knowledge of the locality to help with quicker patient discharges. This was an ongoing project.

**There were arrangements to help address inequalities and to meet the diverse needs of local people.** There was a recognition, particularly in the Exeter locality, as to its diversity. In one part of the cluster, frailty among older people was common, yet in another part of the cluster, homelessness, drugs and alcohol dependency presented a big challenge for the teams. Work was ongoing to look at opportunities available in the local community to support diversity and how this could be supported. The idea of ‘touch down’ bases were also being explored in different, more accessible locations across the cluster. Touch down bases were desks and computer located at other buildings and locations in the local community. The aim of these were to enable more effective service delivery to move towards place based care, and to be more accessible to the diverse groups the community nursing teams supported across the cluster.

In some of the clusters there was a move towards a social prescribing model of care to meet the needs of the local population. Social prescribing involved helping patients to improve their health, wellbeing and social welfare by connecting them to community services which might be run by the council or a local charity. For example, signposting people who have been diagnosed with dementia to local dementia support groups. The cluster was involved in a pilot around social prescribing in conjunction with NHS England. The idea of the model of care was to provide sustainable change for the patient to better manage their health and wellbeing, in line with the prevention agenda.

**Staff had access to translation services to help patients with communication.** Staff reported they could access both telephone and face-to-face interpretation to support and communicate with patients whose first language may not be English. Staff we spoke with had not had the need to use these services, so were unable to inform of how responsive they were to their needs. However, they were aware they were available.

**Meeting the needs of people in vulnerable circumstances**

The service was accessible to all who needed it and took account of patients’ individual needs. Services were planned to consider the needs of individual patients and were non-
judgemental in the way the staff cared for patients. Equality and diversity awareness training was part of mandatory training for all staff. There was 99.5% compliance with nurse’s attendance and 97.6% compliance of therapists attending this training against the trust target of 75%.

**Services were delivered, made accessible and coordinated to account for the needs of different people, including those with protected characteristics under the Equality Act and those in vulnerable circumstances.** Arrangements enabled access to the service for patients in vulnerable circumstances, which also met the diverse needs of local population. The community nursing clinic treated patients in vulnerable circumstances, for example, local homeless patients. The team told us how they recognised the vulnerability of these patients and the impact this had on their ability to benefit from care and treatment from the clinic. The team told us how they spent time with these patients to improve their care and treatment and to try and provide advice and signpost them to get further help and support. The work they carried out at the clinic with these patients aligned with the both the local and system wide prevention agenda (an agenda looking at improving health and wellbeing and avoidance of unnecessary hospital admission).

**Reasonable adjustments were made so that people with a disability, mental health or complex needs could access and use services on an equal basis to others.** Community nursing teams regularly visited patients in their own homes. This meant people with disabilities could access the service on an equal basis to others. Staff also had access to ‘this is me’ documents. These documents contained information to help staff understand and support those patients with additional needs or cognitive impairment. For example, it included information about the patient’s life so far, current issues, things that made them anxious and how they communicated.

The service understood the importance of meeting patients’ mental health needs as well as physical needs, in promoting and ensuring good health. At the time of our inspection, the community service had recently piloted and introduced the role of a wellbeing coach. The role of this coach was to motivate people to improve social and physical aspects of their lives. This included supporting patients who had not left home for several years to attend social groups. The wellbeing coach organised and provided the support for these patients as well as linking with community groups to help identify the gaps within the local community.

The delivery of services under the community adults service were coordinated to be accessible and responsive to patients with complex needs. We visited the community nursing clinic, designed for ambulant (mobile) patients to attend to receive their treatment in a clinic setting. This service was designed to relieve pressure from the community nursing team and the provision of visits to patients’ homes. The team managed a diverse and varied caseload of patients, with patients of all age ranges attending. We heard about a patient who needed to access the service, but worked full time hours. In this instance, to accommodate this patients’ needs to ensure they received their treatment, one of the nurses in the team came in early, before the service opened to other patients, to treat this patient.

Staff understood the need to engage patients with learning disabilities in their care and treatment. We were given an example of a patient with severe learning disabilities who was under the care of a community therapy team. They were clear about the barriers and challenges they faced in engaging the patient. These included a lack of understanding, poor attention and the patient being easily distracted. The therapist then went on to explain that their treatment plan included lots of short, fun activities which incorporated a therapeutic element. The treatment could also be taught and provided by the patient’s carer to have the patient engage in more frequent rehabilitation outside of designated therapy sessions.
Patients attending the pulmonary fibrosis group had their mental health assessed. For example, they were assessed for anxiety and depression at the start and end of the course. Any issues picked up by the clinician running the group would be discussed with the patient. Support and advice would be provided to the patient, and if required, with the patient’s consent, a referral made to their GP to support them further. There were leaflets and additional information available at the group to signpost patients to additional support for mental health problems. There was an education session following one of the exercise sessions to provide further support to patients. This was important due to the impact the condition had on patients’ quality of life and wellbeing.

Patients were encouraged to develop and maintain relationships with people that mattered to them within the service and wider community. The community team provided a service for elderly people living with a cognitive impairment. This service was provided at Rowan, the aim of this service was not only to assess and help improve or maintain people’s cognitive ability, but also provide a place for interaction and the building of relationships. People we spoke with who used this service all reported that one of the best aspects of this service was being able to spend time with other people and interact, communicate and build friendships. The service provided activities for people to help stimulate memory. This included cooking, reminisce card games, gardening and arts and crafts.

Staff worked across services to coordinate people’s involvement with families and carers, particularly for those with multiple long-term conditions. We observed staff involved with patients living with long term conditions and found they provided a holistic approach to patient care with a clear understanding of the patient’s needs. These staff would also attend hospital appointments with patients to coordinate care.

Patients were supported to follow their interests and take part in activities which were socially and culturally relevant and appropriate to them, including in the wider community. We heard and saw multiple examples of staff encouraging patients and supporting patients to access wider community services. This included setting specific care and treatment goals or targets in relation to being able to improve access to these services. Community teams also provided contact information and linked patients with volunteer transport services to enable them to attend community services.

Access to the right care at the right time

Services provided reflected the needs of the population served and ensured flexibility, choice and continuity of care. The service provided by the single point of access team ensured that the diverse needs of the local populations were met. The service offered support to patients with different needs. There were four pathways of care which the team would use to simplify patient discharge into the community. These included a short-term offer of support from the urgent community response team or social care reablement. There was transfer to a community hospital or an intermediate care bed (a short stay at a facility to undertake rehabilitation). Alternatively, referral into the community teams for previously known patients with complex needs and referral to a social care team for patients with complex needs who were not previously known to the community services. The team could also provide patients to access support from the community’s voluntary sector.

Patients could access care and treatment at a time to suit them where possible. We observed staff in the community arrange appointments at times that were convenient for the patient. For example, appointments being arranged later in the morning for patients who took longer to get ready in the mornings, or got up later. Staff also considered the patient’s condition when booking
patients, for example, later appointments for those patients who may feel more fatigued later in the day.

**Patients with the most urgent needs had their care and treatment prioritised.** The community therapy team categorised patients according to their level of need and urgency to see a clinician. Category one patients had to be seen within two hours. These patients were picked up by the UCR teams. Category two patients needed to be seen in one week and category three patients in four weeks. Category two to four patients were picked up by the therapy teams.

**Patients across the six clusters were not always seen in line with target therapy waiting times they were allocated on triage.** Therapy waiting times were internal targets set by the trust and used as part of the performance assurance framework (PAF) to monitor the service provided to patients. In October 2018, only 40% of patients were being seen by an occupational therapist within a category two (one-week target) and 48% of patients were being seen by physiotherapists. However, a higher proportion of patients were being seen within the category three (four week) target. Occupational therapists had seen 90% of patients within this timeframe and 70% of patients had been seen in this timeframe by physiotherapists. Work was ongoing to look at the impact of patients not being seen within the prioritised target. An audit to review the impact had been carried out with a sample of 21 patients. Of these 21 patients, two patients had fallen, three had been admitted to the acute trust (unrelated to the therapeutic need) and one person no longer required therapy.

Due to increased demand for services and previous staffing issues, there were a number of patients waiting more than these timeframes for physiotherapy and occupational therapy in the Crediton, Okehampton and Moretonhampstead cluster. For example, at the time of our inspection, there were 95 patients on the therapy waiting list. Of these 95 patients, 28 were category two patients and 67 were category three patients. The longest wait for these patients to receive therapy input was 10 weeks.

**Action was being taken to manage and improve performance around access to therapy services and minimise the time patients waited to access care and treatment.** Each cluster had its own local action plan for staff recruitment, and there was ongoing work to recruit therapy staff to the therapy bank. At the time of the inspection, three physiotherapists and one occupational therapist had been recruited, with a further two occupational therapists interviewed for the role in December 2018.

**Work was ongoing to manage the increased demand for the service and to improve the wait for assessment and treatment.** A study was being piloted in the Woodbury/Exmouth/Budleigh cluster around demand management to improve arrangements for patients waiting a long time for an assessment or treatment. This pilot aimed to identify whether a telephone triage would reduce the likelihood that their symptoms would worsen during their wait for services, or would reduce the need for an appoint through signposting and advice. The objective was to look at a different priority for patients who might deteriorate to avoid other complications developing. This work started in November 2018. If the pilot was successful, the system would be used across the clusters to better manage the waiting list and likelihood of patients deteriorating and needing admission to the acute hospital.

Timely discharge of patients from the acute hospital to the community service were helping to reduce the numbers of patients experiencing delayed transfers of care at the acute hospital. There had been an increase in both the number of referrals made to the community adults service. This was coupled with an increase in the numbers of patients transferred out of the acute hospital, back into the community under the care of the community adults service. For the period 31
December 2018 and 6 January 2019, 55% of patient transfers from the acute hospital to the care of the community adults service was completed within 72 hours of the patient being medically fit for discharge. During this reporting period, teams across the Exeter and Woodleigh, Exmouth and Budleigh (WEB) cluster had increased the number of transfers they supported and had reduced their waiting times to support transfers. The Exeter cluster was also reported to have had the overall lowest waiting time of all the six clusters.

There were limited avoidable patient readmissions to hospital. Despite some patients being readmitted to the acute trust as an emergency within 30 days of being discharged with community arrange support, only a small number of these admissions were avoidable. We reviewed data showing the number of patients readmitted across the six clusters. In June 2018, 63 patients (23%) were readmitted within 30 days, and 66 patients (21%) in July. In August 2018, 62 patients (19%) were readmitted and 52 patients (16%) in September. Work had been carried out on a sample of 30 patients who were readmitted within 30 days. A monthly review of a minimum of five cases per cluster were reviewed to understand any lessons learned for avoidable readmissions. This was reviewed at the divisional governance group. From a sample size of 30 patients each month, on average two admissions were deemed avoidable. These were due to the level of care or communication between the wider multidisciplinary team.

The need for community adults service teams to provide backfill was reducing the capacity of the teams to be responsive to patient need, although actions were being taken. Backfill was when teams were completing care visits for patients as domiciliary care agencies were unable to pick up patients care needs. Eastern Devon was challenged with this problem due to the labour market, particularly in Exeter, being saturated. This made recruitment within the domiciliary care market increasingly challenging, impacting on the domiciliary care market’s ability to respond to the referrals from community teams, for people who have long term care needs’. The challenge of backfill was a system-wide problem in eastern Devon, with the problem being wider than the trust could control. This issue was on the community services risk register and action had been taken to reduce the risk this created. The issue of backfill across the community services impacted on the wider trust’s ability to support more patients home from hospital, which in turn impacted on the wider trust’s delayed transfer of care performance to achieve the national target.

The issue of backfill was impacting on the urgent community response teams providing care for patients beyond their allocated seven-day timeframe. The table below shows a breakdown of data between January and December 2018 as to how many patients were held on the teams’ caseloads across the six clusters between this period.

<table>
<thead>
<tr>
<th>Month</th>
<th>Total UCR Referrals</th>
<th>Longer than 7 days care</th>
<th>As a percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>563</td>
<td>169</td>
<td>30.0%</td>
</tr>
<tr>
<td>February</td>
<td>415</td>
<td>117</td>
<td>28.2%</td>
</tr>
<tr>
<td>March</td>
<td>393</td>
<td>124</td>
<td>31.6%</td>
</tr>
<tr>
<td>April</td>
<td>359</td>
<td>126</td>
<td>35.1%</td>
</tr>
<tr>
<td>May</td>
<td>415</td>
<td>149</td>
<td>35.9%</td>
</tr>
<tr>
<td>June</td>
<td>453</td>
<td>182</td>
<td>40.2%</td>
</tr>
<tr>
<td>July</td>
<td>544</td>
<td>191</td>
<td>35.1%</td>
</tr>
<tr>
<td>August</td>
<td>558</td>
<td>178</td>
<td>31.9%</td>
</tr>
<tr>
<td>September</td>
<td>467</td>
<td>164</td>
<td>35.1%</td>
</tr>
<tr>
<td>October</td>
<td>614</td>
<td>233</td>
<td>37.9%</td>
</tr>
<tr>
<td>November</td>
<td>616</td>
<td>230</td>
<td>37.3%</td>
</tr>
<tr>
<td>December</td>
<td>363</td>
<td>137</td>
<td>37.7%</td>
</tr>
</tbody>
</table>
Between 21 August 2018 and 13 November 2018, the trend for backfill had continued to rise. There had also been significant pressure for services in other areas of the county which had impacted on eastern Devon and the community adult’s services. The most challenged areas included Exeter and mid-Devon. Data showed that backfill was provided at its lowest to 26 patients and at its highest to 41 patients across the clusters between August and November 2018.

Action was being taken to manage the issue of backfill, to reduce the demand of community adults service teams, and free-up capacity for teams. Actions included support from other social care and healthcare leaders. The backfill issue was reviewed monthly at the local accident and emergency delivery board. The accident and emergency delivery board is an NHSE initiative which includes them NHSI and CCGs. Other actions across the wider healthcare system and the community adults’ team included over recruitment of support workers to reduce the demand on nursing staff. There had been an increase in the number of social care reviews for patients, and agency secured additional hours in Exeter from December 2018 for 16 weeks. The trust was progressing the arrangement for care home beds for the hospital to use to discharge patients. The trust’s integration director for the community services was working closely with the local council to support this work.

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results. People’s complaints and concerns were listened to and used to improve the quality of care. The trust had a complaints policy. The policy covered the procedure for managing complaints, roles and responsibilities of the staff and timescales for dealing with complaints. The trust had an internal timeframe of responding to complaints within 45 working days unless there was an extenuating circumstance. All complaints had to be acknowledged as received within three working days. The policy also outlined a flowchart outlining for staff how complaints and concerns should be managed.

Patients were aware of how to report concerns about their care and treatment. We saw leaflets in patients notes and homes displaying how patients could make a complaint or who to contact if they wanted to do so. Patients and relatives reported they would feel confident in raising complaints or concerns if they had any.

Complaints were handled effectively to ensure openness and transparency, confidentiality, regular updates for the complainant, and a timely response and explanation of the outcome. We reviewed five responses to complaints provided by the trust. Complainants received a full written response. We found complaints contained a timeline of events, an apology, results of investigation and any actions which may have been taken following the investigation of the complaint. The patient was also provided with details as to how they could escalate their complaint further if they were not happy with the response.

**Complaints**

From June 2016 to May 2017 there were 14 complaints relating to community services for adults.

For the 13 complaints that had been closed at the time of data submission, the trust took an average of 41.8 working days to investigate and close these complaints. This was in line with the trust’s complaints policy, which states complaints should be responded to within 45 working days.

The one complaint that had not yet been closed had been open for 22 working days at the time of data submission. This was in line with the policy statement that complaints should be responded to within 45 working days.
The breakdown by subject can be seen in the table below.

<table>
<thead>
<tr>
<th>Subject</th>
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</tr>
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<td>Communications</td>
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</tr>
<tr>
<td>Patient care</td>
<td>2</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
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</tr>
<tr>
<td>Clinical treatment</td>
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<tr>
<td>Values &amp; behaviours (staff)</td>
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</tr>
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<td>Facilities</td>
<td>1</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – Complaints tab)

Compliments

From June 2017 to May 2018 the trust received 435 compliments. Of these, 23 related to community services for adults.

(Source: Universal Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care. Leaders had the skills, knowledge, experience and integrity they needed on an ongoing basis to lead the service. Senior leaders demonstrated enthusiasm for their roles and demonstrated a commitment to developing the community adults service in line with the prevention agenda (an agenda looking at improving health and wellbeing and avoidance of unnecessary hospital admission). Service leaders were passionate about improving the service, positively engaging staff in this process and ensuring their happiness and wellbeing. They demonstrated integrity during discussions about areas of challenge within the service, such as covering the gap in the provision of domiciliary care (known as ‘backfill’), and how they were working to manage this issue. Managers of the community adults service teams had either therapy or nursing backgrounds and had worked in various clinical roles before taking on their management role.

There was a structured management arrangement within the community adults service and staff at all levels understood how this management structure worked. Each cluster had a designated team lead role in each service. There was then a therapy leader and a nursing leader for each cluster, who were overseen by a community service manager. The community service managers were overseen by the senior leadership team for the community adults service.

Leaders understood the challenges to quality and sustainability, and could they identify the actions needed to address them. Local leaders discussed some of the challenges faced by the service such as recruitment issues and backfill. They also understood and could clearly discuss the work which was needed in their cluster to develop further integration of services to be successful in managing the prevention agenda, ensuring future sustainability of the service.
There was attendance and representation from the senior leadership team at the monthly community adults services cluster meetings. Senior leaders did not attend all meetings, but on a regular basis to ensure better oversight of the service and to provide support to the community service manager for the cluster. Community service managers found this useful and used it as a platform to raise concerns and manage issues at the earliest possible opportunity.

**Staff felt supported by their managers and they were visible and approachable.** Staff felt comfortable to raise concerns with their managers. Staff told us if their managers were not around they could access them by telephone and they would always get support they needed.

**There were clear priorities for sustainable and inclusive leadership.** There were varying leadership programmes for staff. These programmes included less formal programmes such as coaching workshops, which were established to help promote a coaching culture within the organisation. As well as this were more formal leadership programmes with external organisations to enable staff to gain qualifications in, for example, healthcare leadership and management.

**Vision and strategy**

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. The community adults service had a clear vision with quality and sustainability as the top priorities. The vision was strongly focused on the prevention agenda and admission avoidance.

**There was a realistic strategy for achieving the priorities and delivering good quality sustainable care.** The strategy by which to achieve this included engaging with communities, implementing and embedding care closer to home for patients and looking at ways to work innovatively to meet the prevention agenda. The strategy also included a 10% over establishment of support workers to be able to meet the demand for the service, which had been achieved. At the time of our inspection we were told there was still more work to do across the system in eastern Devon to care for people at home and reduce the backfill work for the urgent community response teams.

The strategy was aligned to local plans in the wider health and social care economy, and services were still developing to meet the needs of the local population. The NHS Five Year Forward View called for a radical upgrade in prevention to ensure the future health of patients and sustainability of our national health service. Individual programmes of work were ongoing across each cluster to meet the needs of their local populations, to develop place based care, integration and the prevention agenda. This work was in conjunction with other health, social care and voluntary sector partners in the local community, in line with the strategy.

**Staff were familiar with the vision for the community adults service and their role in achieving it.** Staff at all levels spoke clearly and passionately about how their individual services were contributing to the prevention agenda. Staff could give us examples how they worked with other services to manage patients in their local community, and were clear about their role and responsibility in achieving the prevention agenda.

There was a future vision for the single point of access service. This was to integrate the health and social care teams to better manage flow of patients out of the acute hospital into the care of the community adults service. Work was ongoing at the time of the inspection to co-locate the teams.

**Culture**

**Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.** There was a clear patient-centred culture embedded across the community adults service. Staff spoke passionately about the
provision of holistic care for patients in all conversations. It was clear to see patients were at the heart of the service in the way each cluster team took ownership of their own patients. Staff spoke of supporting patients to remain living independently in the community. This reflected what we saw during the inspection. Leaders we spoke with reported the thing they were most proud of was the level of care staff provided. They also told us about how staff were focused on providing safe and quality patient care regardless of the stresses and challenges they had faced.

**The culture of the service was centred on the needs of the local people who used the service.**

The culture of the community adults service was centred around the prevention of admission of patients to hospital, and to support early discharge for patients back into the community. All staff spoke passionately about what their teams were doing with regards to this ongoing work. They also spoke of the numerous initiatives ongoing in the community of further developing links with the voluntary sector to provide additional support to patients in the community.

The senior leadership team for the community adults service had found the transition to being part of the trust challenging, but were now seeing the benefits of integration and the positive impact this was having on patients. At the time of the transfer of the service to the trust, staff felt that there was a lack of understanding from the acute trust about the community services and the longer-term management of patients which occurred. Staff felt they did not have a voice and that there was an initial push to take on early supportive discharge and admission avoidance work. They felt this was impacting on the other provision of longer term services provided by community nursing and therapy teams.

The intention of the trust of the acquisition of the community adults service was to look at the prevention of hospital admission for patients and to ensure sustainability for the future of the trust. The initial transition was difficult due to the closure of many community hospitals and inpatient beds shortly after the transition. Moving to a focus on admission avoidance was a new way of working for community staff. Work was needed to understand what was required for care to be delivered in the patients’ home. The challenge they felt was around trying to support staff in the delivery of a new way of community working, while developing services to meet the needs of the local populations.

Since March 2018, it was felt the trust had developed more of an understanding of the community services. We were told the senior leadership team had come to spend time and visit the community adult services and there was now more regular representation of senior leaders at management meetings. Staff felt this had been beneficial in building relationships, helping them to feel more valued and integrated into the wider trust.

The community adults service senior leaders now felt included and supported by the executive team in the trust. We were told the transition had been a journey, and the senior leader for the community service had to learn to find their voice to represent the service in a new setting. They now felt included and involved in shaping future of the community adults service, and valued at a level in which they felt they could make an impact. We were told the executive team were interested and were visible in the community setting and there were strong working relationships. The leadership team felt there was mutual support in pathways working across the acute and community services and felt they were seeing positive outcomes of this during the winter pressure months.

**Action was taken to address behaviour and performance which was inconsistent with the vision and values.** The community services managers were committed to ensuring their individual cluster was a happy and supportive place for staff to work. They were clear about the action which would be taken if performance was inconsistent with the values for the trust. We were provided with examples where action had been taken. This action was taken to provide a professional and safe
working environment, conducive of supporting staff and optimising their potential to provide high quality care and treatment for their patients.

**Measures were taken to protect the safety of staff who worked alone and as part of dispersed teams working in the community, although these were not entirely following trust policy.**

Each cluster had developed their own systems of lone working in line with the trust’s policy. There was a lone working policy accessible to staff through the intranet. The policy outlined the role and responsibilities of employees and guidance for staff when lone working.

There were two systems for lone working within the community adults service. These included the buddy system and the system of logging visits. Staff across the service were following the process of logging their visits to ensure other staff were aware of where they should be. However, staff were not following the buddy system as set out in the policy. This was because they felt this system did not always work in their cluster. For example, if their buddy was out on visits in an area of poor mobile phone signal where they were unable to get hold of them. Staff had developed their own buddy system which included calling a member of the administration team based in their office within working hours, or their manager if they were checking in outside of working hours.

There was also inconsistency in the use of a ‘safe word,’ despite there being no requirement for use of a specific safe word identified in the lone working policy. Some staff we spoke to reported that they had a safe word they would use to highlight to staff that support was needed if they felt unsafe during a home visit. This word was discreet to prevent escalation of a situation. However, other areas we visited, did not have a safe word, and relied on being able to access their mobile devices to explain they were at risk. Other staff told us that they had discussed it at team meetings but were unable to remember it.

**There were mechanisms for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations.** Learning and development needs were identified at staff’s annual appraisal. Staff told us there was a culture of encouragement and support to develop their knowledge and skills to support the delivery of high quality care for patients.

**There was a strong emphasis on the safety and wellbeing of staff.** Senior staff across the service spoke of a genuine desire to ensure the happiness of their and provision of a happy place to work. We were told by many staff that they were happy in their role and they enjoyed working for the service. Each cluster provided different opportunities for staff to get involved to ensure their wellbeing. For example, across the different clusters, staff could attend yoga, Tai Chi, or circuit sessions in their lunchbreak or after work. Staff also had signposting to other services for issues which required support for their mental health.

Leaders recognised the impact of the transition and changes to job structures had on staff and understood the importance of supporting staff wellbeing. We were told that each community site had a health and wellbeing champion who helped support activities such as walking groups.

There was a culture which focused on demonstrating and highlighting positive outcomes where improvements had been made to services. The service completed a ‘demonstrating the difference form’ when there had been a positive impact on their service following action being taken to manage a problem. This was then provided as part of the trust’s performance assurance framework to showcase the good work which was going on in each cluster. For example, in the Exeter locality, work had been undertaken by the community rehabilitation team to reduce excessive waiting times for patients attending community physiotherapy services. The form identified the actions which had been taken and evidence of the positive impact which had been achieved. In this example, the physiotherapy waiting list has been reduced from 14 weeks to five weeks, with most patients being
seen within four weeks of referral. Telephone re-screening of patients on the waiting list for this service had also accounted for a 15% reduction in the waiting list as some patients did not need an appointment.

Morale was positive across the community adults service in all but one team. For the out of hours nursing team, although things had improved slightly, morale was still low. Since the community services had transferred to the trust on October 2016, there had been little continuity with four different managers for the team. The team were unhappy with their environment, felt they had no voice and didn’t always feel valued or respected members of the wider service. The out of hours nursing manager and the community service manager overseeing the service had recognised this and work had started to make improvements to the team’s morale.

A service development plan had been established to look at aspects of the out of hours nursing service in which action could be taken to improve the situation for the staff. Some action had already been taken and other action was ongoing. Although staff had been involved in setting up the service development plan, they felt they needed further explanation and understanding behind the action being taken to address each issue. Prior to our inspection, the team had received news about a potential addition to their service which they felt was inappropriate and would impact on them being able to provide their primary service. The community services manager had recognised this and a piece of work was to be undertaken to review data and look at the logistics and how realistic it would be for the team to take on this additional role.

**Governance**

There was a systematic approach to improve the quality of services and monitoring standards of care. There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. There was a straightforward governance structure. The community adults service was represented through an individual cluster-level governance group. This reported through to the monthly divisional governance group and the overarching trust governance group which in turn reported to the trust board.

There were separate governance arrangements with the local social care team. This was due to the community adults service being integrated with the local social care team and the alignment of health and social care. The integration director for the community service linked with the head of adult social care operations for health and social care for the local authority. This meant any governance issue which may impact on the community adults service could be raised and managed at community operational meetings by the community adults service representative.

Minutes from the divisional governance group meetings were consistent in the quality and depth of discussions around safety quality and performance. We reviewed three sets of minutes from August, September and November 2018. The meetings looked at information such as quality and safety, risk, audit, learning and development and complaints. The minutes contained details of discussions held, and provided a good level of scrutiny of the issues raised. Standard agenda items included discussion around escalation of issues from each individual cluster, incidents, complaints and risk.

There was a systematic approach to monitor and improve quality and safety across each cluster. Each cluster ran its own governance meeting once a month, chaired by the community services manager. This then fed up to the divisional governance team for the community adults service which met once a month, chaired by the associate director of nursing. This then fed into the main governance meeting for the trust. Senior leaders for the community adults service felt the governance process ensured there was clear oversight of issues affecting the service. They felt they had good representation at governance meetings and were listened to.
Consistency was ensured around governance issues across each cluster. A member of the senior leadership team would regularly attend each cluster governance meeting. This provided a broad knowledge of how the governance was managed in each cluster and ensured consistency across the patch. This also enabled a level of challenge to be provided to each cluster in relation to issues raised to ensure consistency across the service. The community service leads also had their own senior professional forum where they could learn from each other ensuring consistency in the way each cluster was working.

To ensure that learning and improvement was shared from governance meetings to enable action to be taken at a local level, the trust used communications and boards in the cluster locations to shared information with staff. By doing this, staff were made aware of areas which required improvements, for example, mandatory training and learning from incidents to improve the quality and safety of the service.

Quality and safety was information was regularly audited by the service. Audits included pressure ulcer audits, documentation audits and data was reviewed and collected monthly about waiting times for specific services. This information was shared with staff at communication meetings.

A governance lead for the community services meant better oversight of governance issues across the service. The governance manager for the community services linked regularly with the trust’s safety and risk and patient experience lead. This supported oversight of governance issues across the community services and provided assurance around the consistency of reporting processes.

**Staff at all levels were clear about their role, what they were accountable for and to whom they were accountable.** Staff were clear about who they reported to in their teams and were clear about the roles and responsibilities of other senior managers. Staff told us they regularly communicated with their team leaders for various reasons, for example for advice or for help with a complex case. Team leads were also available day-to-day in the office for staff to contact, and in attendance at daily service meetings or conference calls to provide support and advice if required.

**There were clear service performance measures, which were reported on and monitored.** A monthly performance assurance framework report was produced for each cluster and for the community adults service. This was reported on monthly at a meeting attended by the senior leaders from the community adults service who reported any quality, safety and performance issues to the senior leadership team for the trust.

**There were comprehensive assurance systems where performance issues were escalated appropriately through clear structures and processes.** Communication meetings were held monthly across each cluster to discuss quality and performance. Each team across the community adults service had a communication board displayed. The board contained information about quality, safety and performance issues such as mandatory training, staffing, team performance, incidents and appraisal which were reviewed monthly. This meeting was also held monthly at divisional level to provide oversight of quality, safety and performance across the clusters. From this meeting, information would then be cascaded down to individual teams if required to ensure improvements were made around quality and performance.

**Management of risk, issues and performance**

**The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.** There were arrangements for identifying, recording and managing risks, issues and mitigating actions. The community adults service held its own risk register, with separate local risk registers for each locality. There were risks on the risk register relating to the community adults service. These included the issue of the urgent community
response team covering the gap in domiciliary care provision (known as ‘backfill’). There was the issue of community nursing vacancies in the Exeter community nursing team. Thirdly a medication handover risk when patients were discharged from hospital into the urgent community response teams to prompt or administer medication. The fourth risk was around the GP service which the trust had recently taken on.

Risks were reviewed actively managed and updated. Risk was reviewed at the monthly cluster level governance meeting and the risk register and associated risk assessments were reviewed monthly at the monthly divisional governance group, chaired by the assistant director of nursing.

There were comprehensive assessments associated with the risks identified on the risk register which appropriately moderated them. We reviewed two risk assessments associated with the backfill risk and the staffing risk for the Exeter community nurse teams. The assessments identified when the risk had been reviewed and when it was due for a further review. It identified the hazards, current controls and further controls to manage the risk. For example, for the community nursing vacancies risk. Further action which was being taken to manage the risk included a review or/cancellation of non-essential study leave. Other action included a review of staffing to provide cross staffing cover, monthly Exeter recruitment arranged and a review of the recruitment strategy with the human resources team.

The trust had reduced the risk arising from the backfill operation as much as they could. However, the senior leaders for the community adults service told us system leaders (leaders leading services across the wider health and social care services in the local area) had a big role to play in managing the domiciliary care market. The trust had led on behalf of Devon, to manage this issue, and had worked with providers and primary care commissioners to assess the issue of backfill. At the time of the inspection, the trust had also commissioned research to determine what attracted people into a domiciliary care role. The trust was looking at how the role could be better promoted and attract more people to work in this field. For example, providing alongside a better education and future career development pathway.

The trust was also looking at alternative ways to manage the problem, for example, the use of technology, the volunteer sector, or helping communities to support themselves. This would all help to support and develop the place-based care agenda for the local population. Additional controls to manage the backfill risk included implementation of an additional hours of domiciliary care hours across the system.

Potential risks were considered when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. Part of the ongoing development of the urgent community response teams was to ensure future sustainability of the service. There had been a 10% over-recruitment of support workers to help the teams to meet the demand for the service particularly over the winter months, and on an ongoing basis. The teams continued to develop their work around admission avoidance, the prevention agenda and early supported discharge.

There was alignment between service risk and what senior staff in each cluster said was on their worry list. Senior staff across each cluster spoke clearly of the challenges and risks they faced in their area. Senior staff demonstrated a good understanding around risk and the challenge and impact these had on their teams. There were also clearly able to articulate how the risk was being actively managed in their cluster.

There was alignment of risk across all levels of staff working for the community adults service. Staff of all levels were clearly able to articulate risk and how risks were being managed. For example, the Honiton and Ottery St Mary urgent community response cluster staff were open about the risk
around backfill. They told us how they managed this risk by prioritising or re-prioritising patients in their cluster in case demand exceeded capacity.

**Information management**

The trust collected, analysed, managed and used information well to support all its activities, using secure systems with security safeguards. Information needed to deliver care and treatment was available to some staff. However, at the time of our inspection, patient record systems were not integrated and staff were not documenting patient records in the same place. This meant services did not have full oversight of other care and treatment being provided for patients by staff in their own teams. This made it challenging at times to provide a holistic, more joined-up, integrated approach to care. This occurred in the urgent community response teams where nurses and therapists documented information in different places. Therapy teams recorded their notes in a different place to the urgent community response and community nursing teams and community nursing teams had their own documentation they kept and recorded in the patient’s home. The organisation was due to introduce a new electronic system in 2020 to enable an integrated approach to record keeping and accessing integrated information about patient care.

The majority of records were stored securely, however we visited a small number of services where records were left accessible. For example, we found notes in Exmouth to be left in an unlocked cupboard in a clinic room which was unattended, unlocked and next to a patient waiting room. This meant there was a risk that confidential patient information could be accessed by unauthorised persons.

Teams had access to information but required access to several different systems to access the information they needed. The urgent community response teams had access to an electronic system used by the local GP surgeries. They also used an electronic system which connected them with the hospital so they could see which patients from their cluster were inpatients.

Community nursing patients held their notes at their home so all professionals had access to them when visiting. This also meant if different nurses visited the patient, they would have easy access to information and care plans specific to the individual patient to direct their care and treatment.

The Parkinson’s disease service had access to letters from consultant clinics which patients had attended. The service used an electronic system to access this information. This helped the team to understand the advice which patient had been given by consultants and enabled them to follow up on issues to provide consistent care and treatment for patients.

**Engagement**

Patient and staff views and experiences were gathered and acted on to shape and improve the services and culture. Each cluster collected patient experience information in the form of a monthly patient survey. This looked at whether patients felt they were treated with dignity and respect, whether they had enough information and felt involved in their care. It asked whether they would recommend the service to their friends and family. We had access to data for five of the six clusters which showed that patients had responded very positively to these questions.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system, and the needs of the relevant population. There had been engagement of patients and the wider community in the design and running of the community service. Cluster leaders and the community service managers attended regular community conversations. Community conversations were held locally in each cluster and included the public, a local representative for the community setting such as the Mayor, and representative of local authorities. Other representatives from community organisations also attended. The aim
was to start a dialogue about what could be achieved by working together to develop a common understanding. This included as to what the local community currently had to offer, what the current needs were and how they were changing, to better shape a healthy future for those living in the area. The meeting was used to hear what local people felt they needed from the community services. It provided a place for all the community representatives to build relationships and work together to develop the local community services.

The community adults service kept the local population informed by the production of a monthly community newsletter. One newsletter provided information about the community conversation and another provided information about the single point of access. The newsletter also informed the public of achievements of the community adults service teams and provided examples of multidisciplinary work and positive outcomes for patients.

The service sought feedback from carers and relatives. The community nursing team used a questionnaire known as ‘PALM’ to gain the views of carers or relatives that provided care. The aim of this questionnaire was to help determine how confident carers and relatives felt in providing care.

**Staff were engaged so that their views were reflected in the planning and delivery of services.** There had previously been a culture where staff felt that changes were made without consultation and without being made aware that changes were happening. There was a general feeling that this was changing and we heard of examples where staff had been or were being engaged with to help develop services. There had been the introduction of workshops and workstreams. One of these workshops, for example, had invited link staff to look at and improve out of hours catheter unplanned changes.

**The views of staff in the service were sought and acted on.** Staff were engaged through team meetings, drop in sessions with staff and the annual staff survey. Staff we spoke with reported they felt their views and opinions were sought and acted on.

**Learning, continuous improvement and innovation**

**Leaders and staff strived for continuous learning, service improvement and innovation.** One of the urgent community response teams hosted a nurse from an organisation which provided support specifically for carers of people living with dementia. These nurses were not employed by the trust, but hosted by the trust to be based at the trust community service locations to support the local cluster teams. The addition of this hosting role provided another avenue for the teams to get support with complex patients in the community. Other cluster teams were looking to replicate this model in their own clusters.

The service was involved with a research project in conjunction with universities and other hospitals. The research was around falls prevention. It aimed to study whether an extended rehabilitation programme using a home-based exercise intervention developed for frail older people improved health-related quality of life. Work was ongoing with this research and at the time of the inspection results were yet to be collated.

The musculoskeletal service was looking at innovative ways of working across the system in primary care. The service was currently undertaking a pilot in conjunction with a university to trial the first care practitioner way of working in the community. This was to ensure patients saw the most appropriate clinician for their care and treatment needs. The pilot started in November 2018, and was due to run for six months.

**There were systems to support improvement and innovation work.** The community was in the process of rolling out a chronic obstructive pulmonary disease (COPD) passport. This passport contained specific information about patients living with COPD. The role of the passport was to help
improve information sharing and contained guidance for clinicians and carers on action that should be taken based on signs and symptoms that the patient may be experiencing. We were informed that the piloting of this passport had been supported by a number of different clinicians. At the time of our inspection, a supervision and teaching day were being planned to support staff in the use of the passport.

The service worked with other organisations to help drive improvement. For example, a member of the specialist occupational therapist team had visited a specialist unit. The aim of this was to review the work and impact of high intensity care for patients with upper limb conditions. At the time of our inspection, the service was in the process of re-auditing outcomes for patients following intensive rehabilitation sessions they had implemented following this visit.

Work was being undertaken to improve pressure ulcer prevention. This work was being undertaken with a variety of other healthcare providers and was looking at the impact that immediate assessment of all referrals received had on pressure ulcer prevention.

The pharmacy team had been nationally recognised, and been nominated for an award for their work. They had also published an evaluation of how the service had reduced medicines risks in a clinical journal.
Community health inpatient services

Facts and data about this service

Information about the wards in the trust’s community hospitals is shown below:

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<th>Location / site name</th>
<th>Team/ward/satellite name</th>
<th>Number of inpatient beds</th>
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<tbody>
<tr>
<td>Exmouth Community Hospital</td>
<td>Day case surgery unit</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Elderly care inpatient ward</td>
<td>16</td>
</tr>
<tr>
<td>Sidmouth Community Hospital</td>
<td>Elderly care inpatient ward</td>
<td>24</td>
</tr>
<tr>
<td>Tiverton District Hospital</td>
<td>Elderly care inpatient ward</td>
<td>32</td>
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(Source: Universal Routine Provider Information Request (RPIR) – P2 Sites tab)

The trust’s community hospitals at Exmouth, Sidmouth and Tiverton are part of the Royal Devon and Exeter NHS Foundation Trust and are managed within the community services division of the trust.

Axminster and Exmouth Community Hospitals each have a surgical day case unit. We did not inspect these services during this inspection as this inspection focused on inpatient services. Sidmouth, Exmouth and Tiverton Hospitals each had an elderly care inpatient ward, providing a total of 72 beds and both were inspected as part of this inspection. There were with 32 inpatient beds across two wards at Tiverton hospital, 16 beds at Exmouth and 24 beds at Sidmouth.

The inspection was announced (staff knew we were coming) which ensured we could speak to managers and staff during our inspection. We spoke with 30 members of staff including senior managers, matrons, nursing and therapy staff, medical staff and hospitality teams. We held three focus groups across the hospitals and 38 members of staff attended.

We spoke with 12 patients and their relatives and reviewed 12 sets of records across the three hospitals we visited.

Patients are admitted into the hospitals mainly from the acute hospital, but they also accept patients who require end of life care and treatment direct from the community.

Medical cover is provided by doctors directly employed by the trust, GPs and an advanced nurse practitioner. Each ward is staffed by health professionals such as registered nurses, occupational therapists, physiotherapists and pharmacy staff who provide care and treatment for patients admitted to the wards. All the hospital sites also had oversight from a consultant geriatrician who visited each hospital twice a week.

The trust explain that the community hospitals aims, to:

“Work with colleagues to provide a rehabilitation program in order that ‘home first’ is fully assessed. This is a goals-based program to monitor progress. The hospitals are aiming to integrate more with
the community team with the ethos of facilitating the patient discharge on the continuum of rehabilitation. By that we mean working toward the patient being able to continue their rehabilitation at home”.

“Provide end of life care or supportive palliative care to ensure patients die in their preferred place. If this is home, it will be supported by the multi-disciplinary team or within the community hospital setting.”

(Source: CHS Routine Provider Information Request (RPIR) – CHS1 Context CHS)

Percentage of patients that are children

The trust reported that no children aged 18 years or under attended their community inpatient services within the last 12 months. It should also be noted all three community inpatient wards provide elderly care.

(Source: Routine Provider Information Request (RPIR) Universal P9 – Children)

Is the service safe?

Mandatory training

Staff were provided with training in safety systems, processes and practices, however not all staff had met the trust target for training compliance. The electronic system used to record this was not reliable and so did not provide an accurate and updated reflection of training completed.

The trust set a target of 75% for completion of mandatory training which was met in most areas relevant to the staff role and location trust wide. There was an exception to this within the community inpatients services relating to fire competency and basic life support. Mandatory training compliance was recorded on an electronic system which also provided staff with access to the online mandatory training. Staff expressed frustrations with this system due to the ongoing problems with not being able to access it and inaccurate recording of training which had been completed.

The mandatory training programme was delivered with a mixture of face to face sessions and eLearning. Staff and their line manager received emails generated from the electronic data base to say when staff had updated their training and when training was required to be renewed and updated. We were told that if staff did not comply with the training requirements, a letter was sent to them reminding them of their responsibility to maintain the trust training requirements. Managers we spoke with told us they met with the member of staff to ensure they had booked training to update their compliance.

Trust wide

A breakdown of compliance for role specific mandatory training courses as of May 2018 for staff in community inpatient services is shown below:
In community inpatient services the 75% target was met for 13 of the 17 mandatory training modules for which staff were eligible. Three of the four modules where the training target was not met concerned blood or blood products. However, since the inspection the trust has informed us that the training regarding blood or blood products was not mandatory for all qualified nurses. However, staff who had not completed the competencies regarding transfusion theories were not permitted to complete any of the elements that involved blood products.

A breakdown of compliance for mandatory training courses as of May 2018 for nursing staff in community inpatient services is shown below:
In community inpatient services the 75% target was met for 12 of the 17 mandatory training modules for which qualified nursing staff were eligible. Again, three of the four modules where the target was not met concerned blood or blood products.

The electronic system used to record the training was not always accessible to staff and did not provide up to date and accurate information. The 75% target was met for 12 of the 15 mandatory training modules for which nursing staff at the community hospitals were eligible. Senior staff told us that their teams had attended and completed additional training which was not reflected on the electronic system at the time of our inspection. This was due to the system showing data from one month previously and not real time. Staff we spoke with confirmed that they had attended additional training which was not showing on the training matrix’s we were shown. However, the following tables show that not all staff had completed appropriate eLearning relating to blood or blood products. The senior staff we spoke with were aware of this and provided assurances that additional training had been booked to address this.

### Exmouth Community Hospital community inpatient services

A breakdown of compliance for mandatory training courses as of May 2018 for qualified nursing staff at Exmouth Community Hospital is shown below:

<table>
<thead>
<tr>
<th>Safety &amp; compliance area</th>
<th>No. passed</th>
<th>No. targeted</th>
<th>% passed</th>
<th>75% target</th>
<th>Compliance</th>
<th>Competency in the inspection</th>
<th>Additional comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality &amp; diversity</td>
<td>78</td>
<td>79</td>
<td>98.7%</td>
<td>75%</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dementia and delirium</td>
<td>76</td>
<td>79</td>
<td>96.2%</td>
<td>75%</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pressure ulcer classification (PUCLAS)</td>
<td>73</td>
<td>77</td>
<td>94.8%</td>
<td>75%</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic abuse</td>
<td>73</td>
<td>78</td>
<td>93.6%</td>
<td>75%</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food safety awareness</td>
<td>45</td>
<td>49</td>
<td>91.8%</td>
<td>75%</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manual handling</td>
<td>71</td>
<td>79</td>
<td>89.9%</td>
<td>75%</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information governance</td>
<td>70</td>
<td>79</td>
<td>88.6%</td>
<td>75%</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls, slips and trips (patients)</td>
<td>64</td>
<td>77</td>
<td>83.1%</td>
<td>75%</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection prevention &amp; control (including hand hygiene)</td>
<td>65</td>
<td>79</td>
<td>82.3%</td>
<td>75%</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfusion theory</td>
<td>11</td>
<td>15</td>
<td>73.3%</td>
<td>75%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic life support</td>
<td>40</td>
<td>58</td>
<td>69.0%</td>
<td>75%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fire competency</td>
<td>49</td>
<td>79</td>
<td>62.0%</td>
<td>75%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration of blood/blood products (practical)</td>
<td>7</td>
<td>14</td>
<td>50.0%</td>
<td>75%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collecting blood/blood products (practical)</td>
<td>0</td>
<td>10</td>
<td>0.0%</td>
<td>75%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

20171116 900885 Post-inspection Evidence appendix template v3  Page 230
<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcer classification (PUCLAS)</td>
<td>15</td>
<td>15</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Food safety awareness</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Waste management</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution (level1)</td>
<td>15</td>
<td>15</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention &amp; control (including hand hygiene)</td>
<td>15</td>
<td>15</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia and delirium</td>
<td>15</td>
<td>15</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>15</td>
<td>15</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Exeter pressure risk assessment tool</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>14</td>
<td>15</td>
<td>93.3%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Domestic abuse</td>
<td>14</td>
<td>15</td>
<td>93.3%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling</td>
<td>14</td>
<td>15</td>
<td>93.3%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Transfusion theory</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls, slips and trips (patients)</td>
<td>13</td>
<td>15</td>
<td>86.7%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administration of blood/blood products (practical)</td>
<td>7</td>
<td>10</td>
<td>70.0%</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>6</td>
<td>12</td>
<td>50.0%</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Fire competency</td>
<td>7</td>
<td>15</td>
<td>46.7%</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Collecting blood/blood products (practical)</td>
<td>0</td>
<td>10</td>
<td>0.0%</td>
<td>75%</td>
<td>No</td>
</tr>
</tbody>
</table>

On the day of our inspection at Exmouth hospital, staff were not able to log into the system to demonstrate the training completed for individual members of staff or provide an overview of the ward staff completion rates. We were told this had been an ongoing issue for two years.

The training data supplied by the trust showed one member of medical staff in post in community inpatient services as of May 2018, based at Exmouth Community Hospital. This member of staff had completed the one mandatory training module he was eligible for as of that date (basic life support). There were medical staff working within the other community hospitals overseen by GPs but we were not provided with training records for these staff.

### Sidmouth Community Hospital community inpatient services

A breakdown of compliance for mandatory training courses as of May 2018 for qualified nursing staff at Sidmouth Community Hospital is shown below:
<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfusion theory</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Waste management</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Exeter pressure risk</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Exeter pressure risk assessment tool</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>19</td>
<td>20</td>
<td>95.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution (level 1)</td>
<td>19</td>
<td>20</td>
<td>95.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Food safety awareness</td>
<td>14</td>
<td>15</td>
<td>93.3%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>18</td>
<td>20</td>
<td>90.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia and delirium</td>
<td>18</td>
<td>20</td>
<td>90.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Pressure ulcer classification (PUCLAS)</td>
<td>17</td>
<td>19</td>
<td>89.5%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Domestic abuse</td>
<td>16</td>
<td>19</td>
<td>84.2%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling</td>
<td>16</td>
<td>20</td>
<td>80.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention &amp; control (including hand hygiene)</td>
<td>16</td>
<td>20</td>
<td>80.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls, slips and trips (patients)</td>
<td>13</td>
<td>19</td>
<td>68.4%</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>12</td>
<td>18</td>
<td>66.7%</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Fire competency</td>
<td>9</td>
<td>20</td>
<td>45.0%</td>
<td>75%</td>
<td>No</td>
</tr>
</tbody>
</table>

Tiverton District Hospital community inpatient services

A breakdown of compliance for mandatory training courses as of May 2018 for qualified nursing staff at Tiverton District Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waste management</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Exeter pressure risk assessment tool</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>36</td>
<td>36</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution (level 1)</td>
<td>36</td>
<td>36</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia and delirium</td>
<td>35</td>
<td>36</td>
<td>97.2%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Domestic abuse</td>
<td>35</td>
<td>36</td>
<td>97.2%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Pressure ulcer classification (PUCLAS)</td>
<td>33</td>
<td>35</td>
<td>94.3%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling</td>
<td>33</td>
<td>36</td>
<td>91.7%</td>
<td>75%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Falls, slips and trips (patients) | 31 | 35 | 88.6% | 75% | Yes
--- | --- | --- | --- | --- | ---
Food safety awareness | 21 | 24 | 87.5% | 75% | Yes
Information governance | 30 | 36 | 83.3% | 75% | Yes
Infection prevention & control (including hand hygiene) | 29 | 36 | 80.6% | 75% | Yes
Basic life support | 20 | 26 | 76.9% | 75% | Yes
Fire competency | 27 | 36 | 75.0% | 75% | Yes
Transfusion theory | 20 | 22 | 90% | 75% | Yes
Administration of blood/blood products (practical) | 12 | 22 | 54% | 75% | No

(Source: Universal Routine Provider Information Request (RPIR) – P38 Training)

Safeguarding

Systems, processes and practices kept people safe and safeguarded from abuse.

Safeguarding training completion

The trust set a target of 75% for completion of safeguarding adults training. Staff completed safeguarding training to level 2. In community inpatient services the 75% target was met for both safeguarding training modules for which staff in community inpatient services were eligible.

A breakdown of compliance for safeguarding training courses as of May 2018 for all staff in community inpatient services is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults level 2</td>
<td>150</td>
<td>156</td>
<td>96.2%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection level 2</td>
<td>150</td>
<td>156</td>
<td>96.2%</td>
<td>75%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Trust wide

A breakdown of compliance for safeguarding training courses as of May 2018 for qualified nursing staff in community inpatient services is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults</td>
<td>76</td>
<td>78</td>
<td>97.4%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection group 2</td>
<td>76</td>
<td>78</td>
<td>97.4%</td>
<td>75%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
In community inpatient services the 75% target was met for both safeguarding training modules for which qualified nursing staff were eligible.

**Exmouth Community Hospital community inpatient services**

A breakdown of compliance for safeguarding courses as of May 2018 for qualified nursing staff at Exmouth Community Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults</td>
<td>15</td>
<td>15</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection group 2</td>
<td>15</td>
<td>15</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 75% target was met for both safeguarding training modules for which qualified nursing staff at Exmouth Community Hospital were eligible.

**Sidmouth Community Hospital community inpatient services**

A breakdown of compliance for safeguarding courses as of May 2018 for qualified nursing staff at Sidmouth Community Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child protection group 2</td>
<td>18</td>
<td>19</td>
<td>94.7%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>17</td>
<td>19</td>
<td>89.5%</td>
<td>75%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 75% target was met for both safeguarding training modules for which nursing staff at Sidmouth Community Hospital were eligible.

**Tiverton District Hospital community inpatient services**

A breakdown of compliance for safeguarding courses as of May 2018 for qualified nursing staff at Tiverton District Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults</td>
<td>36</td>
<td>36</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection group 2</td>
<td>35</td>
<td>36</td>
<td>97.2%</td>
<td>75%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 75% target was met for both safeguarding training modules for which nursing staff at Tiverton District Hospital were eligible.

(Source: Universal Routine Provider Information Request (RPIR) – P38 Training)
Safeguarding referrals

Staff were knowledgeable and understood how to safeguard patients against abuse and worked with other agencies when needed

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has its own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to children’s services, adult services or the police should take place.

The trust was unable to provide numbers of safeguarding referrals specifically for community inpatient services; instead they provided the numbers for community services overall.

The trust’s community services made 35 adult safeguarding referrals from June 2017 to May 2018.

This showed an upward trend earlier in the year in the number of adults safeguarding referrals, with 26 of the 35 referrals (more than two thirds) reported in the five-month period from January to May 2018.

(Source: Universal Routine Provider Information Request (RPIR) – P11 Safeguarding)

Staff were provided with information and guidance on the action to take to safeguard patients from abuse within policies and procedures. These were available electronically through the trust’s intranet system. The policies and procedures provided staff with guidance on safeguarding vulnerable patients such as those living with dementia, mental health conditions and female genital mutilation.

Staff we spoke with were confident in reporting concerns relating to safeguarding. For example, Tiverton hospital staff shared an example of when, following concerns identified on the ward, safeguarding measures had been put into place prior to the discharge of a patient.

The staff raised concerns through the trust electronic system which shared the information with the relevant people. The senior nurse in each hospital was provided with information on all safeguarding alerts through this system. Coloured paperwork in the patients’ medical records alerted staff to previous concerns which meant potential risks to the safety and safeguarding of the patient were not missed. Information was shared at safety briefings and handover between shifts to ensure all staff were appraised of the situation. The trust wide safeguarding team provided support to ward staff where necessary regarding safeguarding patients. Staff were aware of how to contact the team and we saw their contact details were displayed on wards for easy access for the staff.

Deprivation of liberty safeguards (DOLS) were assessed and where necessary applied to keep patients safe, for example, if a patient requested to be discharged against medical advice. Letters of approval were received within a few days of DOLS application but the wards had not been
contacted or visited in relation to these applications. Staff stated that to their knowledge no DOLs application had been declined.

**Cleanliness, infection control and hygiene**

Standards of cleanliness and hygiene were maintained and there were reliable systems to prevent and protect people from healthcare associated infections.

The community hospitals looked clean and hygienic. The hospitality staff maintained cleaning schedules which identified the areas to be cleaned each day and these were signed when completed. At Exmouth hospital there were three days in January for which the cleaning schedule had not been signed. The team leader and supervisor of the hospitality team monitored the cleaning schedules and action was taken when needed regarding gaps or issues raised from the schedule.

Water outlets were flushed regularly and recorded to reduce the risk of legionella. Legionella is a bacterium which can cause illness.

Privacy curtains between beds were disposable and changed regularly and when needed. For example, when soiled or during a deep clean following the discharge of a patient with an infectious illness. This reduced the risk of cross infection. The curtains were labelled with the date on which they were hung to inform staff of when the next routine change would take place.

The clinical staff informed the hospitality team of when patients were admitted or contracted an infection illness. When a deep clean was required hospitality staff from other hospitals provided help. For example, several staff provided support at Sidmouth Hospital to carry out a deep clean following a period of building works. This meant there was less disruptive impact to patients and staff.

Audits were carried out of the cleanliness of wards and departments. At Tiverton hospital the ward audit assessed the cleanliness at 93%. Immediate action had been taken to address the issue and return to 100% compliance.

There were isolation policies and procedures to reduce the risk of cross infection. Staff were familiar with these procedures. Whenever possible patients with a known infection were placed in a side room and appropriate signage was displayed to make all staff and visitors aware of the restrictions. Sidmouth hospital had recently recognised and swiftly isolated a patient with suspected influenza (flu). Staff told us they had learnt from the flu epidemic in 2018 and staff put measures into place immediately to reduce the spread of infection.

**At Tiverton hospital, the control of infection was not consistently promoted by all staff which resulted in a risk from cross infection.**

At Tiverton hospital, we observed the records for patients who were isolated remained in their room. When it came to completion of the nursing notes, the nurse removed the records to the corridor and then on completion returned them to the room. This provided a risk of cross infection. At the other hospitals we saw that the patient notes were stored outside of their rooms when isolation was required.

Single use or one patient only equipment was used where possible, for example hoist slings. Staff ensured equipment was cleaned after use and identified clean equipment with clearly visible stickers. Appropriate cleaning equipment was readily available on the wards and this promoted the control of infection and reduced the risk of cross infection. Body fluid spillage kits were available on the ward to remove body waste safely. Clinical waste was disposed of correctly, in colour coded, pedal operated bins. Full waste bags were sealed and regularly removed from the wards during the day.
Patients we spoke with were positive about the cleanliness of the wards and two patients complemented the food hygiene practiced by staff.

Staff were seen to wash their hands and use antibacterial hand gel between patient contacts. Handwashing facilities were available in all clinical areas and patient areas on the wards. Antibacterial hand gel was available within clinical areas and staff carried hand gel on their person. Staff complied with the trust policy and procedure and were bare below the elbows in all clinical areas. Hand hygiene audits were carried out and displayed on notice boards on the wards. The audits showed staff complied with the hand hygiene procedures adopted by the trust.

Standards of food hygiene were high. For example, Sidmouth hospital had an Environmental Health Rating of five, which was the highest awarded, in March 2018.

Patients we spoke with were positive about the cleanliness of the wards and two patients complemented the food hygiene practiced by staff.

PLACE Assessments

These self-assessments are undertaken by teams of NHS and private/independent health care providers, and include at least 50 per cent members of the public (known as patient assessors). They focus on the environment in which care is provided, as well as supporting non-clinical services. These include cleanliness, food, hydration, the extent to which the provision of care with privacy and dignity is supported and whether the premises are equipped to meet the needs of people with dementia against a specified range of criteria.

All three of the trust’s community hospitals reported similar results for cleanliness and condition, appearance and maintenance compared to the England averages.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Cleanliness %</th>
<th>Condition, appearance and maintenance %</th>
<th>Dementia friendly %</th>
<th>Disability %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exmouth Community Hospital</td>
<td>99.2%</td>
<td>89.2%</td>
<td>63.8%</td>
<td>75.3%</td>
</tr>
<tr>
<td>Sidmouth Community Hospital</td>
<td>96.0%</td>
<td>98.5%</td>
<td>73.8%</td>
<td>86.9%</td>
</tr>
<tr>
<td>Tiverton District Hospital</td>
<td>98.0%</td>
<td>95.5%</td>
<td>72.7%</td>
<td>84.9%</td>
</tr>
<tr>
<td>Trust community inpatients</td>
<td>97.8%</td>
<td>94.7%</td>
<td>70.5%</td>
<td>82.9%</td>
</tr>
<tr>
<td>England average (NHS community)</td>
<td>98.8%</td>
<td>93.1%</td>
<td>80.6%</td>
<td>86.4%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital)

Environment and equipment

The maintenance and use of facilities, equipment and premises kept people safe.

The hospitals were well furnished and equipped to provide patients with the care and treatment they needed and kept them safe. Exmouth hospital was an older style building while Sidmouth and Tiverton were newer in style.
There was maintenance and refurbishment work waiting to be carried out at Exmouth hospital. This meant areas of the ward were cold.

It had been identified in June 2018 the windows in the ward required replacement as the ward temperature was cold. This work had not been completed at the time of our inspection. The day room also felt cold and one radiator was not hot. There was a patient toilet located off the day room which had no form of heating and no double glazing so felt cold to enter. There was an action plan which showed the work was due to be carried out to improve the environment but no time scale was identified. Staff we spoke with made no reference to monitoring the temperature of these areas but said the heating was managed from the main trust site and they therefore had no control over this.

The wards provided a mix of four bed bays and single rooms and staff moved patients to different areas according to their care needs and outcome of risk assessments to ensure they were cared for in the optimum location.

Improvements were being made to increase the storage facilities at each hospital. The corridors and bays on the wards were clutter free and fire exits were accessible. However, the day room on Twyford ward at Tiverton hospital was cluttered with furniture and stored equipment. For example, there were a lot of chairs, tables and mobility equipment stored in the corner of the room. This did not provide patients with sufficient space to move around the room freely. A maintenance plan identified in September 2018, the removal of a bath, toilet and shower to provide an additional storage room. The bath, sink and toilet was still there although had been disconnected from the water supply. The room was being used as a storage room at the time of our inspection.

Staff had access to sufficient equipment to support the care and treatment needs of the patients. We saw there were supplies of walking aids, hoists, commodes and pressure relieving equipment both in use and ready to use. Tiverton hospital had additional equipment to support patient discharges such as hoists and walking aids. The equipment was maintained and serviced regularly and stickers showed when the next service was due to take place. Portable electrical equipment was tested annually to ensure it was safe to use and again stickers showed this testing had been carried out. However, at Exmouth hospital two electrical items did not have a date recorded on them. Staff stated the management of this testing was maintained by the estates department as part of an ongoing programme. This programme did not ensure the equipment was safe to use.

Sterile single use equipment such as needles, syringes and dressings were available. At Exmouth we noted several syringes were past the expiry date. Staff removed these from circulation immediately. The ward sister we spoke with said there was a system to check expiry dates and that these had been missed during the checks.

The day rooms at the community hospitals were used for patients to dine in and spend time relaxing or with their families away from their bedside. Tiverton and Sidmouth provided a comfortable homely environment with pictures and flowers but Exmouth day room was clinical in appearance with only a few armchairs in the conservatory part of the room. Patients had access to activities such as books, games, music, television, crafts and jigsaws which staff supported them to enjoy. We observed exercise classes taking place in the day room at Tiverton hospital which patients were encouraged to attend as part of their rehabilitation.

Assessing and responding to patient risk

Risks to people were assessed, and their safety monitored and managed so they were supported to stay safe.
Staff completed and updated risk assessments for each patient in line with national guidance. The risk assessments were completed on admission and included the assessment of risks from pressure damage, moving and handling, falls and nutrition. Care plans provided guidance on the action staff were to take to reduce any identified risk.

The template for the falls care plan had been reviewed to identify preventative measures staff could take within a multidisciplinary team. The falls risk assessment for one patient had been reviewed after they experienced a fall on the ward. The care and treatment plan had been updated and preventative measures put into place to reduce the risk of the patient sustaining another fall. The therapy staff also completed a falls screening tool which was scored according to identified risks and gave an overall risk.

Some areas of risk assessment were not fully completed and so did not ensure all areas of risk and associated care planning were undertaken. We observed the nutritional risk assessment for one patient which identified they did not have any additional nutritional risks. However, the staff had commenced a food chart to record the nutritional intake of the patient as they were not eating all meals. This was attributed to their confusion and not having any teeth. The risk assessment should have identified and addressed these issues.

Medical and nursing staff completed risk assessments for venous thromboembolism (VTE). A VTE is a blood clot forming in the vein, often in the legs. The outcome of the VTE assessment was recorded in the patient medication record. The risk assessments were reviewed within 24 hours of admission in line with the national Institute for Health and care Excellence NG89 (2018).

Staff followed processes to identify the deteriorating patient. Physical observations were taken and recorded using an early warning score (EWS). This enabled staff to score the observations in a numerical format and so measure against a baseline of observations. Should the calculations show signs of change staff would escalate to the senior nursing or medical staff for appropriate care and treatment to be provided. Medical and nursing staff confirmed that concerning EWS were escalated and acted upon promptly. Patient medical records supported this and provided an audit trail of actions taken in response. We observed conversations between nursing and medical staff regarding identified concerns about two patients and the action which was planned and taken.

The trust was due to implement the National Early Warning Score 2(NEWS2) system which was an updated version in line with national guidance. An adult sepsis screening tool was due to be implemented as part of the NEWS2 documentation. At the time of our inspection staff were alerted to the risks from sepsis by a flow chart that was inserted into patient notes. Staff we spoke with were familiar with the signs of sepsis and were alert to this possibility when identifying a deteriorating patient. When urgent medical attention was needed the ward doctor was alerted to the patient condition if they were on the ward and an emergency ambulance was called to transfer the patient to the acute hospital when necessary.

Information was shared with staff during the daily safety briefings, board rounds (held at the whiteboard which included detail regarding each patient’s care and treatment) and patient handovers. These took place during the day and at the start of each shift and ensured staff were aware of risks and the action they were required to take to keep patients safe.
At Tiverton hospital we observed the afternoon ‘huddle’ meeting. This involved a group of staff, led by a senior team member reviewing the actions highlighted in the earlier board meeting and sharing any update to the care and treatment for patients.

A weekly virtual ward meeting took place at the hospitals attended by community and hospital staff to review the patients in the community and in the hospital. This was to ensure the multidisciplinary care and treatment for patients, particularly for patients with long term and often complex conditions. Community Matrons came onto the ward to support the discharge planning of their patients. This included sharing information of the patient home circumstances, environment and assisting in the planning of ongoing care and treatment that would be needed on discharge from the ward.

Emergency and resuscitation equipment and trolleys were available on the wards at Sidmouth and Tiverton hospitals. The equipment and medicines were checked daily and weekly to ensure they were safe to use and records were maintained to evidence the check had taken place. The trolleys were tamper evident to provide assurance to staff that they were safe to use and had not been used since the last recorded check. The emergency trolley at Exmouth hospital was stored in the minor injury unit (MIU) which was located in close proximity to the ward. When the MIU was closed the trolley was moved to the ward.

**Staffing**

**Staffing levels and skill mix of staff were planned and reviewed so that people received safe care and treatment.**

At times due to vacancies, holiday or sickness, wards did not have sufficient staff to always meet their staffing establishment. The shortfall was met by permanent staff working additional hours, moving staff from other areas when able and the use of bank and agency staff. The introduction of the intermediate care model within the community hospitals had resulted in further recruitment of therapy and rehabilitation support workers who would work across the therapy and nursing teams. Tiverton hospital had recruited four rehabilitation support workers who were due to start at the end of January 2019 and two health care assistants had been recruited who were also due to commence work at the end of January 2019. Further staff were being recruited to support the intermediate care model.

During our inspection we saw that two wards were above the planned establishment for registered nurse cover. Staff said this often happened as there had been additional staff available following the closure of some community hospitals previously.

Staff were not all clear about how staffing levels were reviewed. We were told by senior community service staff that the levels of nurse staffing were reviewed twice a year by the assistant director of nursing who had responsibility for the community services. Many staff we spoke with were not aware of this process or when it had last been carried out. Several staff believed this to have taken place in 2016. Staff recalled that following this review several beds had been reduced at Sidmouth hospital due to a low number of available qualified nursing staff.

Staff confirmed they could request additional staff when required to meet the care and treatment needs of patients to ensure their safety. A virtual bed meeting took place each day which was attended by senior representatives from each community hospital and the acute trust. The acuity and dependency of patients was assessed by each ward using a nationally recognised nurse staffing
tool. This review was completed three times a day and the levels of dependency were discussed at the meetings. We attended a meeting during our inspection and heard that staffing was discussed and staff moved between community hospitals when necessary to provide additional support. However, staff we spoke with said that at times qualitative information was not reflected in the staffing tool as there was no provision to record supporting narrative about the specific situations on the wards. For example, regarding patients who required one to one support from staff. This information was however, shared verbally during the virtual bed meeting.

Staff we spoke with said they rotated between day and night shifts and that the competencies of health care assistants were being reviewed to provide additional skills to support the registered nurses.

All hospitals had vacancies for nursing staff and a programme of recruitment was ongoing. The week following our inspection there were open days planned in the hospitals and it was reported there had been a good response to this approach.

Exmouth hospital had submitted a business plan for an additional health care assistant and were waiting the outcome for this from the trust.

**Safer staffing levels**

Staff fill rates compared the proportion of planned hours worked by staff (nursing and care staff) to actual hours worked by staff (day and night). Acute trusts are required to submit a monthly safer staffing report and undertake a six-monthly safe staffing review by the director of nursing. This is to monitor and in turn ensure staffing levels for patient safety. Hence, an average 70% fill rate in January 2016 for qualified nursing staff during the day means that in January 70% of the planned working hours for daytime qualified nursing staff were actually ‘filled’.

Details of staff fill rates within community inpatient services for registered nurses and care staff in May 2018 for each site published on their website by the trust are below:

For community inpatient services, there is information for three locations. These are:

- Exmouth Community Hospital
- Sidmouth Community Hospital
- Tiverton District Hospital

**Qualified nursing staff**

<table>
<thead>
<tr>
<th>Location</th>
<th>Day Required shifts</th>
<th>Day Filled shifts</th>
<th>Night Required shifts</th>
<th>Night Filled shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exmouth Community Hospital</td>
<td>940.5</td>
<td>1,119.7</td>
<td>620.0</td>
<td>609.4</td>
</tr>
<tr>
<td>Sidmouth Community Hospital</td>
<td>1,520.3</td>
<td>1,638.0</td>
<td>620.0</td>
<td>631.5</td>
</tr>
</tbody>
</table>
The data show that day time qualified nursing staff shifts were overfilled at all three community hospitals. They also show that night-time shifts were overfilled at Sidmouth Community Hospital, but moderately underfilled at the other two sites.

### Care staff

<table>
<thead>
<tr>
<th>Location</th>
<th>Day Required shifts</th>
<th>Day Filled shifts</th>
<th>Night Required shifts</th>
<th>Night Filled shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exmouth Community Hospital</td>
<td>1,176.5</td>
<td>1,442.7</td>
<td>310.0</td>
<td>591.3</td>
</tr>
<tr>
<td>Sidmouth Community Hospital</td>
<td>1,734.0</td>
<td>2,006.5</td>
<td>939.0</td>
<td>1,030.5</td>
</tr>
<tr>
<td>Tiverton District Hospital</td>
<td>2,318.0</td>
<td>2,542.4</td>
<td>713.0</td>
<td>1,321.5</td>
</tr>
</tbody>
</table>

The data show that both day time and night time care staff shifts were overfilled at all three community hospitals. Night time shifts were especially heavily overfilled at Tiverton District Hospital, with 1,321.5 shifts filled compared to 713 required shifts.

(Source: Safer Staffing Data – Trust website)

### Planned v Actual Establishment

Details of staffing levels within community inpatient services by staff group as at May 2018 are below.

#### Community inpatient services total

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Planned staff WTE</th>
<th>Actual Staff WTE</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add prof scientific and technic</td>
<td>0.8</td>
<td>1.4</td>
<td>188.2%</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>68.1</td>
<td>70.8</td>
<td>104.0%</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>1.0</td>
<td>1.0</td>
<td>100.0%</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>86.1</td>
<td>66.2</td>
<td>76.9%</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P16 Total Staffing)

### Vacancies

The trust set no target for vacancy rate. From June 2017 to May 2018, the trust reported an overall
vacancy rate of 11.4% in community inpatient services.

Across the trust the overall vacancy rate for qualified nursing staff was 10.9%; for medical staff there was a staffing surplus of 2.5%.

Breakdowns of vacancy rates by staff group at trust level and by community hospital site as of May 2018 are shown below. Where the trust reported negative values, this indicates that an area is over-establishment.

### Community inpatient services total

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total number of substantive staff</th>
<th>Number of substantive vacancies</th>
<th>Total % vacancies overall (excluding seconded staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>1.4</td>
<td>-0.7</td>
<td>-88.2%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>70.8</td>
<td>-2.7</td>
<td>-4.0%</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>1.0</td>
<td>0.0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>66.2</td>
<td>19.9</td>
<td>23.1%</td>
</tr>
<tr>
<td>Total</td>
<td>139.4</td>
<td>16.6</td>
<td>10.6%</td>
</tr>
</tbody>
</table>

### Qualified nursing staff by site

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total number of substantive staff</th>
<th>Number of substantive vacancies</th>
<th>Total % vacancies overall (excluding seconded staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exmouth Community Hospital</td>
<td>12.9</td>
<td>6.1</td>
<td>32.0%</td>
</tr>
<tr>
<td>Sidmouth Community Hospital</td>
<td>18.2</td>
<td>5.7</td>
<td>23.9%</td>
</tr>
<tr>
<td>Tiverton District Hospital</td>
<td>30.1</td>
<td>8.2</td>
<td>21.4%</td>
</tr>
<tr>
<td>Total</td>
<td>66.2</td>
<td>19.9</td>
<td>23.1%</td>
</tr>
</tbody>
</table>

### Medical staff by site

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total number of substantive staff</th>
<th>Number of substantive vacancies</th>
<th>Total % vacancies overall (excluding seconded staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exmouth Community Hospital</td>
<td>1.0</td>
<td>0.0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

### Allied health professional by site

The staffing data supplied by the trust show no allied health professionals in community inpatient services. However, each ward we visited had therapy staff working in the teams. Staff told us the therapy staff establishment was met and that additional staff had been recruited prior to introducing the intermediate care models.
Turnover

The trust had a target for turnover rates which was less than 11%. From June 2017 to May 2018, the trust reported an overall turnover rate of 13.0% in community inpatient services. The trust informed us that information from exit interviews was being acted upon and the retire and return rate was consistent at 30%

Across the trust overall turnover rate for qualified nursing staff was 10.3%. No medical staff left the trust’s community adults service over this period.

Breakdowns of turnover rates by staff group at trust level and by community hospital site for the year ending May 2018 are shown below:

Community inpatient services total

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Average staff in post</th>
<th>Total number of substantive staff leavers in the last 12 months</th>
<th>Total % of staff leavers in the last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>2.2</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>65.7</td>
<td>10.8</td>
<td>15.3%</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>0.9</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>65.8</td>
<td>6.8</td>
<td>10.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>135.2</strong></td>
<td><strong>17.6</strong></td>
<td><strong>13.0%</strong></td>
</tr>
</tbody>
</table>

Qualified nursing staff by site

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total number of substantive staff</th>
<th>Total number of substantive staff leavers in the last 12 months</th>
<th>Total % of staff leavers in the last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exmouth Community Hospital</td>
<td>13.3</td>
<td>0.0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Sidmouth Community Hospital</td>
<td>18.8</td>
<td>0.8</td>
<td>4.3%</td>
</tr>
<tr>
<td>Tiverton District Hospital</td>
<td>28.7</td>
<td>4.8</td>
<td>16.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60.8</strong></td>
<td><strong>5.6</strong></td>
<td><strong>21.3%</strong></td>
</tr>
</tbody>
</table>

Medical staff by site

All medical staff in community inpatients are allocated to Exmouth Community Hospital in the data supplied by the trust. However, there were medical staff working at the other community hospitals who rotated from the main trust.
Sickness

The trust set a target of 4% for sickness rates. From June 2017 to May 2018, the trust reported an overall sickness rate of 7.5% in community inpatient services. This did not meet the trust’s target.

Across the trust overall sickness rates were 4.4% for qualified nursing staff and for 1.4% for medical staff.

Breakdowns of sickness rates by staff group at trust level and by community hospital site for the period from June 2017 to May 2018 are shown below. The 44.8% sickness rate for the medical and dental staff relates to one member of staff.

Community inpatient services total

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total available permanent staff days</th>
<th>Total permanent staff sickness days</th>
<th>Total % permanent staff sickness overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add professional scientific and technical</td>
<td>582.8</td>
<td>15.0</td>
<td>2.6%</td>
</tr>
<tr>
<td>Additional clinical Services</td>
<td>23,941.3</td>
<td>2,335.7</td>
<td>9.8%</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>61.2</td>
<td>-</td>
<td>0.0%</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>270.0</td>
<td>121.0</td>
<td>44.8%</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>23,930.7</td>
<td>1,205.3</td>
<td>5.0%</td>
</tr>
<tr>
<td>No staff group allocated</td>
<td>48,786.1</td>
<td>3,677.0</td>
<td>7.5%</td>
</tr>
<tr>
<td>Total</td>
<td>97,572.1</td>
<td>7,354.0</td>
<td>7.5%</td>
</tr>
</tbody>
</table>

Qualified nursing staff by site

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total available permanent staff days</th>
<th>Total permanent staff sickness days</th>
<th>Total % permanent staff sickness overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exmouth Community Hospital</td>
<td>4,826.0</td>
<td>208.5</td>
<td>4.3%</td>
</tr>
<tr>
<td>Sidmouth Community Hospital</td>
<td>6,810.1</td>
<td>341.0</td>
<td>5.0%</td>
</tr>
<tr>
<td>Tiverton District Hospital</td>
<td>10,452.5</td>
<td>592.1</td>
<td>5.7%</td>
</tr>
<tr>
<td>Total</td>
<td>19,104.7</td>
<td>1,141.6</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

Medical staff by site
All medical staff in community inpatients are allocated to Exmouth Community Hospital in the data supplied by the trust. However, during our inspection we saw there was a staff grade doctor working at Tiverton hospital on Mondays through to Friday from 9am to 5pm. A consultant geriatrician attended the hospital on two days a week and out of hours medical cover was provided by Devon Doctors. An nurse consultant who was also a non-medical prescriber, worked with the junior doctor at Sidmouth Hospital. They were supported by local GPs who, attended the hospital twice a day on Mondays to Fridays. The trust was considering the development of similar roles in the other community hospitals.

Nursing – bank and agency qualified nurses

It should be noted that:

- Data was provided from May 2017 to May 2018, excluding February 2018, to provide 12 months of data. The trust was unable to provide data for February 2018 due to the migration to a new computer system that took place in that month. Bank and agency shifts booked in advance were entered on both systems, therefore due to the risk of double counting providing inaccurate data the trust decided to omit this month.

- The trust was only able to provide unfilled shifts for the period from May 2017 to January 2018. This was also due to issues related to the change to the new roster system in February 2018 leading to a risk of double-counting and inaccurate information being provided.

- The trust was unable to supply the total number of shifts worked by all permanent and temporary staff. Therefore, it was not possible to calculate the percentages of shifts worked by bank and agency staff and left unfilled.

From May 2017 to May 2018, excluding February 2018 1,016 qualified nursing shifts were filled by bank staff and 611 were filled by agency staff to cover sickness, absence or vacancy for qualified nurses.

Over the same period, 84 shifts were not filled by either bank or agency staff. Staff told us where possible permanent staff worked extra hours to fill these shifts or staff moved areas to cover gaps in the rotas.

The trust did not provide reasons for bank and agency usage. However, following the inspection the trust informed us there is a request reason on both the form completed by the service and on the booking/rostering system.

<table>
<thead>
<tr>
<th>Ward/team</th>
<th>Bank usage</th>
<th>Agency usage</th>
<th>NOT filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exmouth (Doris Heard ward)</td>
<td>365</td>
<td>233</td>
<td>44</td>
</tr>
<tr>
<td>Sidmouth - Inpatient</td>
<td>397</td>
<td>119</td>
<td>12</td>
</tr>
<tr>
<td>Tiverton - Inpatient</td>
<td>250</td>
<td>259</td>
<td>28</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,016</strong></td>
<td><strong>611</strong></td>
<td><strong>84</strong></td>
</tr>
</tbody>
</table>
Nursing - bank and agency non-qualified nurses

From May 2017 to May 2018, excluding February 2018 1,451 non-qualified nursing shifts were filled by bank staff and 28 were filled by agency staff to cover sickness, absence or vacancy for qualified nurses.

Over the same period, 143 shifts were not filled by either bank or agency staff.

The trust did not provide reasons for bank and agency usage.

<table>
<thead>
<tr>
<th>Ward/team</th>
<th>Bank usage</th>
<th>Agency usage</th>
<th>NOT filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exmouth &amp; Sidmouth Day Case Units</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Exmouth (Doris Heard ward)</td>
<td>272</td>
<td>14</td>
<td>35</td>
</tr>
<tr>
<td>Sidmouth - Inpatient</td>
<td>828</td>
<td>3</td>
<td>100</td>
</tr>
<tr>
<td>Tiverton - Inpatient</td>
<td>351</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>1,451</td>
<td>28</td>
<td>143</td>
</tr>
</tbody>
</table>

We discussed this with senior staff during the inspection. They explained that where shifts were identified as not filled by bank or agency staff this was because either permanent staff had worked additional hours or staff had been moved from other areas and the bank or agency request had been cancelled.

Medical locums

The trust reported no medical staff bank or locum usage in community outpatients.

Suspensions and supervisions

During the reporting period from May 2017 to May 2018, the trust reported that there were no cases of staff in community inpatient services being suspended or placed under supervision.

Quality of records
Staff did not consistently have access to the information they needed to deliver care and treatment to patients. Risk assessments were consistently completed but the quality of care plans did not support the risks identified.

We reviewed the nursing and medical records for 12 patients across the hospitals. Staff completed signature logs to evidence their involvement in the care plan documentation and enable others to identify the staff member’s signature within the records. Each registered nurse signed the record to demonstrate their responsibility for the oversight of the patients care and treatment at the end of each shift.

Patient records were recorded in a paper format and provided information and guidance to staff on the care and treatment required. The medical and therapy notes were combined while the nursing notes were maintained separately. This resulted in some duplication of information for example, moving and handling and falls risk assessments. There was a risk that updated information may not be shared between the clinicians and that work was duplicated. However, we saw information was shared at board meetings and staff were aware of their colleague’s roles and action they had taken. Staff handovers between each shift also provided update information regarding the care and treatment of each patient discussed at the board meeting.

Risk assessments were completed by the therapy and nursing staff including risks associated with pressure damage, falls, moving and handling and nutritional needs. Each patient had a care and treatment plan which reflected the completed risk assessments. For example, one patient required specialist moving and handling and pressure relieving equipment which was documented fully in their care plan and risk assessment. The medical and therapy records were clear and detailed regarding the planned and delivered care and treatment. Nursing care plans were stored at the patient bedside for ease of use.

The care plans provided brief guidance on the care required. For example, the record advised staff when patients required assistance with washing, dressing or eating but did not specify what this assistance was. The records did not consistently identify when patients had washed by the bedside or taken a shower. For three patients who had been in hospital for longer than two weeks and one for over four weeks there was no record they had been offered or had a shower. One patient used a medical device to manage their breathing overnight. The patient was familiar with the machine as they used it at home. The nursing staff were required to help with the initial preparation and bring the machine to the patient. There was no detail contained within the patient care plan regarding the settings or action to take should the patient become unwell. This did not ensure staff had the correct information and guidance to follow in the case of an emergency.

The documentation in patient notes was not always completed fully. For example, we saw property record forms were often blank or partly filled in. Staff commented that while the form detailed use of blue property bags for patient property, the community hospitals were not supplied with these. Fluid charts were not consistently totalled at the end of each day which meant there was not an overall summary of the intake and output of the patient.

Important documents to support a patient with increased needs were not accurate or well completed. This may place the person at risk. We reviewed the records for one patient who lived with a learning disability. Their medical records contained a copy of ‘my passport’ which outlined specific information relating to the patient and the care and support they would require while in hospital.
However, this did not appear to have been updated since 2015 although we noted the document indicated there had been a significant change in their family circumstances. The patients next of kin was recorded as different people throughout the documentation and there was no mention of power of attorney either for financial or health and welfare.

**Medicines**

*Staff ensured the proper and safe use of medicines.*

Staff followed trust guidance set out in the medicines policy and procedure which included information relating to ordering, transporting, storage, administration and disposal of medicines. Staff told us this was a policy which had been implemented by a previous trust which managed the community hospitals and had not been updated.

Patient Group Directions (PGD) were not used in the community hospitals. PGDs are written instructions for the supply and/or administration of medicines to groups of patients Staff were administering medicines under a policy and procedure from the trust they were previously managed by. This had expired in Jan 2017. We were told it was in the process of being updated. During our inspection the trust released an updated version of the medicines policy and procedure to inform and direct staff. Staff had access to up to date hard copies and online British national Formulary for medicine information. An electronic application was available for staff which had an up-to-date guidelines and formulary – this can be particularly useful when there are shortages with medicines.

The pharmacy team supported training for nurses in medicines updates when needed. They had introduced a new programme to deliver training to therapy staff regarding the use of medicine compliance aids and when it is appropriate to use them. There was no formal update for medicines training at the time of our inspection, staff reported it was carried out when needed for example, following incidents/changes.

Medicines were ordered from the acute hospital pharmacy each week. Additional medicines could be ordered when needed and delivered by courier to the hospitals. The medicines were delivered in secured boxes to ensure security. At Tiverton hospital medicines needed urgently were obtained from a pharmacy on site.

**At Tiverton hospital, staff did not consistently follow a system to track and record the FP10 prescription pads. This meant there was a risk of the prescription pads being misused.**

All hospitals held FP10 prescription pads which the medical staff could use to prescribe medicines and enable patients or staff to collect promptly from a local pharmacist. The FP10s were stored securely and the serial numbers were tracked and recorded to provide an audit trail of each prescription and its use. However, in Tiverton hospital, when the printed recording sheet finished not all the prescriptions were recorded. On Blackdown ward we saw that six prescriptions forms had not been recorded and on Twyford ward three had been missed. Staff were not aware as there was no oversight to monitor the tracking. This meant that prescriptions could not be audited and so no assurance was available of their safe use.
The independence of patients was not always supported as they were unable to fully self-administer their own medicines as there was no system to enable them to access their medicines independently. Medicines were stored securely in locked cupboards within a treatment room. Those medicines prescribed and obtained for patients on the ward were stored securely in bedside lockers to which the registered nurses held the key. As the keys opened all the lockers, even if a patient could self-administer their medicines, the nurses still had to open the cupboards. This did not promote full independence despite a risk assessment being carried out to assess the safety of the patient to do so.

Fridges were in use for medicines which required cool storage. These were used for medicines only and locked when not in use. Fridge temperatures were recorded daily and were all within range. There was one exception to this at Exmouth hospital. The records showed that when it had been out of range it had been escalated and action taken to address the shortfall. Room temperatures had not been recorded but there was fan in the room if it was too warm. Medicinal gases, such as oxygen, were stored appropriately. Signs advised staff, patients and visitors where oxygen was located.

There were suitable arrangements for controlled drugs (CDs). These were prescription medicines controlled under the Misuse of Drugs legislation (and subsequent amendments). The CDs were stored securely in a separate cupboard to other medicines. Weekly balance checks for CDs were carried out and recorded in a controlled drugs register. We randomly reviewed the balance in the CD register, against the stock levels for several CDs, and found these tallied correctly. A separate register was maintained for patients own CDs, for example those brought into hospital with them.

Date checking was completed by ward staff each week and audited by a pharmacy technician every three-month period. This ensured medicines were safe to use within the manufacturers guidelines. We observed that medicines within a short time of the expiry date were highlighted for use first and to reduce the risk of out of date medicines being administered to patients.

Opening dates were not consistently written on all liquid medicines and creams. This is important so that medicine is used within the timescales advised by the manufacturers. We saw medicines in all three hospitals which had not been dated on opening. For example, eye drops, pain relief and cough medicine which had been opened and used but not dated. In Exmouth hospital there was a bottle of potassium supplement which had been opened, this medicine has an eight-week expiry date following opening, but as there was no date recorded it had to be disposed of as a safety measure.

Pharmacy support was provided in each hospital on Mondays to Fridays. The pharmacist’s role included counselling patients, supporting discharges, clinically screening prescription charts and attending ward rounds. Pharmacy technicians were embedded into the ward team and completed medicines reconciliations, ordered top ups for patients own medicines and encouraged patients to become more independent in managing their medicine and supporting them in self-administration.

Medicine reconciliation is the process of creating the most accurate list possible of all medications a patient is taking, including drug name, dosage, frequency, and route, and comparing that list against the physician’s admission, transfer, and/or discharge orders, with the goal of providing correct medicines. At Sidmouth the pharmacy team also attended the consultant ward round. They had a specific time with the prescribing team and could discuss guidance and best practice there.
Nursing staff administered medicines to patients by following a medicine administration chart. We reviewed ten charts and saw they were completed in full to include the patient allergy status, medicines reconciliation and the VTE assessment. Medicines were given as prescribed. If a medicine had not been given as prescribed the reason was documented. Where medicines were not required each day, the chart was amended to clearly inform staff of which day the medicine was to be administered. This reduced the risk of a medicine error.

At Exmouth hospital the pharmacy team conducted monthly medication audits which included a review of the administration of medicines and documentation of reasons for omissions. A copy of the report was shared with ward. Recent issues identified failure to sign for administration with no documented reason. This was followed up with the nursing staff to reduce the risk of this reoccurring.

Medicines for disposal, except for CDs were sent back to the main pharmacy at the acute hospital. These included out of date stock and those no longer required by patients. CDs requiring disposal were denatured on the ward and all pharmacists were authorised to be an accountable witness. This meant they could witness a registered nurse place the CD in the denaturing kit to destroy it. Denaturing is the process which mixes the CD with a substance to make it unusable. This protects the CD from being misappropriated. The patient CD register had a section at the bottom which stated; ‘Return or transfer – i.e. to patient for example, on discharge, transfer to another ward or hospital or to Royal Devon & Exeter Hospital (RDE) pharmacy for destruction’. The community hospitals denature CDs, but there was no space to record destruction. Destruction was recorded in this section. Staff did not always reduce the balance to zero following destruction to accurately reflect the stock of CDs in the cupboard.

Medicines incidents and errors were recorded on the trust electronic incident reporting system. We were given an example how changes had been made to their practice following a recent incident. There was a system to cascade medicines safety alerts and recalls. Staff held a safety briefing three times a day at handovers and information regarding incidents and alerts were discussed at this meeting.

Medicines for patients to take home, known as TTOs (tablets to take out) could take up to 24 hours and up to 48 hours for a blister pack to obtain from pharmacy. The pharmacists explained the proactive work that was ongoing to make sure there was no delay with medicines on discharge. They attended the board round each day and pre-empted discharges. The patient supply of medicines in their bedside cupboards were also topped up to ensure each patient had enough medicines with them for a speedy discharge. Staff confirmed the pharmacy support enabled timely discharges.

Incident reporting, learning and improvement
Staff reported incidents and lessons were learned and improvement made when things went wrong.

Staff we spoke with were confident in recognising and reporting incidents appropriately. Some staff members sought advice and guidance from their line managers before reporting an incident such as housekeeping staff and health care assistants. They confirmed that their managers were helpful and approachable when they reported any issues to them.
Staff considered the teams were proactive in incident reporting and were open and honest when things went wrong. They were all aware of the duty of candour legislation. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

The staff learnt from incidents which occurred. For example, following an incident at Tiverton hospital further training had been provided to staff, a review of moving and handling equipment available had been undertaken and further detail was included in the patient monitoring records. This learning was shared across the community hospitals.

Never events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2017 to September 2018, the trust reported no never events in community inpatient services.

(Source: Strategic Executive Information System (STEIS))

Serious Incidents

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include ‘never events’ (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in community services for inpatients which met the reporting criteria set by NHS England between October 2017 and September 2018. This was a treatment delay concerning Sidmouth Community Hospital in November 2017, reported in January 2018.

(Source: Strategic Executive Information System (STEIS))

Serious Incidents (SIRI) – Trust data

From June 2017 to May 2018, trust staff within community inpatients services reported one SI.

This was the same SI as reported to STEIS (described in the previous section above).

(Source: Universal Routine Provider Information Request (RPIR) – P29 Serious Incidents)

Prevention of Future Death Reports (remove before publication)
The Chief Coroner’s Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations made by coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last 12 months, there have been no prevention of future death reports sent to trust.

(Source: Universal Routine Provider Information Request (RPIR) – P76 Prevention of future death reports)

Safety performance

Safety Thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

From October 2017 to October 2018 the trust reported nine new pressure ulcers, no falls with harm and two new catheter urinary tract infections in patients with a catheter in community inpatients wards.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and urinary tract infections in patients with a catheter at Royal Devon and Exeter NHS Foundation trust
Is the service effective?

Evidence-based care and treatment

Peoples care, treatment and support achieved good outcomes, promoted a good quality of life and was based on the best available evidence

Policies, procedures and guidelines for staff were in line with national best practice recommendations such as the National Institute for Health and Care Excellence (NICE). For example, the policy and procedure relating to the care of urinary catheters had been updated and training provided to staff regarding the changes. The policy and procedure relating to dementia and delirium had been reviewed at the dementia and delirium committee and additional guidelines and information inserted into the policy. When changes were made or national guidelines updated this information was cascaded to staff through email, at team meetings and during board rounds.

The trust complied with the World Health Organisation (WHO) 5 moments for hand hygiene and posters were displayed to inform patients, visitors and the staff of the importance of hand hygiene. The location of antibacterial hand gel followed the recommendations within the Patient Safety (NPSA) Guidelines and ensured that hand gel was readily available in clinical areas.

Not all staff were familiar with which national guidelines were in use.

Some registered nursing staff were unsure of where to access information on national guidelines. Student nurses confirmed policies and procedures were up to date and they were aware that NICE guidelines were embedded within the policies. The students were fully aware of the policies as they used them for their assignments.

Not all policies and procedures had been reviewed and aligned since the community hospitals had become part of the acute trust.

Staff were concerned that not all the policies and procedures considered the community setting. For example, the end of life care policy and procedure did not consider the provision of just in case medication bags. However, we were told that as policies were reviewed consideration was included regarding the community setting. The assistant director of nursing had recently implemented a
process for consultation prior to policies and procedures being approved which provided an opportunity for discussion and accurate reflection of services.

Audits were carried out to ensure staff were complying with policies, procedures and national guidelines. For example, the safety thermometer, catheter and naso-gastric audits. Action was taken when improvements could be made. For example, documentation regarding the care of catheters and early removal had been improved.

The hospitals supported the end pyjama paralysis which is a national campaign to support patients to get up and out of bed, dressed and move more. We saw patients were dressed and encouraged to mobilise around the ward when able.

**Nutrition and hydration**

*Patients nutrition and hydration needs were identified, monitored and met.*

Staff assessed the nutrition and hydration needs of patients on or soon after admission. The Malnutrition Universal Screening Tool (MUST) is a nutritional screening tool commonly used in health care throughout the UK. It is a simple five step tool designed to identify adults at risk of malnutrition and to categorise them as being at low, medium or high risk. The tool identified when a referral was required to be made to a dietician (NICE QS15 statement 10). Records we reviewed showed that the patient nutritional needs had been assessed and action taken to ensure the assessed needs were met.

Specialist support from a team of dieticians, was available to staff to assist them in delivering additional support to patients with their diet. The dieticians were based at the acute hospital and provided telephone advice and discussion in the first instance. If necessary a dietician would visit the patient at the community hospital.

A red tray system was in operation which provided an immediate visual reminder to ward staff that extra support was needed for specific patients. Nursing staff were responsible for delivering and assisting patients whose meals were on a red tray. While the hospitality staff removed the trays from patients after meals, the nursing staff were made aware of any patient with a red tray prior to removal. This ensured that appropriate assistance had been provided and staff recorded the amount of food eaten on the patient’s food chart. During our inspection we saw this process was complied with and records were completed appropriately.

We observed staff assisted patients with their meals discreetly and in a way which met their needs. For example, one patient required adapted cutlery, another needed their food cutting up and we saw one member of staff sat with a patient feeding them as they were unable to manage this themselves. Care plan documentation provided brief guidance to the needs of patients but did not provide the specific actions which we saw staff undertake. The staff knew their patients well and could discuss with us individual needs regarding meals.

Menus were delivered to the patients to choose their meals for the next day. There was a choice of hot and cold meals, including for specialised diets. During our inspection we saw specialised diets included vegetarian, weight reducing, soft and pureed diets. The hospitality staff provided assurances that diets could be provided to meet cultural and religious needs when required.
Hospitality staff were made aware of special diets by nurses and these were written on a noticeboard in kitchen as reminder. At Sidmouth hospital we saw a health care assistant sitting with patients discussing the menu and helping them to choose their meals. For patients who used the red tray system, a registered nurse reviewed the choice to ensure it was suitable. Hospitality staff also made staff aware if patients appeared to have a limited choice of food. For example, they had raised concerns regarding one patient who ordered a cheese sandwich every day as they were concerned this did not provide sufficient nutritional intake. Additional meals were available each day in case the patient changed their mind as to what they wanted to eat.

Patients we spoke with were complementary about the meals they were provided with and the choice available to them. One patient however, had not seen the menu to choose their meal for the day of our inspection. They did not see this as a problem as they always liked the food. The hospitality staff could provide patients with a meal, such as lasagne, cottage pie or fish pie, outside of the normal meal times. They told us this happened when patients were absent from the ward or felt unwell at a meal time.

Patients were encouraged to make meal times more of a social occasion by eating in the dining room. At Exmouth hospital we saw two patients and a member of staff having lunch together in the dining room.

Snacks and drinks were available throughout the day. During the afternoon we observed patients were served with hot and cold drinks and a plate of finger food. This included crisps, biscuits, chopped fruit, cake and chocolate finger biscuits. Patients expressed their enjoyment of this.

The hospitality and nursing team at Sidmouth hospital had celebrated a nutrition and hydration awareness week by arranging several events. These included; fruity Friday – trying different fruits, thirsty Thursday – promoting different drinks, muffin Monday and tasty Tuesday – which was a tasting session for relatives and staff of food from the hospital kitchen.

Pain relief
Peoples pain was assessed and managed, including those people who had difficulties in communication.

Staff asked patients if they had any pain and administered pain relieving medicines accordingly. For those patients who experienced communication difficulties the staff used a recognised pain scale assessment tool to assess and monitor any pain the patient had. The tool monitored the use nonverbal signs to pain. At Exmouth hospital we observed records for one patient who had a cognitive impairment. Their pain chart and assessment showed their pain had been assessed and body language had been considered.

One patient at Sidmouth hospital, told us that the staff regularly asked them if they had pain and provided pain relieving medicines when needed. They added their pain had been well controlled since admission to the hospital.

Patient outcomes
Peoples care and treatment outcomes were monitored and compared favourably to other similar services.

Relative risk of readmission – medical specialties
EXMOUTH COMMUNITY HOSPITAL

From June 2017 to May 2018, Exmouth Community Hospital had only 27 elective and emergency admissions across all medical specialties. Therefore, it was not practical to calculate readmission rates.

SIDMOUTH COMMUNITY HOSPITAL

Sidmouth Community Hospital – elective admissions

From June 2017 to May 2018, nearly all medical elective admissions to Sidmouth Community Hospital were in general medicine. There were also a very small number of neurology admissions (fewer than six). This means that it was only practical to calculate a readmission rate for general medicine.

The hospital had a lower than expected risk of readmission for elective general medicine admissions compared to the England average.

Elective Admissions – Sidmouth Community Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

Sidmouth Community Hospital – non-elective admissions

From June 2017 to May 2018, Sidmouth Community Hospital had a small number of non-elective general medicine admissions (fewer than 20). Therefore, it was not practical to calculate readmission rates.

TIVERTON DISTRICT HOSPITAL

Tiverton District Hospital – elective medical admissions

From June 2017 to May 2018, patients at Tiverton District Hospital had a lower than expected risk
of readmission for elective medical admissions compared to the England average.

- Patients in gastroenterology had a lower than expected risk of readmission for elective admission compared to the England average.

- Patients in clinical oncology and medical oncology had higher than expected risks of readmission for elective admissions.

Elective medical admissions – Tiverton District Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity.

Tiverton District Hospital – non-elective medical admissions

According to Hospital Episodes Statistics data submitted by the trust, there were only 61 medical non-elective admissions to Tiverton District Hospital the hospital from June 2017 to May 2018. These patients had a higher than expected risk of readmission for non-elective medical admissions compared to the England average.

These admissions were split between four specialties: geriatric medicine, general medicine, dermatology and neurology. However, as there were fewer than 30 admissions to each, it is not practical to calculate readmission rates by specialty.

Non-Elective Admissions - Tiverton District Hospital
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

Audits – changes to working practices

The trust carried out audits to ensure staff followed policies and procedures to provide positive outcomes for patients. Action was taken because of the findings of the audits. For example, the most recent audit of the early warning score system had identified that whilst deteriorating patients had consistently been escalated to and reviewed by medical staff this had not always been documented. Feedback had been provided to staff on the importance of this.

The daily whiteboard meetings had been used to improve compliance with completion of the pressure damage risk assessments. This audit had found that while staff carried out appropriate care and treatment, risk assessments had not always been updated.

The trust carried out two local clinical audits relevant to this core service as part of their Clinical Audit Programme from July 2017 to June 2018.

The trust's descriptions of key successes and key concerns and actions from these two audits can be seen in the table below.

<table>
<thead>
<tr>
<th>Audit name</th>
<th>Area covered</th>
<th>Key Successes</th>
<th>Key concerns and actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapid Tranquilisation of Adults</td>
<td>Healthcare for Older People</td>
<td>Improvement in capacity and LRMS system documentation has been achieved. Although the previous audit cannot be directly compared, it</td>
<td>Further education on correct prescription of drugs and time between repeat administration is required.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Roll out revised RT reference</td>
</tr>
</tbody>
</table>
does appear that the number of patients being RT and repeatedly RT have reduced.

| National Audit of Dementia 2016 | Healthcare for Older People | The Trust did well in key areas, namely assessment, discharge and nutrition. | Areas of non-compliance:
1. No recording of capacity or consent in notes when a proposed change of accommodation.
2. Cognitive assessment repeated on discharge (NAD Key recommendation).
3. Delirium recording on discharge summaries to be completed properly.
4. Personal Information to be available for all staff (‘This is Me’).
5. Staff support out of hours.
6. Carer communication.
7. Non-assessment of delirium
8. Meeting nutritional needs of people with dementia.
9. Improving staff training.
10. Environmental change to make RDE dementia friendly
12. Monitoring of night time bed moves.
13. Ward champions on all wards.

(Source: Universal Routine Provider Information Request (RPIR) – P35 Audits)

**Competent staff**

Staff had the necessary skills, knowledge and experience to deliver effective care, support and treatment

The community hospitals had a programme of training to support staff who provided intermediate care. Rehabilitation support workers had been appointed and were provided with an induction and role specific training which was competency based. Health care assistants were provided with
additional training to develop their competencies to support the rehabilitation care and treatment for patients under the direction of the registered nurses and therapists. Staff reported the training sessions were well attended. The training sessions included; an introduction to intermediate care, goal setting, falls, mobility and transferring patients, functional independence.

New staff were provided with both a corporate and a local induction to familiarise them with the trust and their new working environment. Newly appointed staff we spoke with felt welcomed to their workplace and supported in their new role.

Student nurses on the wards were provided with an induction and told us they were supported to meet their learning objectives during their placement.

Nursing staff held link roles which meant they could attend meetings and training and cascade information to their colleagues. The link roles included nutrition and hydration, end of life care, continence, documentation, dementia and mental health, diabetes, falls, bladder and bowel care, infection promotion and control. Both registered nurses and health care assistants held link roles.

Group training sessions were held to promote learning and lead to improvements in care for patients. For example, one link nurse had provided training on nutrition and hydration which had included the use of thickened fluids and promotion of community meals in the day room.

At Sidmouth hospital staff told us they had the support of their managers to access external training through a local organisation. In the past this training had included the promotion of independent living for patients.

**Clinical Supervision**

**Staff did not consistently receive supervision.**

The trust provided the following information about their clinical supervision process:

“For medical and dental and nursing and midwifery, we do not routinely monitor and record clinical supervision and there is no target rate for the trust. We have pockets of more formalised clinical supervision in teams, most often, specialist teams such as clinical specialist nurses in cancer services who received regular supervision and the cystic fibrosis team who have support from the psychology component of the multi-disciplinary team.”

*(Source: CHS Routine Provider Information Request (RPIR) – CHS4 Clin Supervision)*

At Tiverton hospital the band 6 nurses had arranged a programme of group supervision to which they invited appropriate clinicians and managers to attend. Staff were provided with one to one supervision with their line managers. We were told that there was not a supervision policy and procedure although there had previously been one. It was unclear from talking to staff why this had been removed.
**Appraisal rates**

Staff were not consistently provided with an annual appraisal.

From June 2017 to May 2018, 70.5% of permanent staff within the community inpatients core service received an appraisal compared to the trust target of 80%.

The appraisals data do not show any medical staff in community inpatients.

**Community inpatients service total**

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Number completed</th>
<th>Number required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add prof scientific and technic</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>59</td>
<td>76</td>
<td>77.6%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>45</td>
<td>72</td>
<td>62.5%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>105</td>
<td>149</td>
<td>70.5%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P39 Appraisals)

**Qualified nursing staff by site / location**

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Number completed</th>
<th>Number required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exmouth Community Hospital</td>
<td>9</td>
<td>14</td>
<td>64.3%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Sidmouth Community Hospital</td>
<td>17</td>
<td>20</td>
<td>85.0%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Tiverton Community Hospital</td>
<td>28</td>
<td>35</td>
<td>80.0%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Total</td>
<td>59</td>
<td>76</td>
<td>77.6%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>

**Multidisciplinary working and coordinated care pathways**

Staff teams and services within and across organisations worked together to deliver effective care and treatment.

The community hospitals provided intermediate care which was managed by a multi-disciplinary team made up of nursing, medical, therapy and social work staff who were based in the hospital. Multi-disciplinary team meetings were held to discuss any issues arising during the embedding of the model of care. Staff reported the model was still embedding but felt that staff were working well together to provide a seamless service to patients.

Daily board meetings took place on the ward. This enabled the multidisciplinary team to gather twice a day to discuss each patient and their care and treatment plans. We attended board meetings at each hospital and found there was good communication between the clinicians with constructive challenge which resulted in a positive outcome for patients. For example, at one board round a discussion ensued regarding the level of independent mobility to ensure one patient’s safety. Other discussions included those regarding medicines, home circumstances and social needs prior to discharge.
Hospitality staff worked with clinicians to share information and prevent risks to patients. For example, informing staff where floors were wet to reduce risk of patient falls.

The community hospitals worked well with colleagues in the acute trust. A single point of access to services had moved from being community based to acute based which enabled direct contact with relevant specialists and facilitated face to face clinician conversations thereby streamlining the process for patients.

The multi-disciplinary team planned and managed the discharge of patients from the wards. This included liaison with external providers to arrange and ensure continuing care and treatment once patients were discharged from the hospital. For example, for patients requiring end of life care and treatment, positive working relationships were maintained with the local hospice service. A discharge summary letter was sent to the patients GP.

**Health promotion**

*Patients were supported to live healthier lives and where the service was responsible it improved the health of its population.*

Patients were encouraged to become independent prior to their discharge home. This included getting out of bed, washing and dressing themselves and mobilising to the dining room to eat with others where possible.

Health education was provided by the nursing and therapy staff. One patient at Tiverton hospital told us they had been provided with advice, support and education regarding healthy eating and reducing their weight.

The trust was a no smoking trust and patients were provided with advice and guidance on how to give up smoking. Medical staff could prescribe nicotine replacement therapy to assist with this. The trust had a no smoking specialist service to which patients could be referred to. Patients at Exmouth hospital had been referred to the internal no smoking service as well as provided with external support services.

Patients who required support to reduce their alcohol intake were referred to the trust specialist service which was based at the acute hospital. Staff were also aware of external organisations they could refer patients to following their discharge from the hospitals.

The diabetic specialist team could provide dietary advice and information regarding foot care for diabetics. Referrals could be made to the podiatrist service. Health care assistants could complete additional training and obtain competencies to carry out diabetic feet checks and trim toe nails. They were trained to identify potential issues and problems and make referrals to the podiatry service.

Registered nurses in each hospital were competent to provide advice and administer the flu vaccine for patients admitted to the wards.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**
Consent to care and treatment was always sought in line with legislation and guidance.

Consent to care and treatment was sought from patients where possible. We saw staff asking patients for their consent prior to carrying out care and treatment. For example, prior to providing personal care to a patient and before examining them.

Staff were knowledgeable about how to assess the mental capacity of patients when making decisions about their care. Treatment escalation plans (TEP) were used when necessary. The TEP identifies all appropriate treatment options for the patient, considering their wishes, or treatment which will be in their best interest. However not all TEPs were completed in full. One TEP we reviewed did not identify discussion with the patient or their family, next of kin or carers. Another TEP did not clearly identify the date which the discussions had taken place. However, we saw five other TEP which were completed in full, including an assessment of the patient’s capacity to make decisions about their healthcare needs.

Where patient’s wishes were unclear, staff assessed their mental capacity and where necessary held a best interest meeting to ensure the care and treatment plan was appropriate. We saw records which showed one such meeting had been attended by a multi-disciplinary team and the patient’s family to ensure the best outcome for the patient. Another patient with delirium did not have a known power of attorney to make decisions regarding their health care needs. The patients next of kin was consulted and their views taken into consideration when the clinicians were planning care and treatment.

Mental Capacity Act and Deprivation of Liberty training completion

Training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) is included in the trust’s safeguarding adults training modules.

As of May 2018, the trust reported that this training module had been completed by 96.2% of staff within community inpatient services.

A breakdown of compliance by staff group is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing staff</td>
<td>76</td>
<td>78</td>
<td>97.4%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>73</td>
<td>76</td>
<td>96.1%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Add professional scientific and technical</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>75%</td>
<td>No</td>
</tr>
</tbody>
</table>

The target was met for both for qualified nursing and additional clinical service staff. One of two eligible additional professional, scientific and technical staff had completed the training.

(Source: Universal Routine Provider Information Request - P38 Training)

The trust had identified a lead clinician with responsibility for ensuring compliance with the Mental Capacity Act. They could discuss the clear process that had been developed for the application of the MCA and ensuring the best interests of patients.
Deprivation of Liberty Safeguards

Staff we spoke with were aware of the Deprivation of Liberty Safeguards (DoLS) but there was a lack of clarity regarding when a DoLS should be applied for with the focus being on patients trying to leave the ward as opposed to other forms of restraint.

From May 2017 to April 2018 the trust reported that 188 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority, 12 of which were pertinent to community inpatients services.

The greatest number of DoLS applications in community inpatients services (three in total) were made in January 2018.

Is the service caring?

Compassionate care

The service involved and treated patients with compassion, kindness, dignity and respect.

Patients we spoke with were positive regarding the care and treatment they received. They said staff were kind, caring and helpful. Specific comments included: ‘the staff always want to help, they go the extra mile’, ‘the cleaning staff always have time to make extra drinks and chat with me’ ‘nothing is too much trouble for them, I don’t think they could improve how they treat me’.

Thank you cards received from patients were displayed on the wards. Comments made included; ‘you are doing a fantastic job’, ‘very pleased and impressed with the service’, ‘everything lovely, kind and helpful staff’ and ‘the care could not be better staff very kind and helpful’.

We observed interactions between the staff and patients. The staff were considerate and empathetic to the needs of the patients while at the same time, encouraging the patients to be as independent as possible. Patients approached the staff with ease and the staff always stopped, responded and chatted with them. Patients confirmed staff answered their call bells promptly and provided any assistance requested.

During discussions with the staff it was clear there was a strong patient centred focus on all the wards we visited. During our visit to Sidmouth hospital, the emergency bell sounded. Staff responded promptly and in a large number to the emergency. This meant there were a lot of people purposefully moving through the central area of the ward. One patient was walking in this area with a mobility aid and looked bewildered by the sudden activity. A member of staff noted this and approached the patient, spent time talking with them and they carried on walking together.

The staff were respectful to the patients and their relatives during conversations and their privacy and dignity was promoted. We saw one patient and their relative were helped to the day room to have a private conversation and one relative was asked to wait in another area while the doctor saw the patient.
PLACE - data in relation to privacy, dignity and wellbeing

The 2018 PLACE score for privacy, dignity and wellbeing for the trust’s community inpatient service was similar to the overall England average for NHS community services.

These self-assessments are undertaken by teams of NHS and private/independent health care providers, and include at least 50 per cent members of the public (known as patient assessors). They focus on the environment in which care is provided, as well as supporting non-clinical services such as cleanliness, food, hydration, the extent to which the provision of care with privacy and dignity is supported and whether the premises are equipped to meet the needs of people with dementia against a specified range of criteria.

The 2018 PLACE score for privacy, dignity and wellbeing for the trust’s community inpatient service was 82.9%. This was similar to the overall England average for NHS community services of 85.3%.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Privacy, dignity and wellbeing score 2018 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exmouth Community Hospital</td>
<td>77.8%</td>
</tr>
<tr>
<td>Sidmouth Community Hospital</td>
<td>86.1%</td>
</tr>
<tr>
<td>Tiverton District Hospital</td>
<td>84.6%</td>
</tr>
<tr>
<td>Trust community inpatients</td>
<td>82.9%</td>
</tr>
<tr>
<td>England average (NHS community)</td>
<td>85.3%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital)

**Emotional support**
Patients and those close to them were provided with emotional support when needed.

One relative told us the staff felt they were part of their family, always listened and offered support and sympathy when it was needed. They said staff were comforting to their relative who was a patient. One patient said, ‘I feel like I am the only person they look after, they encourage me to be independent but I can talk to them about anything that worries me’.

**Relatives, friends and carers were able to choose the time they visited the wards.**
The hospitals had flexible visiting to allow relatives and friends to visit at a time convenient to them and support to be given to patient by relatives when needed. Two relatives told us they could be involved in the care of their loved one which helped them feel included and be prepared for when the patient was able to go home.
Staff provided opportunities for patients to be engaged in activities to provide person centred and group care. We observed an exercise group that not only formed part of the patient’s rehabilitation programme but provided a social experience with patients laughing and chatting with each other.

Staff recognised when patients were low in mood. At Sidmouth hospital, we observed one conversation where the patient had not appeared their usual self and the staff member encouraged them to talk about any issues which may have been bothering them. Another patient was due to be discharged following a lengthy stay in both the acute trust and the community hospital. The staff spent time exploring how the patient felt about their imminent discharge home.

Staff handovers referred to the psychological and emotional needs of patients, as well as those of their relatives / carers. Staff told us they could recognise if a patient’s mood was altering and would seek medical advice for the possible need for treatment for depression or anxiety.

**Understanding and involvement of patients and those close to them**

The staff supported people to express their views and be actively involved in making decisions about the care, support and treatment as far as possible.

At Tiverton hospital we observed that the views of the relatives were sought and discussed at the board meeting which resulted in several actions to support the patients planned discharge.

However, involvement varied from patient to patient, with one patient was not aware of their care and treatment plan or their discharge arrangements. The patient had capacity to understand but said staff had not informed them of when they were likely to go home. The patient records did not evidence any conversations had been held with the patient regarding this. Other patient records showed clear written records of patient and relative involvement in their care and treatment plans. These records included the outcomes of assessments of the patient’s home and social circumstances where needed.

We spoke with a patient and their spouse at Sidmouth hospital. They both felt involved in the decision-making process. They told us they had raised a health issue with the staff, had felt listened to and appropriate action had been taken to address the issue. They added they had confidence in the nurse consultant and other staff on the ward to keep them informed.

At Sidmouth hospital staff told us they had helped a patient who was receiving end of life care and treatment and their partner arrange their wedding. This had been arranged at short notice and the staff team pulled together to support the legal requirements, decorate the room and provided a cake and afternoon tea.

At Sidmouth hospital there was a relative’s room which was used for confidential or potentially difficult conversations. This afforded families and carers privacy and the right environment to ask questions to help them understand situations.

**Is the service responsive?**
Planning and delivering services which meet people’s needs
People received personalised care that was responsive to their needs. The service took account of the needs and choices of different people.

The community hospitals were part of the trust community services division. The community hospitals had moved to a model of intermediate care which aimed to provide patients with a seamless service delivered by a multi-disciplinary team across the hospital and patients own homes. The wards were staffed by nursing and therapy staff who worked closely together to plan and deliver care and treatment with support from medical staff. The intermediate care model had been introduced to Tiverton, Exmouth and Sidmouth Hospitals in 2018 and staff agreed this was developing well.

There was a standard operating procedure regarding the admission criteria and operating guidelines for each hospital. This was due to be reviewed in April 2019. During our inspection the patients we spoke with and reviewed the medical notes for met the admission criteria.

The staff had planned the care and treatment provided on the community wards to assist patients on their rehabilitation programmes. For example, the breakfast club to promote independence and exercise classes which also provided social interaction for patients.

The multi-disciplinary teams worked with patients and their families / carers to plan the patient’s discharge from the wards. Equipment was available to promote the patient’s safety, independence and wellbeing following discharge from the ward. The times of discharges were monitored and most took place between 9am and 3pm with a minimal number after 6pm.

The wards could provide support to patients who lived in the local community. For example, at Tiverton hospital staff told us one person came in from home to be weighed on the ward. Their condition required the monitoring of their weight but they did not have the facility to weigh at home. The ward also enabled patients attending day case at the hospital, to wait on the ward either before or after their appointment if required. We were told this happened when patients were waiting for transport home or if they arrived early for their appointments.

The day care transfusion service at Sidmouth had increased in size to provide facilities for five patients to have treatment at any one time. Patients on the ward were also supported to attend this service for treatment when required.

Each hospital had a League of Friends who provided amenities and services for patients and staff. At Sidmouth hospital the League of Friends committee consisted of people from the local community. They visited the ward regularly to speak with staff and patients to establish if any needs had been identified and to propose improvements as suggested by the committee and local people. Recent provision by the League of Friends included; flowers in the garden and portable air cooling fans.

The x-ray service provided at Sidmouth Hospital had recently been extended due to involvement and expressed wishes from the local community.
The trust held events to which staff could attend and take part in activities to identify and demonstrate where they believed money should be spent. Staff from community hospitals had attended these events and were able to share the views for development of the community services. Patients and visitors to the community hospitals had access to free parking. However, at Sidmouth and Exmouth hospitals this was limited and at times this caused problems for those attending the hospital. The staff at Sidmouth hospital and the League of Friends were looking at options to improve the parking facilities. At Exmouth hospital there was the option for on street parking close to the hospital. At each hospital there was the availability of space to drop patients and visitors to the hospital off outside the entrance, before moving to find a space to park.

Ward moves

The trust did not provide any ward moves data for community inpatient wards. Staff we spoke with did not perceive this as a problem as patients did not move between wards unless their care and treatment required readmission to the acute hospital.

The trust was asked to list ward moves for a non-clinical reason during the last 12 months. For example, if a patient had to move wards several times because there is no room in the speciality ward they should be on.

(Source: Universal Routine Provider Information Request (RPIR) Universal P43 – Ward moves)

Moves at night

The trust did not provide any ward moves at night data for community inpatient wards. The trust was asked to list ward moves between 22:00 and 08:00am for each core service for the most recent 12 months.

(Source: Universal Routine Provider Information Request (RPIR) Universal P44 – Moves at night)

Mixed sex breaches

The trust reported that between June 2017 and May 2018 there were no mixed sex breaches within community inpatients services.

Mixed Sex Breaches are defined by CQC as a breach of same sex accommodation, as defined by the NHS Confederation definitions. While these are specifically for mental health providers, the same definitions apply to community health services and acute providers from a CQC perspective.

(Source: Universal Routine Provider Information Request (RPIR) P47 –Mixed sex)

Meeting the needs of people in vulnerable circumstances
The staff took account of patient’s individual needs, including for patients who lived with dementia, learning disability, physical disability and sensory loss.

Place assessments are self-assessments which are undertaken by teams of NHS and private/independent health care providers, and include at least 50% members of the public (known
as patient assessors). They focus on the environment in which care is provided, as well as supporting non-clinical services such as cleanliness, food, hydration, the extent to which the provision of care with privacy and dignity is supported and whether the premises are equipped to meet the needs of people with dementia against a specified range of criteria.

All three of the trust’s community hospitals scored lower than the England average for being dementia friendly. The overall result for the trust’s community inpatient services for this metric was 70.5% compared to the England average of 80.6%. Exmouth reported a particularly low result of 63.8%.

The trust’s community inpatient services also reported a lower result for being disability-friendly, scoring 82.9% compared to the England average of 86.4%. Exmouth reported the lowest result of 75.3%. Sidmouth was the only one of the three community hospitals that outperformed the England average for this metric.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Cleanliness %</th>
<th>Condition, appearance and maintenance %</th>
<th>Dementia friendly %</th>
<th>Disability %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exmouth Community Hospital</td>
<td>99.2%</td>
<td>89.2%</td>
<td>63.8%</td>
<td>75.3%</td>
</tr>
<tr>
<td>Sidmouth Community Hospital</td>
<td>96.0%</td>
<td>98.5%</td>
<td>73.8%</td>
<td>86.9%</td>
</tr>
<tr>
<td>Tiverton District Hospital</td>
<td>98.0%</td>
<td>95.5%</td>
<td>72.7%</td>
<td>84.9%</td>
</tr>
<tr>
<td>Trust community inpatients</td>
<td>97.8%</td>
<td>94.7%</td>
<td>70.5%</td>
<td>82.9%</td>
</tr>
<tr>
<td>England average (NHS community)</td>
<td>98.8%</td>
<td>93.1%</td>
<td>80.6%</td>
<td>86.4%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital)

Staff told us of the work that was ongoing to improve the environment for patients living with dementia. For example, at Tiverton hospital plans there were plans to have murals painted on certain doors which would discourage patients with dementia from entering, such as staff only areas.

Resources were being sought to provide meaningful activity for patients with dementia admitted to the wards such as music therapy, washing baskets (for the provision of folding activities), dolls and rummage bags. The day rooms at Tiverton hospital provided activities which patients were encouraged to use. These included jigsaws, games, craft materials, colouring, knitting and books and magazines.

At Sidmouth hospital an external organisation employed a specialist nurse who supported people and their carers, in the local area, who lived with dementia. They attended the hospital when necessary and were also part of the community hospitals dementia care strategy group. Staff reported this service was responsive and supportive. Sidmouth hospital were part of a dementia and delirium pathway initiative / collaborative with the trust and the local mental health services (provided by an external mental health trust). This enabled information sharing between organisations, increased patient and carer knowledge reducing the patient’s length of stay and staff development.
At Exmouth hospital the environment did not support those patients living with dementia. There was limited signage to clearly orientate patients around the ward. For example, the use of clear wording and pictures to show where the toilets and bathrooms were. The ward environment did not use colour or pictures to indicate where the patients bed was located. However, there were clocks on the ward which clearly identified the date, day, time and weather.

Families were asked to complete documentation to show the likes and dislikes of their relatives to help staff meet individual needs.

Specialist dementia care support was provided from an external NHS trust, although staff reported at times the organisation was slow to respond to referrals. The community matrons also attended the wards to see patients with a diagnosis of dementia and provide support to the staff during the discharge planning.

At Sidmouth hospital the hospitality team, supported by the ward staff, organised events for patients to enjoy. For example, a royal wedding tea party with the day room decorated in style, Wimbledon week saw strawberries and cream provided and Christmas events such as carol singing and decoration making.

The breakfast group at Sidmouth hospital was well attended and staff reported this promoted independence and assisted patients getting home with established routines. Verbal feedback received from patients had been positive. Staff could demonstrate through a written timeline that one patient who had been identified as low in mood had experienced positive outcomes from attending the breakfast club.

Johns campaign, supported by the Gold Standard framework for patients with dementia, recognised the value of open visiting for patients with dementia and the value of input from people familiar with the patient and best approaches to their care. This had been introduced into the community hospitals and information provided for patients and visitors.

Patients living with a learning disability received support when necessary from the trust learning disability specialist nurses. Staff were aware of this service but those we spoke with could not recall this service being accessed. A document known as ‘my passport’ was used within the community hospitals which advised staff of the patient’s individual needs and support. Case managers for people with learning disability sometimes visited patients on the ward and onward care nurses made appropriate contact with support as part of discharge planning.

Patients who required additional support, such as those at risk from falls or requiring additional observation were admitted or moved into bays where additional staff were placed. We saw at each hospital staff remained in these bays. The staff spent time chatting to patients and providing observation care in an unobtrusive but individualised manner.

Patients who were receiving end of life care and treatment were cared for in a side room when appropriate. Staff and patients received specialist care and support from the local hospice when necessary.

However, at Tiverton hospital, planning of care for patient’s preferences was not always individual to the patient’s needs. Two patients told us the lights were put on at 6.30am, whether they wanted to be awake or not. One patient added that they had not been provided with support to wash and dress until 10.30am despite being woken at 6.30am. Staff we spoke with confirmed that
the patient observations, such as blood pressure, were taken and recorded at 06.30 hours and medicines administered soon after. Therefore, the lights were turned on then.

Information leaflets and posters were readily available on each ward. These covered a range of topics such as illnesses, infections, end of life care (for patients and their carers) and support groups in the local communities. The leaflets could be obtained in large print and other formats. At Sidmouth hospital we saw information for patients regarding accessing large print, British Sign Language, braille or easy read to aid effective communication.

Additional advice could be sought from the trust psychiatric liaison service, although they did not visit the community hospitals. An external trust provided ongoing mental health support for patients and carers.

Other services from specialist nurses and teams within the trust included diabetes, speech and language therapy, Parkinson’s and dietician support. Staff reported these services as accessible and helpful.

**Access to the right care at the right time**

**People could access the right care at the right time within the community hospitals.**

A virtual bed meeting was held each day and was attended by matrons and senior staff from each hospital together with the deputy director nursing for community services. The meeting discussed any delayed transfers of care, the planned admissions and discharges for the day and the next day, complex needs of patients and staffing. This enabled patients to be admitted to the right hospital for appropriate care and treatment when possible.

The admission criteria was detailed in the standard operating procedure for the community hospitals. Staff reported that at times of escalation in the acute trust not all patients required rehabilitation care and treatment. However, they were aware of the pressure on the beds and worked with the trust to manage the flow of patients through the hospitals.

The community hospitals each had arrangements for medical staff to provide timely assessments and treatment for patients.

Therapy support such as occupational and physiotherapy was available on weekdays from 8.30am to 4.30pm. At the time of our inspection a review was taking place regarding the increase of therapy support. It was hoped to increase this to provide cover on the wards from 7am to 7pm but this had not been finalised or agreed.

At times patients remained on the wards for long periods of time due to the insufficient availability of packages of care to support their discharge home. For example, one patient had spent over 70 days on the ward while a care package was waited for. Staff worked with external providers to help arrange ongoing care and treatment. The trust had arranged for several beds to be available to them for a period of time in a local care home. This meant discharges could be arranged from the wards in a timely way for those patients who required social care provision when leaving the hospitals.
Pharmacy staff visited patients on the ward and at home following discharge where necessary. This was to ensure compliance with and reduce the risks associated with medicines and their administration.

**Accessibility**

**The trust supported patients from ethnic minorities when necessary.**

The largest ethnic minority group within the trust catchment area is “white other” with 2.5% of the population.

<table>
<thead>
<tr>
<th>Ranking</th>
<th>Ethnic minority group</th>
<th>Percentage of catchment population (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First largest</td>
<td>White British</td>
<td>94.9%</td>
</tr>
<tr>
<td>Second largest</td>
<td>White other</td>
<td>2.5%</td>
</tr>
<tr>
<td>Third largest</td>
<td>Asian/Asian British</td>
<td>1.2%</td>
</tr>
<tr>
<td>Fourth largest</td>
<td>Mixed Heritage</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request – P48 Accessibility)

Staff had access to interpretation and translation services through the trust to support patients whose first language was not English.

**Bed occupancy**

**The community hospitals consistently had high bed occupancies on the wards.**

The trust provided information regarding average bed occupancies from June 2017 to May 2018.

The breakdown of bed occupancy levels in May 2018 by ward for community health inpatient services is shown below:

<table>
<thead>
<tr>
<th>Ward</th>
<th>Average bed occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exmouth Community Hospital – Doris Heard ward</td>
<td>83.5%</td>
</tr>
<tr>
<td>Sidmouth Community Hospital – elderly patients ward</td>
<td>100.0%</td>
</tr>
<tr>
<td>Tiverton Community Hospital – Blackdown ward</td>
<td>95.0%</td>
</tr>
<tr>
<td>Tiverton Community Hospital – Twyford Ward</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Both Sidmouth and Tiverton Community Hospitals reported 100% bed occupancy for their community inpatient wards as of May 2018.

Both hospitals reported 100% bed occupancy in eight out of 12 months from June 2017 to May 2018.
Average length of stay data

Exmouth Hospital

The average length of stay for discharged patients during December 2018 was 23 days against a target of 14. However, this included one patient who had been on the ward for 28 days prior to discharge.

Referrals

The trust did not provide local targets for ‘referral to initial assessment’ and ‘assessment to treatment’.

The trust has identified the below services in the table as measured on ‘referral to initial assessment’ and ‘assessment to treatment’.

For the period from June 2017 to May 2018 the longest waiting time from referral to initial assessment were reported by Blackdown ward at Tiverton District Hospital (26.6 days).

Patients on these three wards reportedly waited for less than one day from assessment to treatment.

<table>
<thead>
<tr>
<th>Name of hospital site or location</th>
<th>Name of in-patient ward or unit</th>
<th>Service Type</th>
<th>Days from referral to initial assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>National / local target</td>
</tr>
<tr>
<td>Sidmouth Community Hospital</td>
<td>Elderly patients ward</td>
<td>General medicine</td>
<td>-</td>
</tr>
<tr>
<td>Tiverton</td>
<td>Blackdown ward</td>
<td>General medicine</td>
<td>-</td>
</tr>
<tr>
<td>Tiverton</td>
<td>Twyford ward</td>
<td>General medicine</td>
<td>-</td>
</tr>
</tbody>
</table>

Delayed discharges

The trust provided delayed discharged data for the period from June 2017 to May 2018. However, this data did not cover any of the trust’s community inpatients wards.
Discharges were managed to ensure patients got home in daylight hours. The majority of discharges from the community hospitals were between 9am and 3pm. During December 2018 there had been seven and eight discharges from Sidmouth and Tiverton hospitals between 3pm and 6pm. In December 2018 all discharges had taken place on weekdays with most being on a Monday.

Learning from complaints and concerns
Concerns and complaints were listened and responded to and used to improve the quality of care.

Complaints

Complaints were listened to and taken seriously by the trust.

From June 2017 to May 2018 the trust received three complaints about community inpatient services. The subjects were:

- Admissions and discharges (excluding delayed discharge due to absence of care package)
- Communications
- Patient care.

The trust took an average of 54.7 working days to investigate and close these complaints. This was not in line with the trust’s complaints policy, which states complaints should be responded to within 45 working days. Senior staff told us that where complaints were complex additional time was necessary to fully respond to the complainant.

Information was available on each ward which identified how to make a complaint. Patients we spoke with said they would know how to make a complaint although none had needed to do so. They added they found the staff approachable and helpful and if they had any issues they would speak with them rather than make a complaint.

Feedback was provided to staff as a result of complaints made by patients within the community hospitals. This was cascaded through the trust information sharing system and discussed at team meetings. Individual feedback was provided to staff following a concern/complaint to ensure learning was taken.

Compliments

From June 2017 to May 2018 the trust received 435 compliments. Of these nine related to the trust’s community inpatient services, which accounted for 7.1% of all compliments received by the trust as a whole.
The breakdown by community hospital site is shown below:

<table>
<thead>
<tr>
<th>Team</th>
<th>Number of compliments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sidmouth</td>
<td>3</td>
</tr>
<tr>
<td>Tiverton</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
</tr>
</tbody>
</table>

However, we also saw compliments cards displayed on the ward at Exmouth community hospital but these were not logged in the above data provided by the trust.

(Source: Universal Routine Provider Information Request (RPIR) – P53 Compliments)
Is the service well-led?

Leadership

There was leadership with the capacity and capability to deliver high quality sustainable care.

Each community hospital was managed by an experienced senior nurse and a matron. Ward managers, referred to as the ward sister, were in post on each ward. The senior managers were visible on each ward. Staff reported the senior leaders were approachable and helpful. Leadership quality review visits took place each week on each ward, during these visits the senior nurse and/or matron talked to patients and staff and reviewed the quality of the delivered care and treatment.

Regular band 6 management meetings took place across the community hospitals. We were told the purpose of these meetings were to ensure the development, learning and continuity of management between the sites.

The senior leaders attended a multi-professional forum for the trust’s managers and leaders. This was attended by the deputy chief executive/chief nurse who had responsibility for community services. The deputy director of nursing formed and encouraged links between the acute and integrated services of the trust. Staff reported the links were getting stronger due to the shared learning and skills developed within the forum.

The senior managers at the community hospitals had received support from the trust’s practice coaches on the ward during the period of changing to an intermediate care service. Senior staff at the community hospitals said they felt valued and the challenges when implementing the changes were understood.

Hospitality supervisors and team leaders were visible on the wards. They provided support to the staff at times of low staffing numbers. The supervisors we spoke with had attended training to develop leadership skills. The supervisor and team leader had been awarded staff recognition awards – outstanding leader and exceptional team member – at the trust’s recognition awards in 2018.

Vision and strategy

The vision and strategy formed a base from which to deliver high quality sustainable care to people use services and a plan to monitor delivery of the care.

The community hospitals were part of the community services division of the trust following amalgamation from another trust in 2016. The vision of the community services division was to provide well run services while engaging the local communities and population and implementing innovative practices.

The trust values were displayed throughout wards and departments – respect, dignity, fairness, honesty, openness, integrity, inclusion and collaboration. Staff we spoke with were familiar with these. Staff demonstrated the values through their work, discussions with us and from having observed them with patients.

The senior leaders of the division provided information on the strategy for the division, the main objective of which focussed on admission prevention and enabling patients to stay in their own homes and environments. The decision had been made to close several community hospital beds prior to the trust taking over the management of the hospitals in 2016. A workstream had been
ongoing which had reviewed the patients admitted to the community hospitals to ensure they were in the right place at the right time. This had also reviewed the numbers and skill mix of staff working across the hospitals.

Integration with the wider trust continued as part of the trusts vision and strategy with work ongoing to ensure continued development of policies, procedures and practice development across the acute and community services. For example, senior nurses worked with specialist teams such as the end of life specialist team and the mortuary manager to ensure consistency and compliance. Another example of standardising the care across the trust was the introduction of a modified pressure ulcer assessment tool. This provided clear instructions for staff on the actions to take depending on the assessment outcome.

Culture

Managers across the community hospitals promoted a positive culture that valued and support staff.

Staff we spoke with were proud to work for the trust at the community hospitals. Senior staff expressed a feeling of pride in their staff and spoke of a motivated, engaged staff team who had and continued to embrace change in a positive and proactive manner.

Staff were respectful about and towards their colleagues within meetings and conversations. They could challenge each other in a positive and constructive way, with the patient at the heart of conversations and meetings. The hospitality staff felt part of the ward teams and spoke of feeling included and valued.

New staff, including students, felt welcomed and supported to the wards. One member of staff told us they had found the hospitals an inclusive environment to come into.

The health and wellbeing of the staff was supported by the trust. For example, at Sidmouth hospital there was information regarding access for the staff to occupational health and counselling services. Posters displayed local gyms and exercise classes for staff to attend.

The introduction of an intermediate care model had been a considerable change for many staff. The trust had supported this change positively with project groups which staff of varying roles attended. This had enabled the staff to feel listened to and provided the opportunities to share concerns and success across the hospitals. Staff reported access to their managers at all times and said they were approachable.

Governance

The trust used a systemic approach to improve the quality of its services and safeguard high standards of care.

A series of governance meetings were held across the community services to ensure issues, risks and positive outcomes were discussed, assessed and shared with the wider trust as necessary.

Monthly governance meetings took place in each hospital / cluster of community services. Minutes and outcomes from the meetings were escalated to the monthly divisional governance group which was attended by senior managers. The meeting was chaired by the deputy director of nursing. This process enabled ward to board escalation and feedback to the wards.

The governance systems also provided an opportunity to ensure shared learning across the services and hospitals and informed the divisional quality improvement plan. The outcomes and action plans
from completed clinical audits were reviewed and signed off at the divisional governance meeting which meant a clear process for improvement was shared across the services.

Managers and staff were positive about being proactive and encouraged to report incidents with an awareness of the duty of candour regulation. For example, at Tiverton hospital a full investigation took place following the death of a patient. Staff felt supported and received support during the investigation. The outcome of the investigation was ongoing at the time of our inspection. A serious incident and incident review group was held which included round table reviews. Following a serious incident, the matron/ward sister for the service was invited to present and discuss the individual incidents.

The trust had developed a ‘care matters’ forum which was attended by staff from both the acute and community services. Information was shared and cascaded to all staff. This helped to develop an understanding of challenges faced by staff across the whole trust.

The hospitality supervisors and team leaders collected all completed cleaning schedules for review, with attention paid to any comments/ issues identified. Action was taken to address these with a discussion with staff, providing additional support if needed or reporting a maintenance issue. Weekly and monthly audits of cleanliness and hygiene were completed on by the hospitality supervisors to provide assurances through the management and governance systems on the cleanliness and infection control within the hospitals.

Data supplied to us from the trust informed that all medical staff in community inpatients were allocated to Exmouth Community Hospital. However, during our inspection we saw there was medical cover provided by a staff grade doctor at Tiverton hospital and a junior doctor and nurse consultant at Sidmouth hospital. Support was also provided in the community hospitals from GPs and consultant geriatricians who visited the wards twice each week. The lack of data provided prior to the inspection did not provide assurances that the medical cover arrangements were monitored by the trust.

Management of risk, issues and performance
There were clear and effective processes for managing risks, issues and performance

The service was represented to the trust board by the patient safety and quality lead for the community services and the governance lead, who prepared reports to share relevant information and cascaded information from board level to staff.

Divisional risk registers were in operation. Not all staff were familiar with their local risk registers or what was included on it. However, during discussions with staff, issues which were placed on the local registers were those staff were aware of. They were also able to discuss with us action which was being taken to reduce the risks. For example, all staff knew the action to take when the wards were short staffed due to sickness or holiday and the medical cover arrangements for their wards.

Senior staff could share issues from the local risk registers and provided us with an up to date risk register. The divisional risk register for community services included staffing in the community hospitals, medication handover risk and the reduction in the number of local GPs which affected the medical provision at the hospitals.
All incidents and risks were reviewed by senior managers. Low risks were managed within the team which had raised the issue and higher risks were escalated to the cluster and divisional governance groups. This meant the risk was reviewed by senior staff from other areas to ensure appropriate actions taken and the risk management processes were overseen by a wider senior staff group. The divisional risk register was updated on alternate months at the divisional governance meetings to reassess the risk rating and review actions taken to reduce the risk.

A daily virtual bed meeting held by telephone and chaired by the deputy director of nursing was dialled into by a senior manager from each community hospital. Risks were identified and discussed at this meeting. For example, staffing levels and individual patient risks. This ensured immediate escalation of the risk took place and action taken to reduce the risk.

A further telephone meeting took place at the end of the day which reviewed access and flow through the community hospitals and a further review of any identified risks from the virtual bed meeting.

There was a contingency plan to manage potential risks to the continuity of the service due to bad weather. Learning had been taken from a previous episode of bad weather which had affected the ability of staff to access the hospital. The contingency plan meant staff were prepared and ready to activate the actions such as drawing in staff and the provision of accommodation overnight.

There was a programme of internal audits to monitor quality and operational processes. There were action plans resulting from the audits and staff were aware of these.

**Information management**

Appropriate and accurate information was available to staff to support their work. However, this was not always stored securely.

The trust used an electronic system known as to record and inform staff regarding performance in the hospitals. Printouts from the performance dashboard were displayed and provided information on staffing, quality and performance. For example, quality outcomes and audit results. Meetings were held to share information with the staff and discuss actions to improve the service. Minutes of the meetings were provided to ensure staff who did not attend had access to the information.

Daily board rounds took place which involved a multi-disciplinary team discussion at the white board. The whiteboards provided at a glance information for staff regarding each patient on the ward and was used to discuss their care needs and treatment plans. The whiteboard at Exmouth hospital was in a staff only area, while those at Tiverton and Sidmouth hospital were in areas where the information could be viewed by patients and visitors to the ward. This meant personal information was not stored securely and accessible to others. Information recorded on the board included; the patient name, admission and discharge dates, clinical assessments and tasks which required to be followed up during the day. There was a section for comments which included information such as; commode by bed at night, CRT referral, night plan with pads, trial wheelchair, plan family meeting, diabetic management plan – new insulin, stairlift, bed and equipment needed, refer to Devon carers, for rehabilitation. We attended board rounds at Tiverton hospital and during this time there were visitors on the ward who potentially could hear the discussions about each patients’ care and treatment.

Patient’s medical records were stored securely in locked offices or notes trolleys. The patient nursing records were stored at the bedside.

**Engagement**
The trust engaged with and involved people who used services, the public, staff and external partners to support high quality sustainable services.

The trust had engaged with staff of all levels during the planning and introduction of the intermediate care model at the community hospitals. Ward meetings known as ‘scrum’ had taken place to seek staff views prior to the implementation of the model. This had helped to develop appropriate training and service delivery. For example, staff had identified the need for specific equipment which had subsequently been purchased. The range of equipment had enabled staff to familiarise patients with the available in their homes providing confidence with the use of the equipment prior to discharge. The introduction of assessments had been introduced following recommendations from staff to measure the patient’s ability/independence with activities of daily living (ADL). The registered nurses completed a nationally recognised assessment on admission and therapists on discharge to help add value and make a difference to the patient outcomes.

The senior nurse carried out a ward visit twice a week with the specific intention of speaking with patients, families, visitors and staff to seek feedback and observe practice. The senior nurse had identified incomplete documentation at a previous visit and the nurse in charge of each shift now had responsibility to ensure all documentation was completed appropriately.

At Tiverton hospital the Matron had recently introduced the concept of ‘tea with matron’ to provide an opportunity for staff, patients and relatives to share concerns and ideas. This had yet to commence.

Noticeboards provided information for patients and their relatives. For example, there were results from audits completed on the ward. These included hand hygiene audit outcomes and safety performance information relating to falls and pressure damage.

Information regarding the staffing levels each day was prominently displayed at the entrance to the wards. This showed the planned staffing establishment and the actual staffing levels for each shift. The exception to this was at Exmouth hospital where the staffing establishment was not displayed. **The staff notice board at Exmouth hospital was not relevant for public display.** The staffing noticeboard at Exmouth hospital was also not clear to visitors to the ward as it also contained information on the staff coffee breaks. As there was no explanation of the additional numbers and times this was not self-explanatory to patients or visitors to the ward although the staff understood the chart and provided an explanation when asked.

Feedback from a quality patient experience survey was displayed on notice boards on notice boards in the wards. These reflected positive outcomes from patients had been shared.

Information and updates from the trust were shared with the staff electronically. All staff received a weekly newsletter which included a section highlighting the ten top changes within the trust in addition to updates and other information. This information was also accessible on the trust intranet to which all staff had access.

**Learning, continuous improvement and innovation**

**Staff were supported with learning and continuous improvement. Ideas and innovation were welcomed and considered.** The trust had a system to enable staff to raise innovative ideas and
apply for funding to support these. Staff said the senior nurses were approachable and willing to discuss staff ideas and would support them to forward these ideas to the trust for approval.

The community hospitals had reviewed the recruitment procedures and had planned open days/evenings in the community hospitals. This enabled applicants to attend the local area in which they were applying to work, meet the staff and be provided with an interview at the same time. A variety of times and days were available thus increasing the opportunities for applicants to attend.

Staff at Sidmouth hospital identified and described the learning and changes in practice which had taken place following a patient becoming unwell with sepsis at the hospital. A learning package had been developed which included face to face and eLearning to ensure staff had the knowledge and skills to recognise and respond promptly to a patient developing sepsis. A flow chart informing of the pathway for the treatment of sepsis was now included in each patient notes.

Students were required to complete a study as part of the learning objectives while on placement in the community hospitals. They told us that the staff were supportive and helpful to them and two students we spoke with were undertaking a project regarding the management of patient fluid intake and output charts. Staff we spoke with were enthusiastic about this piece of work and were eager to learn from the project to improve outcomes for patients.
Community end of life care

Facts and data about this service

On 1 October 2016, the trust became the providers of community end of life care for adults in Exeter, East Devon and mid Devon. The trust does not provide a community end of life care service for children.

There are three community hospitals providing a total of 72 inpatient beds, located in Sidmouth, Exmouth and Tiverton. The community hospitals provided rehabilitation care and end of life care or supportive palliative care to enable patients to die in their preferred place. Registered nurses, therapists and healthcare assistants provided end of life care in the inpatient setting.

End of life care for community patients includes assessment, provision of equipment, symptom management, care provision, fast track eligibility assessment, ‘just in case’ contingency planning, support for relatives and carers and signposting.

There is no specific team that provide specialist end of life care in the community setting. The community end of life care service is delivered primarily by the community nursing teams, the urgent care nursing teams and the urgent care response teams. However, any member of staff working any area of the community services, for example, community rehabilitation teams, may provide care for patients in the last 12 months of their lives.

The patient pathway for an adult patient in the last twelve months of life is likely to include services from more than one care provider. The trust works closely with partners to enable patients to receive end of life care in their place of choice. This includes collaboration with GPs, out of hours GP services, charities and domiciliary care providers.

Local charities employ teams of nurses who visit patients at home for support and symptom management, carers who provide overnight care plus in-patient hospice services. In Seaton and Exmouth, a local charity provides a ‘hospice at home’ service. Community teams can also access support from the specialist palliative care team based in the acute hospital.

There was a small mortuary at Tiverton hospital. This consisted of one room with a refrigerated mortuary cabinet with lifting equipment and a patient transfer trolley. The other community hospitals did not have mortuary facilities.

The trust does not hold service-wide data regarding the number of end of life care patients that are cared for in the community setting. There is no available data to provide context to service provision.

For the announced inspection we visited community nursing and urgent care response teams based at Exeter Community hospital, Exmouth Community Hospital, Okehampton Community Hospital, and Tiverton and District Community Hospital. We also carried out an unannounced visit to Sidmouth community hospital. We attended a core group meeting and gold standards framework meeting at a GP surgery. We accompanied staff on eight visits to patients’ homes. We spoke to inpatients staff about the care of a patient at Tiverton Hospital. We spoke with urgent care nurses who cared for patients out of hours. We visited the community mortuary at Tiverton Hospital. We facilitated three focus groups. We spoke with three patients who were receiving end of life care and four relatives. We also reviewed 18 patient records. We spoke with 50 staff, including registered nurses, therapists, pharmacy technicians, a nurse consultant for older people, and a ward clerk. We also spoke with a GP and a nurse employed by a local charity. We reviewed the minutes of meetings pertaining to community end of life care provided by the trust.
Is the service safe?

Mandatory training

Mandatory Training completion
There was no separate team for community end of life care. This service was provided by a combination of several teams including community nursing, urgent care response, urgent care nursing and community rehabilitation teams. The data for mandatory training compliance is reported on in the community adults and community inpatients evidence appendices.

The service did not make sure that staff maintained knowledge of essential safety systems specifically relevant to end of life care. This was because there was no mandatory end of life care training for community staff.

Safeguarding

Safeguarding Training completion
There was no separate team for community end of life care. This service was provided by a combination of several teams including community nursing, the urgent care response, the urgent care nursing and community rehabilitation teams. The data for safeguarding training compliance is reported on in the community adults evidence and community inpatients evidence appendices.

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Staff we spoke with knew how to identify a safeguarding concern and demonstrated a clear understanding of their role in reporting safeguarding concerns. Staff caring for end of life care patients were confident regarding the process for reporting safeguarding concerns. For example, a staff member gave an example of a recent safeguarding concern they reported and explained how the safeguarding team based in the acute hospital supported them through the process.

The safeguarding referrals for the service were monitored as part of community services for adults and is commented upon in the community inpatients evidence appendix and the community adults evidence appendix.

Cleanliness, infection control and hygiene

Staff kept themselves clean and, for the most part, used control measures to prevent the spread of infection.

We observed community staff giving end of life care in patients’ homes. On all visits we observed, staff complied with good practice guidelines around prevention and control of infection and followed trust policies. For example, staff were bare below the elbows, used antibacterial hand gel between patient care, wore personal protective equipment such as aprons and gloves and disposed of waste correctly. This ensured patients receiving end of life care were cared for as safely as possible. When
patients died in the community hospitals, the ward clerks completed a checklist for care of the deceased patient. This included informing funeral directors of known infection, for example, deceased patients who were known to have an infectious illness.

There was no separate data regarding infection prevention and control specific to the community end of life care service. Evidence such as data from hand hygiene audits and prevalence of healthcare associated infections is reported in the community adults evidence and community inpatients evidence appendices.

**Staff did not always keep equipment clean.** There were insufficient assurance mechanisms to mitigate the risk of cross contamination in the community mortuary as recommended in Health and Safety Executive guidelines ‘managing infection risks when handling the deceased’ 2018. There were no documented cleaning and decontamination procedures for the mortuary. We checked the cleaning records completed by housekeeping staff and these only required that staff ‘check’ the mortuary. There were no records of cleaning of the equipment used in the mortuary, such as the refrigerated mortuary cabinet or the trollies and trolley covers used to transport deceased patients. A senior nurse told us the usual practice was to clean the trollies with disinfectant wipes before use but not after use. There was no sink in the mortuary room for staff to wash their hands.

**Environment and equipment**

**The inpatient environment was adequate for the needs of end of life care patients and their relatives.** Appropriate for the needs of end of life care patients at one of the three community hospitals. The team at Tiverton Hospital had developed the resources available for end of life care patients and their loved ones. One side room was equipped with extra items to improve the comfort of these patients. For example, framed photos on the walls, hooks in the bathroom and easy access to the communal garden. At the other community hospitals, teams tried wherever possible to accommodate patients in a side room. There were facilities for relatives to stay overnight at the two community hospitals we visited.

**Staff could access appropriate safety equipment for patients.** This included: adjustable electric beds, pressure care mattresses and moving and handling equipment such as hoists and slings. We observed staff using safe methods to operate this equipment.

Staff could readily access syringe pumps for patients requiring palliative medicines in the last few days of their lives. All community nurse teams and community hospital inpatient teams had access to a store of syringe pumps and when necessary staff could request to use a pump from another base. The consumable equipment that nurses needed to set up syringe pumps was readily available and stored safely. We checked the use by date of a sample of this equipment and these were all within date.

**Equipment was maintained and monitored for safety.** Syringe pumps were maintained and used in accordance with manufacturers’ instructions. The trust used one brand of syringe pump across all community settings. This reduced the likelihood of confusion or error by staff, particularly temporary (bank or agency) staff. When syringe pumps were in use, nurses checked this equipment every time they visited the patient ensure it was working effectively. Patients using syringe pumps in their own homes were given written instructions explaining what to do if the syringe pump alarm sounded. Nursing staff knew what to do if a syringe driver was faulty. INPTs syringe pump checks

Staff monitored mortuary refrigeration equipment for safety. In the mortuary at Tiverton hospital, staff recorded the temperatures inside the refrigerated mortuary cabinets daily. If any faults with the refrigeration system were identified, staff telephoned an external contractor to fix the problem. There was an audible alarm and flashing light positioned outside the mortuary that identified when a power
failure affected the function of the refrigeration system. However, we were not assured that this alarm system was routinely tested.

There were systems to monitor when deceased patients were delivered and collected from the community mortuary. Nursing staff worked in pairs to transport a deceased patient to the mortuary. A nurse was required to sign a deceased patient book when they left a deceased patient in the mortuary. The ward clerk supervised the collection of deceased patients by funeral directors. The ward clerk arranged this in advance, met the funeral provider at reception and accompanied them to the mortuary. Funeral providers signed a record when they collected a deceased patient.

**However, there were no systems to prevent unauthorised access to the mortuary.** The security system in use at the community mortuary did not provide adequate assurance that unauthorised persons were prevented from accessing this area. Staff accessed the mortuary by entering a code into a keypad. Keys to the refrigerated mortuary cabinet were stored in a key cupboard inside the mortuary that was accessed using another code. There was no swipe card identification or visual recording using closed circuit television. Managers did not keep a list of staff with authorised access to the mortuary. Managers did not know how often the key code for the keypads were changed or which staff were aware of these codes. The entrance to the mortuary was not monitored and was at the end of an infrequently used corridor. There were indications that the mortuary was accessed for reasons unrelated to patient care because we saw that miscellaneous equipment such as a stepladder and a porter’s trolley were stored in the mortuary.

There was no risk assessment for the security systems at the community mortuary. However, there had been no reported incidents of patient harm related to the mortuary security.

**Assessing and responding to patient risk**

**Systems and processes enabled staff to seek support when they needed to.** When patients deteriorated, staff contacted the patients GP to escalate their concerns. Urgent care nurses liaised with the out of hours doctors service. For more specialist expertise, staff could telephone doctors at the hospice who were on-call 24 hours a day or the palliative care team based at the acute hospital. Staff also sought advice from nurses employed by for the hospice charity.

**Staff closely monitored the safety of patients in the last few days of their lives.** We checked patient records and saw that staff completed essential risk assessments for each patient in a timely way. These included risk assessments for pressure damage to skin, malnutrition, wound care, moving and handling, diabetes, memory and falls. Risk assessments were reviewed in a timely way and actions for corresponding care plans were systematically completed. Staff ensured carers knew how to contact the community teams for help and support when patients experienced a deterioration in their condition.

**Staffing**

There was no separate team for community end of life care. There were no palliative care clinical leads or consultants employed in this service. This service was provided by a combination of several teams including community nursing, urgent care response, urgent care nursing teams and community rehabilitation teams. The data for staffing is reported on in the community adults and community inpatients evidence appendices.

**Team managers ensured staffing was available to meet the needs of end of life care patients.** When staffing levels fell short, this did not impact on patients at end of life, because their needs were prioritised. Staff had reported no incidents related to staffing concerns in the end of life care service.
The quality of patient handover meetings was not consistent. We observed two handover meetings, one was well executed with individual patient priorities for end of life care and other safety concerns clearly identified. However, the other meeting lacked focus, did not highlight the needs of end of life care patients and did not have a clear remit around patient safety.

**Quality of records**

Record keeping audits did not inform managers specifically about the quality of records in the community end of life care service. The community nursing service audited five records of community patients in each team per month. This audit focussed on accuracy and completeness of records, for example, whether entries were signed and dated. However, the data was not specific to the community end of life care service. For this reason, the evidence from these audits is reported on in the community adults and the community inpatients evidence appendices.

The quality of records of treatment escalation plans was audited in the community hospitals. In December 2018, managers completed an audit of the treatment escalation plans for the inpatients at Tiverton, Exmouth and Sidmouth community hospitals. The audit identified that all patients had a treatment escalation plan. Some documentation was not consistently recorded, such as mental capacity assessments and details of discussions around the treatment escalation plans. To address these concerns, senior nurses discussed the findings of the audit with GPs and junior doctors at the acute hospital. Going forward, the community inpatient teams planned to complete a monthly audit of treatment escalation plans. However, there were no plans to audit the treatment escalation plans for patients living in their own homes.

**Staff did not consistently use specific documentation designed to meet the needs of end of life care patients.** We checked the care records of 15 end of life care patients living in their own homes. In all these records, staff used the community adult care plans rather than the end of life care assessment documentation launched for the community service in October 2018. However, in community inpatient facilities, the end of life care documentation was used more consistently. We checked the inpatient care records of three patients. Staff had used the end of life care documentation for two of these patients. Staff told us the documentation was not practical to use in community settings because a doctor was required to complete one of the sections.

**Records were not always available to all staff providing care.** Nurses did not always have access to all the information necessary to deliver end of life care. There was an electronic palliative care coordination system but staff did not regularly refer to this. Patient records were not electronic. Records were usually stored in folders in patients’ homes. We observed on patient visits that nurses did not always know the patient’s diagnosis and care needs prior to arriving at the patient’s home. Community nursing teams did not always know the details of care given by other teams because they relied on those staff members to record in the nursing notes for communication purposes. Staff told us and an incident report confirmed that sometimes staff arrived to treat a patient and their record was not available in the patient’s home. In these circumstances, nurses told us they relied upon the contents of the referral received which was not always thorough.

**Records did not contain all information relevant to the care of end of life care patients.** We looked at a total of 18 patient care records for patients in the last few days of life and patients approaching the last 12 months of their lives. Records contained the information nursing staff needed to complete designated tasks. For example, for a patient with a wound, the record contained the relevant wound risk assessment and documentation of wound reviews plus adequate description of care tasks undertaken related to the wound to provide continuity of care. However, records did not contain the information needed for nurses to respond to the broader needs of patients who were
approaching the end of their lives. Patients records did not clearly indicate those patients who were identified as being in the last 12 months of their life. None of the records indicated the patients preferred place of care or death. Only one of the 18 records included a holistic assessment and a review of the spiritual and emotional needs of the dying patient.

**Medicines**

**During our inspection, we saw that nurses gave, recorded and stored medicines well.** **Patients received the right medication at the right dose at the right time.** We checked the medicine records of 12 end of life care patients. These records showed staff prescribed and administered medicines in line with current national guidance. This included the use of ‘just in case’ medicines. Nurses completed prescription charts for syringe pumps clearly. We saw evidence nurses checked syringe drivers regularly for: rate, volume remaining, battery charge and patient comfort.

**Patients received advice about their medicines.** Nurses talked to patients about their medicines, taking extra time to explain how to get the most benefit from the medicines designed to relieve pain. For inpatients in the community hospitals, inpatient nursing staff explained the contents of the ‘just in case’ bags to patients and their carers. Nurses explained what the medicines were used for and how to store them at home.

**Staff shared learning from medicines incidents.** Several nursing staff told us they spent significant time travelling to and from pharmacies to collect emergency medicines for end of life care patients. Staff reported this as an incident and subsequent learning from the investigation was shared with the community nursing teams. Managers ensured staff were informed about the location and opening hours of designated enhanced pharmacies with high stock levels of end of life care medicines.

**Safety performance**

**The trust did not use safety performance data to specifically monitor the safety of the community end of life care service.** There was no separate team for community end of life care. This service was provided by a combination of several teams including community nursing service, community inpatient teams, urgent care response, urgent care nursing and community rehabilitation teams. The evidence for safety performance of these teams is reported in the community adults evidence appendix and the community inpatients evidence appendix.

**Incident reporting, learning and improvement**

**The service managed patient safety incidents well.** Staff recognised and reported incidents. There were 146 end of life incidents reported during the 12 months preceding our inspection. Most of these incidents were staff reporting pressure damage or moisture lesions on patient’s skin. Staff in community teams were aware of the process to report incidents and described several examples of incidents reported. For example, community nursing staff reported all incidents of moisture lesions and pressure ulcers.

**Managers investigated incidents and shared lessons learned within teams.** For example, all staff in the community nursing teams were aware of an incident when a patient’s wife had travelled a long way to find a pharmacy that stocked end of life care medicines her husband needed. Managers held round table reviews about specific incidents involving patients that were shared between teams, for example, when a grade three pressure ulcer was reported. However, some staff
told us they were not routinely updated about learning from incidents across teams. For example, nurses working in the out of hours team or the inpatient teams would not be advised of learning from incidents in the community nursing team and vice versa.

**Learning from incidents was used to inform service development.** For example, the new syringe pump prescriptions were printed on one side only because there had been an incident of a GP not completing both sides of the form. However, the incident reporting system did not categorise end of life care incidents separately to distinguish them from other community service incidents.

**Never events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From October 2017 to September 2018, the trust reported no never events in community health services for end of life care.

(Source: Strategic Executive Information System (STEIS))

**Serious Incidents**

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include ‘never events’ (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in community health services for end of life care, which met the reporting criteria, set by NHS England from October 2017 to September 2018. From June 2016 to May 2018, staff reported no serious incidents related to the community end of life care service.

(Source: Strategic Executive Information System (STEIS))

**Is the service effective?**

**Evidence-based care and treatment**

**There were no systems to ensure that the service provided care and treatment based on national guidance and evidence of its effectiveness. Managers did not check to make sure staff followed guidance.**

Managers had not audited the community end of life care service against evidence based guidance published by the National Institute for Health and Care Excellence (NICE) and other expert professional bodies such as the NHS England Leadership Alliance for the Care of Dying People.

Managers had not acted to ensure compliance with the quality standard NICE QS144: Care of Dying Adults in the last days of life, published in 2017. This quality standard highlights the need for staff to closely monitor patients in the last days of their life to ensure the person is comfortable. This standard also stresses the need to use a personalised care plan that reflects any changes to the patient’s personal needs and preferences in the last few days of life. The personalised care plan includes vital information, for example the patients preferred place of care and their preferences for symptom management and maintaining hydration.

In June 2017, the lead cancer nurse had partially completed a baseline assessment tool for the quality standard NICE QS144: Care of Dying Adults in the last days of life. This tool had not been
signed off by a manager and did not include details of any audits to demonstrate compliance, despite the author designating the service as ‘compliant’ for all four standards.

Managers had not acted to ensure compliance with the quality standard NICE QS13: End of life Care. This quality standard, published in 2011, highlights the need to identify patients with advanced, progressive, incurable conditions; patients with life threatening acute conditions and patients who may die within 12 months. Services should identify these patients with sufficient time to enable provision of high-quality end of life planning with care and support in accordance with the person’s needs and preferences. This includes opportunity to discuss physical, psychological, social, spiritual and cultural needs and to develop and review a care plan detailing the patient’s preferences for current and future support and treatment. This is important because in addition to physical symptoms such as pain, breathlessness, nausea and increasing fatigue, people who are approaching the end of life may also experience anxiety, depression, social and spiritual difficulties.

A baseline assessment tool was partially completed for this quality standard. However, this document was not dated and or signed by either the lead or the manager. There were no actions recorded against the standards deemed as partially complaint.

Managers had not acted to ensure compliance with the five priorities of care identified by the NHS England Leadership Alliance for the Care of Dying People in 2014 despite this being recognised in the trust policy. These include

- The possibility that a person may die within the coming days and hours is recognised and communicated clearly, decisions about care are made in accordance with the person’s needs and wishes, and these are reviewed and revised regularly by doctors and nurses.
- Sensitive communication takes place between staff and the person who is dying and those important to them.
- The dying person, and those identified as important to them, are involved in decisions about treatment and care.
- The people important to the dying person are listened to and their needs are respected.
- Care is tailored to the individual and delivered with compassion – with an individual care plan.

**There had been no audit of the care given to end of life patients.** Community staff expressed very limited awareness of the priorities for care identified in national guidance. When we observed patient visits and checked patient records, we were not assured staff were consistently incorporating all these guidelines into their practice. For example, staff did not consistently provide personalised individual care plans for end of life care patients.

**Pain relief**

Community nursing staff were not consistently assessing and reviewing patients pain in a comprehensive way. Nurses did not always describe patients’ pain thoroughly, for example, they did not use the pain assessment tools available. Nursing staff did not always identify the location of the pain. This included patients who were having treatment for wounds.

Nurses prepared in advance to try to avoid a lapse in symptom control which could otherwise cause distress for the person who was dying and those close to them. We saw that pain relief prescriptions
were written in anticipation in readiness for when they were needed, in accordance with NICE quality standard QS144 Care of Dying Patients in the last days of life.

**There was a risk that nurses might not administer pain medicines correctly.** Managers could not be assured that anticipatory or ‘just in case’ medicines were used as intended as they did not complete any audits of medicines for community patients.

**Nutrition and hydration**

We checked patient records. These showed that teams were considering the nutrition and hydration needs of patients. Nurses completed regular assessments of patient’s nutritional needs. In the community inpatient setting, nurses referred patients with complex nutritional needs to community dietitians who visited them on the ward.

**Patient outcomes**

Managers did not have any objective information regarding the quality of the community end of life care service for patients living in their own homes. The service did not routinely collect and monitor information about the end of life care and treatment for these patients. There were no audits of the quality of care for community end of life care patients living in their own homes. The service did not use the End of Life Care Quality Assessment Tool or similar self-assessment tool to support local service improvement.

Managers had begun to audit one aspect of end of life care for community inpatients. The scope of this audit activity was very limited. In 2018, the community inpatients service contributed data to the National Audit for Care of the Dying. The results of this audit were not yet published at the time of the inspection. Managers completed the first audit looking at how many patients died in their preferred place between July and September 2018. The audit was limited to inpatients of community hospitals who were in receipt of continuing health care, whose discharge from hospital was facilitated by the supportive and palliative care team based in the acute hospital. The audit included 111 records, of these 80 patients died in their preferred place, 23 patients did not die in their preferred place, and for 8 patients, staff had not identified the patient’s preferred place of death.

The information from the community inpatients audit was limited in its application. The results of this audit did not give any qualitative information for the reasons why patients did not die in their preferred place or why their preferred place of death was not identified. The results could not be separated into cluster teams for actions targeted within localities. Managers did not use completed the information from the inpatient audit to identify local or trust-wide actions. At the time of our inspection, the audit had not triggered any change of practice in community teams.

The community end of life care service was not working towards the Gold Standards Framework accreditation. The gold standards framework accreditation scheme for end of life care is a systematic, evidence based approach to optimising care for all patients approaching the end of life care.

**Competent staff**
New staff participated in an induction programme. Community nurses were allocated a buddy for the first six months of their employment in a community role. Additional evidence about the general induction programme is reported in the community adults and the community inpatients evidence appendices.

Staff could access optional training about end of life care. This was provided at the acute trust or the local hospice. This included training on addressing the spiritual needs and emotional wellbeing of people who were dying. The acute hospital team held twice yearly training events for GP’s and for nurses and allied health professionals. These were well-attended and evaluations of the events showed positive feedback from attendees. Managers had supported a nurse caring for inpatients at a community hospital to apply to study an end of life care module at a local university. However, numbers of attendees at these events was relatively low. For example, only one member of staff had completed training in bereavement skills and only two members of staff had completed training in advance care planning. The trust did not provide this data as a percentage of all staff delivering community end of life care.

Nursing team managers did not have systems to provide assurance that staff maintained ongoing competencies in critical end of life care tasks, for example use of the syringe pump, and administration of anticipatory medicines. All community nursing staff were involved in the delivery of community end of life care, and were responsible for using syringe drivers and administering anticipatory medicines. However, community nurse team managers were unable to provide evidence to show they had checked staff competencies in these tasks, either at induction or at subsequent intervals.

End of life care policies identified the need for ongoing competency checks. However, there was a lack of clarity regarding how these were completed and how compliance was audited. For
example, the trust-wide syringe pump policy identified a requirement for community nurses to adhere to the 'community nursing syringe pump competency'. This document stated registered nurses working in the community must renew this competency every year. Community nurse team managers did not audit compliance this requirement.

After our inspection, the trust informed us teams planned to introduce a template for recording staff competencies for use of anticipatory medicines, syringe pumps and verification of death procedures. There were plans to begin a programme of community service quality walk arounds that would involve senior nurses accompanying nursing staff on their visits. This had not been set up at the time of our inspection. In therapy teams, managers observed each therapist’s practice on two occasions per year.

The trust did not routinely monitor and record clinical supervision and there was no target rate for the Trust. There was no separate team for community end of life care. This service was provided by a combination of several teams including community nursing, urgent care response, urgent care nursing teams and community rehabilitation teams. The evidence related to clinical supervision is reported in the community adults and community inpatients evidence appendices.

(Source: Universal Routine Provider Information Request (RPIR) – P42 Clinical Supervision)

Appraisal rates

There was no separate team for community end of life care. This service was provided by a combination of several teams including community nursing, urgent care response, urgent care nursing and community rehabilitation teams. The data for appraisal rates is reported in the community adults and community inpatients evidence appendices.

Multidisciplinary working and coordinated care pathways

Staff followed processes to provide continuity of care when patients transferred between services. When end of life care patients were discharged from the acute hospital to community inpatient settings or to their own home, the community teams received information from the palliative care discharge team. Relevant community teams, for example the community matrons, liaised with the acute hospital to ensure a seamless transfer of information. Nurses in the inpatient units spoke to the patient’s family to understand the patient journey so far. Some information was available on the patient transfer system, for example, the referral to community services as well as relevant progress updates, for example, continuing health care funding applications completed. Teams in the community hospitals used the electronic whiteboard to view previous risk assessments and discharge summaries completed by staff in the acute hospital.

Staff of different kinds worked together as a team to benefit patients in the last few days of life. Patients received care from all relevant disciplines of staff. Health and social care professionals from different organisations worked well together to meet the needs of the patient and carers they discussed. Community staff attended meetings in GP surgeries to discuss and agree the treatment plans for patients who were nearing the end of their lives. Members of community staff and GPs put patient’s names on the agenda for discussion. In inpatient settings, patients with end of life care needs were discussed in the regular ward multidisciplinary meetings.

Staff made appropriate referrals to other teams in a timely way. For example, a team referred a patient to a voluntary befriending service because they were isolated at home. Community teams...
liaised extensively with nurses employed by local hospice charities. Community teams also accessed support from the specialist palliative care team based in the acute hospital.

Health promotion

**Staff promoted patients’ health by giving them information.** Staff gave patients leaflets produced by the department of health that were designed to help patients to have difficult conversations about their end of life care. However, not all community teams could access stocks of these leaflets, in one case a nurse had laminated a copy and presented this in a folder to loan to patients.

We observed patient visits and saw staff advised patients and carers regarding the benefits of healthy sleep patterns. Staff gave patients health promotion leaflets that offered information and support relating to topics such as preventing pressure sores, and stopping smoking.

Staff in the community nursing team and the urgent care response team encouraged patients to remain mobile and independent if this was appropriate for their condition. For example, a community nurse ordered a plastic cover for a patient with a leg wound so that the patient could enjoy a shower without making their dressings wet. A therapist encouraged a patient to use their walking aid.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**When patients deteriorated, there were clear systems to communicate the agreed pathway of emergency treatment escalation for individual patients.** We looked at a total of 45 treatment escalation plans for inpatients and community patients. The records showed that Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were made appropriately and in accordance with national guidance. Decisions were clearly documented and contained adequate detail. Community patients kept these records in their own homes. For community inpatients, the record was stored in the patient record.

There was no available data specific to the community end of life care service to demonstrate compliance with legislation around consent, the Mental Capacity Act and Deprivation of Liberty Safeguards.

**Staff understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support patients who lacked the capacity to make decisions about their care.** Consent was recorded in line with legislative requirements. We checked patient records and observed patient visits and saw staff obtained consent before proceeding with treatment. Staff we spoke with understood the responsibility to assess mental capacity and to make best interest decisions when needed. Inpatient staff had experience of applying for deprivation of liberty safeguards for patients who were not safe to leave the ward.

**Mental Capacity Act and Deprivation of Liberty training completion**

There was no separate team for community end of life care. This service was provided by a combination of several teams including the community nursing, urgent care response teams, urgent care nursing and community rehabilitation teams. The data for Mental Capacity Act and Deprivation of Liberty training completion is commented upon in the community adults and the community inpatients evidence appendices.
Compassionate care

Staff cared for patients with compassion. Staff were consistently caring. We observed staff visiting patients in their own homes and saw all staff showed a genuine compassion and determination to 'do the right thing' for end of life care patients. One relative told us their nurse ‘always came to the door with a smile on her face, even at the end of a long shift’. We saw staff were reassuring and patient, taking time to allow patients and carers to share their worries.

Staff frequently checked patients comfort while undertaking tasks, such as adjusting the angle of the bed rest, or adjusting clothing. Staff considered what was important to patients and made extra effort to accommodate patients’ wishes. We were told how an urgent care support worker had found the time to assist a patient to wash their hair in their reclining chair.

In care planning discussions, teams carefully considered the comfort of patients and prioritised patients quality of life. For example, teams stopped unnecessary medicines and tried wherever possible to limit invasive procedures such as catheter insertion.

Community nursing staff tried wherever possible to protect patients’ dignity and treated patients with respect. Nurses used covers to avoid patients feeling exposed when they were required to undress. Staff ensured curtains were drawn to protect patients’ privacy.

Emotional support

Staff provided emotional support to patients to minimise their distress. When relatives were distressed, staff offered support and listened to their concerns. We saw staff adapted their communication style to meet the needs of patients, using humour where appropriate and when patients found this to be beneficial. When patients expressed their anxieties, staff gave patients one to one support.

Nurses explained how simple acts, such as holding a patient’s hand, could communicate a clear message of empathy and kindness. Nurses signposted patients and their carers to additional resources such as befriending schemes and chaplaincy services for further emotional support. Nurses at the community hospitals explained how they would contact the patient’s own religious leader, for example, the vicar at the patient’s church, to request spiritual care for dying patients.

When patients died, staff provided support for relatives. In the community hospitals, staff identified how they would use side rooms or patient lounge areas to talk to relatives who were distressed. Following the death of a patient, community nurses completed a follow up visit and offered bereavement support.

Understanding and involvement of patients and those close to them

Staff showed empathy and kindness towards patients’ relatives/carers. On some patient visits, community nurses knew their patients well and showed a genuine interest in the welfare of the whole family.

Community nurses and therapists listened carefully to patients. Staff reflected what they had heard to ensure they understood their patient’s perspective. We noticed one community nurse remembered details from her last conversation with the patient and this communicated that she was taking an interest in him as a person. Patients told us they felt listened to.

Staff involved patients and those close to them in decisions about their care and treatment. Patients and carers told us the community nurses understood the pressures of being a carer. One carer explained how the community nurse had taught her to change her husband’s wound dressing
so they were able to go away for a weekend together. One carer said she was given just the right amount of information to help her to understand her partner’s care and treatment.

Is the service responsive?

Planning and delivering services which meet people’s needs

Managers did not have a reliable system of knowing whether the service provided was meeting the needs of their population. The trust did not collect specific referral or outcome data about the community end of life care service. Best practice in end of life care as identified in NICE guidance requires teams to identify patients approaching the last 12 months of their lives to help those patients to prepare and make choices about the end of life care. The systems to identify community patients approaching the last 12 months of life were not thorough. There was no system to record or highlight patients who were deemed to be in this category. Best practice in end of life care as identified in the Gold Standards Framework requires teams to meet patient’s preferences for their place of care in their last days of life. The community end of life service did not capture locality or service wide data regarding the preferred place of care of patients living in their own homes.

There were localised examples of proactive planning at a local level to meet the needs of community end of life care patients. For example, in Okehampton, when the community inpatient beds closed in August 2017, the team retained the employment of the chaplain to provide a service for the community patients. The remit of this role was not fully confirmed but managers expected it to focus on providing support for staff and community end of life care patients in that locality.

All staff told us they could meet the needs of community end of life care patients who were approaching the last few days of their lives. During our inspection, we observed when staff identified a need for a patient, they identified resources to meet that need within or outside of their team. This involved teams working closely with other services such as GPs, the local hospice, and voluntary services.

The service took some account of individual need. The inpatient environment at one community hospital was enhanced to meet the individual needs of end of life care patients. For relatives who wished to stay overnight, the team offered relatives a ‘comfort bag’ containing toiletries and an electric recliner chair to sleep in. The chair was purchased using charitable funds. Extra resources were contained in an ‘end of life’ box containing a hot water flask, insulated milk jug, tea, coffee, sugar cannisters, six mugs, a music player, a bedside clock, lap trays, a night light, aromatherapy essential oils and four syringe pump bags. Relatives were also offered free hospital meals. The ‘end of life; boxes were not all available at the other two community hospitals.

On each of the community hospital wards, there was a ‘silver box’. This was a collection of resources for end of life care for staff. For example, the box included contact details of specialist teams, information for doctors about how to complete treatment escalation plans, end of life care documentation templates. The same resources were available online for community teams.

Community mortuary facilities were limited in capacity. There was no mortuary at Sidmouth or Exmouth hospital. At Tiverton hospital, the refrigerated mortuary cabinets had capacity for six patients. However, only four of the six shelves were used because the transfer equipment could not be positioned safely to access two shelves. However, managers told us the capacity of the community mortuary facilities at Tiverton were appropriate to meet the needs of the inpatient...
population in that locality. The mortuary was rarely at full capacity so this was not a risk to the service.

There was no mortuary viewing room at the Tiverton mortuary, so relatives viewed deceased patients on the ward. This was also the procedure at the inpatient facilities where no mortuary was available. Wherever possible, deceased patients were moved to a side room for this purpose. There were no mortuary facilities for bariatric patients. These patients waited on the ward for funeral providers to collect them.

**Teams made plans to ensure service delivery in the event of adverse weather.** During the heavy snowfall of March 2018, the nursing teams in rural areas went to great lengths to make sure urgent patients, such as those approaching the end of their life, received the care they needed. In one locality, this included arranging a community response in rural areas, coordinating local volunteers to drive staff to patient’s homes using tractors and 4x4 vehicles.

**Meeting the needs of people in vulnerable circumstances**

**Community nursing staff were not completing personalised care plans to meet the holistic needs of dying patients in the last few days of their lives.** We looked at the records of 11 patients who were in the last few days of their lives or had recently died. Only one of these records showed evidence of a personalised care plan. We observed nursing staff visiting five patients living in their own homes who were in the last few days of their lives. Staff focussed on providing attentive care in relation to the needs identified on the referral. We did not see nursing staff reviewing the patients from a holistic perspective.

The ‘Individual End of Life and Communication Care plan’ template was introduced to the community services in October 2018. This was designed to reflect the five priorities identified by the Leadership Alliance for the Care of Dying People (2014). The use of this template had not embedded in the community nursing teams. None of the community nursing staff we spoke with were using this document. However, inpatient nursing staff had comprehensively completed this document for an end of life patient at one of the community hospitals.

GP surgeries hosted meetings to identify and discuss patients with end of life care needs. However, these meetings focussed on those patients who were approaching the end of their lives and did not consider the care plans for patients approaching the last 12 months of their lives. Intervals between meetings were two months in some localities.

**There were no protocols for identifying patients in the last 12 months of life. We were not assured that the needs of these patients were being addressed. Staff were not addressing the care planning needs of patients in the last 12 months of their lives.** We observed nursing staff visiting four patients who were approaching the last 12 months of their lives. Nursing staff focussed on providing attentive care in relation to the needs identified on the referral. We did not see nursing staff reviewing the patients from a holistic perspective. We did not see evidence of staff assessing the spiritual and emotional needs of patients in this category.

**Advance care planning was not routinely offered to patients.** This is a process to help patients communicate and document their decisions about how their future care needs should be met. This is particularly relevant to end of life care when patients might not be able to express their wishes when their condition deteriorates in the last few days of their lives. When patients lose capacity to make decisions related to their care, health and social care professionals make use of information gleaned from the advance care planning process to guide them in decision making when needed.
We looked at 15 sets of patient records and none of these indicated advance care planning had been initiated. Patient records did not consistently identify patients preferred place of death. However, records indicated treatment escalation plans were completed.

The service took account of patients’ communication needs. The largest ethnic group within the trust catchment area is White British with 94.9% of the population.

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<thead>
<tr>
<th>Ethnic minority group</th>
<th>Percentage of catchment population (if known)</th>
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<tbody>
<tr>
<td>First largest</td>
<td>White British</td>
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<tr>
<td>Second largest</td>
<td>White other</td>
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<tr>
<td>Third largest</td>
<td>Asian/Asian British</td>
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<td>Fourth largest</td>
<td>Mixed Heritage</td>
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(Source: Universal Routine Provider Information Request – P48 Accessibility)

Community nurses used interpreter services when required. For example, a team had used the language line to access a polish interpreter for a patient and their family. Staff were aware of communication techniques to help patients with additional needs such as hearing impairment or following a stroke. Community staff could access guidance around cultural needs on the staff intranet.

Access to the right care at the right time

Accessibility

There were systems to ensure equitable access to the community end of life care service. Access to all community services was via the Single Point of Access (SPOA) referral process. This team had a dedicated telephone number available from 07:30 to 23:00 seven days a week. Professionals could use this telephone line to discuss and agree any immediate actions required to support patients at home or to enable patients to return home from hospital.

Patients could access the service when they needed it. Waiting times from treatment were and arrangements to admit, treat and discharge patients were in line with good practice. Nurses were available for community patients 24 hours a day, seven days a week, except for a 30-minute handover period between 08:00 and 08:30 each day. All community teams confirmed end of life care patients were their priority when allocating staff to visits. There was no waiting list for community nursing teams for end of life care. All staff visited patients on the same day as the referral when this was required.

Staff knew the preferences for the preferred place of care for the end of life patients they were caring for at the time of our inspection. Inpatient teams prioritised the discharges of end of life patients who wanted to go home to die. Sometimes domiciliary care was needed to enable patients to stay at home was not available. In these situations, urgent care support workers and urgent care nurses provided personal care until managers could source appropriate domiciliary care.
There was no facility for GPs to admit patients directly to community hospital beds. If the patient preferred to die in a bed-based care setting, staff looked for a bed in a nursing home or at the hospice.

Referrals

This was no referral data reported by the trust relevant to this core service.

(Source: CHS Routine Provider Information Request – CHS10 Referrals)

Learning from complaints and concerns

Patients and relatives knew how to make a complaint. Community patients were given a leaflet that contained contact details. However, from June 2017 to May 2018, there were no complaints about community health services for end of life care. There was no record of informal complaints relating to the community end of life service.

(Source: Universal Routine Provider Information Request (RPIR) – P52 Complaints)

Is the service well-led?

Leadership

At a senior level, there were identified leaders for the community end of life care service. The leadership for end of life care at board level was shared between the medical director and a non-executive lead. There was a responsible lay board member for end of life care. There was a consultant with medical leadership responsibility for end of life care services across the acute and community setting. There was also a lead cancer nurse for the trust. These staff were based in the acute hospital. The senior management responsibility for the community end of life care service rested with the Assistant Director of Nursing for the Community Services Division, the Divisional Business Manager for Community and the Integration Director.

Senior managers were aware of the challenges to provision of the community end of life service. Managers identified a need to agree a combined strategy, ensure enough social care was available to meet patient need, ensure teams were skilled and knowledgeable and improve how teams identified patients approaching the end of their lives.

Leaders at directorate level were visible and approachable. All community staff knew the identity of the senior nurse with a special interest in end of life care who also oversaw community end of life care services as part of their portfolio. This member of staff was visible and approachable and all community staff felt able to ask this member of staff for advice when needed.

At a ward or team level, leadership of the community end of life service was not well defined. Frontline staff were not empowered or given responsibility to drive the community end of life service forward. During our inspection we saw no evidence that these staff were given autonomy and skills to improve the community end of life care service. Local teams had very limited awareness of the
quality or safety priorities for the community end of life service and did not have a clear understanding of the work being done by the community end of life steering group. When improvements were initiated, these were not replicated in other teams. There were no identified leaders, for example link nurses, for community end of life care at band seven or below.

Vision and strategy

The vision and strategy for the service did not provide adequate direction or impetus for service development. The vision and strategy was not clearly documented. The strategy had not been translated into meaningful and measurable plans at all levels of the service. The strategy was not developed with input from community staff and was not communicated to staff delivering care. Staff we spoke with were not aware of the vision for the service and did not know their role in achieving the strategy.

Senior managers of the community end of life care service described their vision for community end of life services. This included the following: to ensure all patients died in the place they choose to die; to simplify and standardise policies and procedures across the whole trust, and where possible, across Devon.

Leaders of the service had identified some priorities in the annual board report. Some of these priorities were pertinent to the community end of life care service, including:

- Agree funding for the end of life Medical lead
- Update End of Life Policy to incorporate the community teams
- Education of all staff regarding the Five Priorities of Care identified by the National Leadership Alliance for the Care of the Dying Person
- Training of non-medics to have discussions around treatment escalation plans advance care plans
- Confirmation of death training for nurses in community
- End of Life Tool boxes to be available in Community Hubs
- All areas to embrace Advance Care Planning
- Dedicated quiet spaces within hospitals

Culture

Managers across the trust promoted a positive culture that supported and valued staff. Staff felt supported, respected and valued in their work. Managers acknowledged the good work done by the teams. Professionals employed by other organisations told us they valued staff contributions to the care of end of life patients. Staff told us they felt encouraged to raise concerns and confirmed their managers would listen. All staff were aware of the trust whistleblowing procedures. However, the trust did not collect staff feedback, for example, staff survey data, specific to the community end of life service.

There was a strong emphasis on the safety and well-being of staff. When patients died, team managers offered individual support to staff. The trust hosted ‘Schwartz rounds’ at various locations. Schwartz Rounds are an evidence-based forum for hospital staff from all backgrounds to come
together to talk about the emotional and social challenges of caring for patients. The aim is to offer staff a safe environment in which to share their stories and offer support to one another.

**Staff were proud to work in their teams.** Staff told us how they supported one another to overcome challenges to give the best possible care for community end of life patients. There were cooperative and supportive relationships between teams. For example, urgent care nurses told us they frequently stayed late to ensure the needs of end of life care patients were met during the community nursing team handover period between 08:00 and 08:30.

**Care was centred on the needs of patients.** Staff placed the patient at the centre of their approach to care, for example, they strived to enable patients to receive care and to die in their preferred place. However, the culture of the service was not focussed on improving the overall quality of the patient experience. The trust did not seek or capture patient feedback specific to the community end of life service.

Staff we spoke with were not aware of the trust values and did not have a sense of shared purpose across the whole trust. Staff told us the acute service did not understand how their community colleagues delivered end of life care in small rural communities.

**Governance**

The mechanisms for governance provided forums to escalate risks and disseminate learning related to the community end of life service. However, the governance structure did not provide an effective overview of specific quality indicators relevant to the community end of life service.

The end of life service was included in the community service governance structure. At a local level, there was a cluster level operational governance meeting each month. This meeting managers discussed safety indicators pertaining to all community patients such as learning from incidents, identification and management of risks, investigations and learning from incidents and complaints and readmission rates. However, these reports were not specific to the community end of life service.

Any items for escalation were reported to the community services divisional governance group. This included items that impacted upon the community end of life service. For example, attendees discussed the prevalence of urgent care response workers providing care for patients in lieu of social care providers when care was not available. Items relating to end of life care were escalated from the community divisional governance group to various committees and ultimately to the trust-wide governance committee, for example, the need for training around use of the treatment escalation plan for community patients. However, attendees of these forums did not challenge the lack of audit in this service or the partial compliance with relevant NICE guidelines.

The ongoing development of the service was not effectively monitored for progress. The community end of life care steering group was responsible for the development of the service in the community setting. This group was led by the medical lead and the lead cancer nurse.

Goals for the development of the community end of life service were included in the trust wide work plan for the end of life care service. There were 57 items on the workplan, 25 of these were not complete, with one rated as red, i.e. not progressing. The group met four times a year. Various sub-groups were responsible for taking projects forward in between meetings, for example there was an education sub-group.
Some of the priorities identified in the board report were partially included in the end of life care work plan, for example, an item referred to increasing awareness of a leaflet about advance care planning. However other priorities were not mentioned in the plan, for example, the confirmation of death training for community nurses.

We were not assured that leaders were adequately focussed on the continual improvement of the service in the community. Leaders explained that the process of reviewing and unifying policies had taken longer than expected. This was partly due to the very different ways of working in the community and in hospitals and the requirement for extensive collaboration across teams within the trust and with other health and social care providers such as GPs, and hospices. For example, the end of life care policy had commenced review in April 2018 and an extension had recently been granted until May 2019.

Management of risk, issues and performance

Managers did not have assurance regarding the quality and safety of the service provided for community end of life care patients. There was no systematic programme of clinical and internal audit to monitor quality of the community end of life service. The scope of current audit activity was very limited. Audits did not measure quality of the care for community end of life patients, particularly those living in their own homes or in residential or nursing care homes.

The service did not make use of all opportunities for learning around end of life care because mortality and morbidity reviews did not occur in the community end of life service. Mortality and morbidity reviews are meetings of involved professionals where patient deaths are reviewed as part of professional learning. When mortality and morbidity reviews are executed effectively, these forums can provide assurance that patients are not dying because of unsafe clinical practices.

Some risks were identified following investigations of incidents. Managers told us they were informed about all incidents related to the service. For example, the lead cancer nurse escalated concerns to the trust wide governance group regarding the use of anticipatory medicines in the community. This was a trend identified in incident reports. In response, the clinical effectiveness committee offered the help of the communications manager to assist in disseminating information to GPs and pharmacies and community staff. However, we did not see this concern reported in any other forum, for example, cluster operational governance group or community services governance group.

Not all risks were proactively identified and mitigated. The specific factors related to the provision of a mortuary at Tiverton Hospital had not been risk assessed. At the time of our inspection, there were no risks for the community end of life service identified on the community services risk register.

Information management

Leaders of the service did not collect or analyse information related to the community end of life care service. The performance assurance framework contained no specific performance measures related to community end of life care.

Quality and risk information about the community end of life care service was not regularly reported to the board. This meant the quality and safety of the community end of life service did not receive adequate challenge at board level. We checked the minutes of board meetings during the twelve months preceding our inspection and found only one sentence relating to the service. The exception to this was the annual end of life care board report presented by the trust wide end of life care leads.
Engagement

There were no forums for patient engagement that related specifically to the provision of community end of life care. There was no patient representative on the community end of life care steering group. There was no patient experience survey specifically related to end of life care.

The trust did not engage well with staff to plan and manage appropriate services. There were no forums for staff engagement that focussed specifically on the provision of community end of life care. Staff were informed about service developments by their team managers. The divisional newsletter for community services included a reference to the results of the preferred place of death audit. However, staff in community teams were not aware of the priorities identified in the board report or the content of the work-plans to improve the community end of life care service.

However, there were positive relationships with external partners to build a shared understanding of challenges within the system. End of life care leads attended the sustainability and transformation plan end of life care group. This was a county-wide forum that was led by the clinical commissioning group and included representatives from multiple providers in health and social care. Leads from the trust used this forum to share the new standard operating procedure for the ‘just in case’ anticipatory medicine bags to facilitate implementation on a regional scale.

The trust engaged with local organisations to plan and manage appropriate health and well-being services. At a local level, team managers participated in forums to engage with local populations about the provision of community services. For example, at Tiverton and at Okehampton, nursing team managers were involved in ‘Community Conversations’. These were community forums that gave opportunity for attendees to discuss the health and well-being needs of the local population and consider ways to work together to meet those needs. Attendees included representatives from key partner organisations, for example, the fire service, the church, local councillors.

Learning, continuous improvement and innovation

Accreditations

NHS Trusts participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. The trust did not report any accreditation schemes for community health services for end of life care that have been awarded.

(Source: Universal Routine Provider Information Request (RPIR) – P66 Accreditations)

At the time of our inspection, staff in the community end of life care service were not participating in research projects. Staff were unable to recall any quality improvement projects related to the community end of life service.

In some instances, where improvements had been introduced, subsequent changes to working practice were not managed effectively. For example, the new end of life care plan documentation was not used by community staff. Staff told us they had not received adequate training in the use of the document and did not feel consulted regarding its introduction. Staff felt that this change had not considered the context of care provided in community settings, for example, where doctors are not readily available to sign care plans.
Facts and data about this service

The trust has one Minor Injury Unit (MIU) located at Honiton Community Hospital. MIUs provide treatment and advice on a range of minor injuries not serious enough to require accident and emergency department treatment.

Royal Devon and Exeter NHS Foundation Trust (Wonford) Emergency Department (ED) is responsible for running the minor injury unit and provides ongoing support and advice.

Services are provided without appointment to adults and children, including local residents and visitors to the area. The unit is open seven days a week from 8am to 10pm.

The MIU is staffed by nurse practitioners. There is access to senior medical support from the ED and access to directly bookable GP appointments out of hours weekdays and all-day Saturday and Sunday, via an out of hours GP service.

The service has a receptionist Monday to Friday between 8am and 4pm, and 10am and 4pm at weekends. There is no receptionist outside of normal working hours.

Two nurses are on duty daily, two nurses were qualified nurse prescribers, the remaining nurses work from a series of patient group directions which enable them to administer identified medicines only.

An X-ray service is available two full days and three half days each week. Funding was agreed for a future change in provision.

Attendance at the MIU service fluctuated, with an increased demand during holiday seasons. The average number of patients seen is between 30-40 patients per day, but this can increase to up to 50 patients per day during the summer period. There was a 22% increase in attendance between October 2016-August 2017 and October 2017 – August 2018.

Between January and December 2018 there had been 11,270 initial assessment and treatment visits to the unit. Of those, 2,486 had been children. Of the overall total, 260 patients left before being seen or self-discharged.

(Source: Acute RPIR - Context tab; Universal RPIR – Sites tab)

During our visits we observed care and treatment and spoke with five staff but did not have the opportunity to speak with any patients as all were receiving treatment. We looked at 10 patient record cards and observed assessment and treatment being provided.

Activity and patient throughput

From November 2017 to October 2018 there were 35,070 attendances in total at the trust’s community urgent and emergency care services. This includes two walk-in centres. It is not
possible to break this data down between the three units. The Walk in Centres only contributed to this total from 1st April 2018.

Over these 12 months there were no emergency admissions via the trust’s community urgent and emergency care services. This does not take account of patients who may have been referred on from these services to the Wonford ED and subsequently admitted through the ED.

(Source: NHS England)

Is the service safe?

Mandatory training

Although a programme of mandatory training was provided for all staff to keep patients safe, mandatory training compliance did not meet the trust’s target of 75% completion.

Mandatory training completion rates

A breakdown of compliance for mandatory training courses as of May 2018 for qualified nursing staff at the Honiton MIU is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict resolution (level1)</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia and delirium</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling</td>
<td>8</td>
<td>10</td>
<td>80.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Food safety awareness</td>
<td>7</td>
<td>10</td>
<td>70.0%</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Domestic abuse</td>
<td>7</td>
<td>10</td>
<td>70.0%</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention &amp; control (including hand hygiene)</td>
<td>6</td>
<td>10</td>
<td>60.0%</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>6</td>
<td>10</td>
<td>60.0%</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Pressure ulcer classification (PUCLAS)</td>
<td>6</td>
<td>10</td>
<td>60.0%</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>7</td>
<td>12</td>
<td>58.3%</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Fire competency</td>
<td>5</td>
<td>10</td>
<td>50.0%</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Falls, slips and trips (patients)</td>
<td>5</td>
<td>10</td>
<td>50.0%</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Transfusion theory</td>
<td>1</td>
<td>9</td>
<td>11.1%</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Collecting blood/blood products (practical)</td>
<td>1</td>
<td>10</td>
<td>10.0%</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Administration of blood/blood products (practical)</td>
<td>1</td>
<td>10</td>
<td>10.0%</td>
<td>75%</td>
<td>No</td>
</tr>
</tbody>
</table>

At the Honiton MIU there was an overall training compliance rate of 59.6% for qualified nursing staff. The 75% target was met for four of the 15 mandatory training modules.
Not all areas of mandatory training had a direct relevance to the MIU, for example transfusion therapy and administration of blood products. However, staff confirmed areas of relevance, for example life support, had been fully completed. Some staff training records were not accurate as an administrative problem had been identified and was being addressed.

All staff in the MIU had been trained to deliver immediate life support (ILS) to both adults and children. This included anaphylaxis training for severe allergic reactions. Staff treating children under the age of 18 received paediatric competency training to ensure they could provide safe care to those children. Emergency practice scenarios were provided at the acute trust for staff to attend.

Training was provided by either e-learning or face-to-face, dependent on the subject. Staff told us they found the trust’s mandatory training and support information both useful and easy to access. They demonstrated how access was available via electronic systems to support their practice. There were systems to monitor and remind staff when training was due; emails were sent to staff to remind them when training was due.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Safeguarding**

Staff demonstrated they were knowledgeable about the risks to vulnerable adults. Safeguarding training had been undertaken and there were prompts to encourage professional curiosity during assessment.

**Safeguarding training completion rates**

The trust set a target of 75% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses as of May 2018 for qualified nursing staff at the Honiton MIU is shown below.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection group 2</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

At the MIU there was an overall safeguarding training compliance rate of 90% for qualified nursing staff. The 75% target was met for both safeguarding training modules for which qualified nursing staff were eligible. There was only one qualified nurse that had not completed each module.

There were policies and procedures to support the safeguarding of vulnerable adults and children. The trust’s safeguarding protocols were available to all staff on the intranet and staff were aware of the procedures and policies to follow.

All staff we spoke with said they had received recent safeguarding training. Managers kept records to indicate who required updating. Staff obtained child safeguarding training to level two as both e-learning and face-to-face training.

The MIU had a safeguarding lead nurse who undertook a specific role to provide any extra support.

Systems were available to enable staff to make safeguarding alerts. Staff confirmed they could contact the acute hospital ED and the safeguarding team would assist in completing the safeguarding alert form. The MIU used a shared system with the acute hospital and so it was possible to see if a child had attended the hospital. Children under the age of two years were not discharged by the MIU; they were referred to their GP, the on-call paediatrician, the GP out of hours service or ED as needed.
Children's triage records differed from adults and had a specific safeguarding checklist to complete. The system also included a prompt for observation of female genital mutilation (FGM). The MIU used the Child Protection Information System to ensure safeguarding alerts from elsewhere in the country could be seen by staff at the MIU. Staff appeared confident to use the system. Any alerts for children would be referred by the acute hospital ED and safeguarding team.

Staff demonstrated a good understanding of the needs of vulnerable people. Those patients at risk of suicide or self-harm were monitored discreetly and pathways were used to ensure they received the help they needed. Staff said that they found the acute hospital safeguarding lead to be very supportive of their safeguarding practice.

The MIU's premises were conducive to the disclosure of abuse. The reception room and waiting room were separate and so patient details could not be overheard by those waiting for treatment. The MIU had two single treatment areas which meant conversations with nursing staff could not be overheard and were private for disclosing abuse.

Emergency contraception was available in the MIU. Patient group directions were available for appropriately trained clinical staff to administer emergency contraceptives. 

(Source: Routine Provider Information Request (RPIR) – Training tab)

Cleanliness, infection control and hygiene

Cleanliness, infection control and hygiene were well managed with systems and processes to reduce and control the risk of cross infection.

Under the Health and Social Care Act 2008, all trusts are required to have clear arrangements for the effective prevention, detection and control of healthcare associated infection, including the procedures to be taken in the event of an outbreak of infection. Infection control policies for many aspects of practice were available on the trust’s website and provided clear guidance on the measures required to prevent the spread of infection.

Cleaning was completed by the community hospital cleaning staff with MIU staff cleaning their own equipment. Cleaning records demonstrated this was consistently undertaken and all areas appeared visibly clean. Curtains were changed by cleaning staff and all actions were recorded to provide an audit trail. Legionella water checks were completed by the estates management staff. There were clearly identifiable domestic and clinical waste disposal facilities, seen to be used appropriately.

Infection prevention was part of the trust’s mandatory training programme. The MIU had two infection control link staff who monitored and audited infection control. Staff followed the hospital policy of being ‘bare below the elbow’, wore the correct uniform and used personal protective equipment, such as gloves and aprons when needed.

We saw all staff washed their hands and used sanitiser gel immediately before and after patient contact. Local hand hygiene audits were undertaken by the unit infection control lead and results over the previous 12 months were mostly 100%.

Environment and equipment

The premises were suitable for their purpose and maintained to ensure patient safety. However, security alarm systems were under consideration to ensure safety of staff and patients.

The department was purpose built with a reception area, waiting area and triage and two treatment areas. An extra room had been reconfigured to enable staff to have a room for any confidential conversations or telephone calls. Work was being undertaken to ensure patient flow access to minor
injury areas through the department was optimised while ensuring confidentiality and suitable work space. There was a designated part of the waiting area for children, which included children’s toys and was visible by staff on the unit CCTV. The waiting room was being reorganised to include an electronic update screen and more comprehensive patient’s information.

Suitable equipment was available and maintained. All equipment we inspected had up to date portable appliance checks and service stickers. We saw there was no piped suction in the MIU, which is noted as required according to Health Technical Memoranda (HTM) guidance. The risk was not noted on the trust register and mitigated by oxygen and suction being available by using portable appliances. All cylinders available were secured or on portable trolleys.

Resuscitation equipment was available with a trolley located for immediate availability and locked to maintain security. Nursing staff completed daily checks of the resuscitation trolley, ensuring the security tag was present and the monitoring equipment, suction and defibrillator tested. A full check of the resuscitation equipment and drugs was completed weekly to ensure sterile or shelf life items did not go out of date.

Security alarm systems were under consideration to ensure safety of staff and patients. The estates department and trust health and safety representatives were aware that alarm systems used during working hours which had been previously suitable were no longer appropriate. The February 2018 Health and Safety report recommended the trust review the effectiveness of current security control systems to include the staff panic alarm and the use of CCTV. CCTV was used in the waiting area to observe for any security issue.

The trust was aware the emergency bell system did not alert neighbouring areas when it sounded, as there was no central panel available to staff working in the hospital. A risk assessment was completed and the trust had identified ways to manage the risk, which included all staff carrying mobile phones and always having two members of staff on duty.

Even with risk management controls as identified above, the current alarm systems could not ensure patient safety. The trust told us loudspeaker intercom phones in MIU were to contact other areas directly. However, staff told us this system was only effective if staff could get to the phone during an incident. Furthermore, the system would only contact staff in the MIU and not in the wider hospital. This was the same issue with mobile telephones, in that access to a mobile telephone was a more protracted process than an alarm and would only alert one person. The local police service was aware of the current issue and responded promptly to any issue raised. Staff did not have access to personal alarms.

Assessing and responding to patient risk

Staff responded appropriately to changing risks including deteriorating health and wellbeing.

Out of hours and at weekends, when reception staff were not employed, there was a risk patients’ initial assessment and risk assessment may be delayed, because nursing staff were seeing other patients. However, patients in the MIU’s were kept safe during normal daily opening hours because they received prompt assessment and treatment.

The trust aimed for all patients to be seen and triaged within 15 minutes. The trust monitored performance against this 15-minute standard and it was consistently met.

Staffing was considered to ensure appropriate care would be provided, to reduce the risk of missing any patient deterioration and ensuring patients were seen promptly. Staff told us there was an increase in the numbers of patients during holiday periods and so reviewed known periods of time
when extra staff would be needed. For example, extra staff had been planned for the period after Christmas and before the GP practices opened for the new year.

Risks to patients were assessed, monitored and managed to maintain their safety and meet their health needs. Patients who arrived at the department having made their own way presented to a reception desk in a waiting room to give their initial details. The receptionist did the initial booking in until 4pm, after which time details were collected by the trained nurses on duty.

Patients were initially booked in by recording their name and presenting condition. A series of questions were asked which were recorded on the computer system. Once the mandatory fields, including presenting complaint and personal details were completed, the attendance would appear on the screen ready for trained nurses to triage the patient. The details were also available at the acute hospital to enable ED staff to be able to see how busy the MIU was and identify if assistance may be needed.

A series of observations were completed to create a baseline of the patient's condition. All risks were assessed and a plan of action completed. Any indications of sepsis were considered and if any triggers were identified the patient was immediately transferred to the acute hospital.

The trust had a policy and escalation guidance for caring for a deteriorating patient. The trust used the ‘sepsis six’ tool. This is a care bundle which should be implemented within one hour. Should a patient present with any of the indications of sepsis, they would be sent directly to the emergency department of the acute hospital. Should there be any potential delays, the MIU staff could commence treatment and then transfer the patient. For children, the Paediatric Early Warning Scores (PEWS) was used and the same pathway of response was followed.

**Delays to emergency patients being transferred by ambulance to the acute hospital were not raised as incidents or monitored.** This was being considered to identify any trends for action. Patients who required transfer were kept under observation in the MIU until the transfer was possible. Should a patient in the MIU have a cardiac arrest, staff would commence resuscitation and request an emergency ambulance. Emergency treatment was also available for anaphylactic shock, allergic reactions and asthma attacks.

**Nurse staffing**

**Staffing levels were consistently maintained at planned levels by staff with appropriate skills.**

The level of staffing was a set level and did not fluctuate as patient numbers varied, unless planned to meet a predicted increase in demand. Agency staff were not used to cover shifts, with trust bank staff used when required. Staff told us they considered staffing levels to be safe.

All registered nurses had completed minor injury training. The unit was staffed by two trained members of staff. There were either two nurse practitioners or one nurse practitioner and one paramedic. All registered nurses were band six or seven and had completed patient group directions (PGDs) training to administer specific and identified medicines. One staff had qualified as a nurse prescriber and so could prescribe the required medicines for some illness and injury.

Staff undertook a handover of information between shifts. For any patients requiring a return visit, staff would check back for the patient’s notes to inform the patient’s care. Student nurses from the local trust had placements at the MIU to support learning and develop practice.

The trust reported their qualified nursing staff numbers as below as of March and May 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Honiton MIU</td>
<td>6.4</td>
<td>8.3</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Vacancy rates**

From June 2017 to May 2018, the trust reported a vacancy rate of 11.6% for qualified nursing staff in community urgent and emergency care. The vacancy rate for qualified nurses at Honiton MIU was 16%.

The trust set no target for vacancy rate.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From June 2017 to May 2018, the trust reported a turnover rate of 16.1% for qualified nursing staff in community urgent and emergency care. The Trust’s turnover rate target is between 10% to 12%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From June 2017 to May 2018, the trust reported a sickness rate of 2.4% for qualified nursing staff in community urgent and emergency care. This was less than the trust's target of 4%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and agency staff usage**

The bank and agency nursing staff data supplied by the trust did not show separate figures for usage in community urgent and emergency care.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

**Medical staffing**

The trust’s staffing data showed no medical staff in post in the MIU from June 2017 to March 2018.

Medical support was provided in an overview arrangement from the acute hospital ED through a “Red Doc” system. Each day a consultant was allocated the role and was available by telephone to answer any queries. We visited the ED and discussed with staff how this worked. The details were received by administration staff, recorded and passed to the consultant to respond. Should a patient transfer to the ED be needed, these details were added to the electronic record.

Staff could also access specialist advice from the acute hospital by telephone. For example, advice from the ophthalmology department or burns advice.

(Source: Routine Provider Information Request (RPIR) – Vacancy, turnover and sickness tabs)

**Records**

All records were fully completed, legible, signed and dated. There were systems to ensure patients’ information was kept safe. We found records were stored securely to ensure confidentiality. Paper records were all scanned into the electronic record system and the paper copies were kept locally for up to four weeks before being transferred to the ED who ensured that all records were scanned appropriately and the paper records were then destroyed. Stored records remained accessible to staff.
We reviewed 10 sets of patients’ paper records. All were legible, up to date and well completed, with dates and signatures to support records made.

Electronic records included all care provided. The system prompted and stored letters to patients’ GPs to inform them of their visit and any treatment provided. When referrals to other health professionals and/or services were made, photocopied records went with the referral to ensure continuity of care and the paper copies were scanned into the system.

Records identified if patients had any mental health or learning disability needs alongside their physical health needs. This ensured the patients’ needs were fully understood and appropriate support considered.

Records audits were used to monitor the content and quality of patients’ records. For each staff member completing records the senior staff reviewed five of their completed patient records. The results were used as a learning tool for staff and as part of appraisal and supervision.

**Medicines**

Medicines were managed in a way that kept patients safe. They were stored safely and recorded correctly. The trust’s medicines policy was available to support staff to manage medicines safely. This policy described the procedures that should be used when prescribing, supplying or administering a medicine.

Controlled drugs were stored securely. The controlled drugs registers were up-to-date and access to the cupboard keys was only by authorised staff.

Medicines, including refrigerated medicines were stored appropriately. Medicines were stored correctly in locked cupboards or refrigerators. Refrigerator and room temperatures were regularly checked by staff and were within required parameters.

Stock levels of medicines were being reviewed to ensure only medicines needed were stored. Some medicines were seen to be ordered but not used. This system was under review to ensure correct stock management.

A pharmacy team was available Monday to Friday 8.30am until 5pm to provide clinical pharmacy, medicines management and advice. In addition, on call pharmacy services were available out of hours for advice. Visits by the pharmacist were not required regularly but did take place to facilitate medicines checks and disposal.

Patient group directions (PGDs) were completed, up to date and reviewed annually. PGDs are written instructions for the administration of authorised medicines to patients and are needed to ensure medicines are only administered to patients by staff with the legal authority to do so.

All patient records we reviewed included any allergies to any medicines and recorded any medicines given as prescribed by a doctor or under PGDs.

One member of staff was qualified as a nurse prescriber and so had their own medicine prescription pad. This was kept securely and managed safely to ensure an audit trail of use.

There were clear disposal processes for wasted or out-of-date medicines. Facilities for the disposal of wasted medicines and destruction could be arranged through the pharmacy.

There was an antimicrobial policy to enable staff to keep updated and aware of any changes in antibiotic stewardship.

**Incidents**
Systems were used to report, investigate and learn from incidents. The trust's policy for the reporting and management of accidents, incidents and near misses set out procedures for managing incidents.

Staff understood their responsibility to report incidents. They said they received feedback from incidents and saw changes in practice as a result. There was a low level of incident reporting; however, staff were clear about the kind of incident they would report and gave examples of when they had reported. Staff explained learning from incidents from the wider trust was shared via the ‘Comms cell’ newsletters and safety alerts.

Staff appeared to have a good understanding of the duty of candour and the circumstances in which it applied. Staff told us that should they have any questions about their duty of candour they would ask senior staff for support. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong.

Never Events

Never events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic barriers are available at a national level, and should have been implemented by all healthcare providers.

From October 2017 to September 2018, the trust reported no incidents classified as never events in community urgent and emergency care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents in community urgent and emergency care which met the reporting criteria set by NHS England from October 2017 to September 2018.

(Source: Strategic Executive Information System (STEIS))

Safety Thermometer

The NHS Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm-free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

The safety thermometer does not contain separate data for the trust’s community urgent and emergency care services for the period from October 2017 to October 2018.

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

The trust’s policies and services were developed to reflect best practice and evidence-based guidelines. The National Institute for Health and Care Excellence (NICE) provides national
guidance and advice to improve outcomes for people using the NHS and other public health and social care services. Other guidance used included the British National Formulary, The Royal Pharmaceutical Society, and the Nursing and Midwifery Council (NMC) code – Professional Standards Practice 2015.

We observed NICE guidance being followed, for example:

We reviewed patient records, which all showed evidence of regular observations including blood pressure, pulse and respirations to monitor the patients’ health. This was in line with NICE guideline CG50: Acutely ill patients in hospital: recognising and responding to deterioration.

NICE medicines practice guidelines two (MPG2) was used to guide practice. This guideline provided good practice recommendations for individual people and organisations involved with PGDs, with the aim of ensuring patients receive safe and appropriate care and timely access to medicines, in line with legislation.

**Nutrition and hydration**

The department was not required to provide food and hot drinks to patients, but water was available. Before offering any drinks to patients, staff checked this was appropriate, considering any limitations to drink in case of future treatment.

Intravenous fluids were not available in the MIU. If fluids were needed the patient would be transferred to the acute hospital.

**Pain relief**

Pain management was well organised and established as part of triage and treatment.

All patient records we reviewed and patients we observed had a pain level assessed and treatment considered. We observed reception staff asking about pain levels on a scale of zero to 10 and patients’ records evidenced they were asked again when assessed and treated. Records showed appropriate pain relief had been administered. This was in line with Core Standards for Pain Management Services in the UK (Faculty of Pain Medicine 2015) 6.4 Standard 2.

**Patient outcomes**

The trust had limited participation in national audit for minor injury units but reviewed the service they provided for effectiveness. The trust provided us with details of local clinical audits undertaken by urgent care services over the previous 12 months and information as to how it had changed practice and so affected how the service was managed. The data was being used to monitor the service against the previous year’s activity. Dashboards were used to monitor referrals to the acute hospital, discharges to the local GP’s and average arrivals per hour. The data was reviewed to look for trends and pathways to help develop the service. For example, the data was considered over a busy period of time to influence the level of staffing at the same time the following year. The monitoring of GP referrals had contributed to the development of pathways with local GP practices to support patients to receive appropriate services promptly.

All X-ray requests were audited monthly to review how many and the type of X-undertaken feedback provided for learning opportunities. Nursing staff were encouraged to keep their own X-ray request log for an audit trail of activity. The X-ray audit fed back into the trust’s missed fracture database looking for themes and trends. There were no significant findings at this time.

(Source: Royal College of Emergency Medicine)

**Competent staff**
Staff had the right qualifications, skills and knowledge to do their jobs effectively. Staff told us they had access to e-learning and face-to-face training. They told us that in addition to mandatory training they had specialist training in minor injury and illness.

Staff told us that learning opportunities were available if appropriate to the MIU. Specific injury training had been provided, for example training on ophthalmology, paediatric burns, paediatric head injuries and medical devices had been undertaken on the unit.

Staff received training in dementia and delirium. Staff spoke about the psychological needs of individuals. Staff described skills and sensitivity when dealing with patients with mental health conditions including dementia.

**Appraisal rates**

Staff appraisals supported staff development. An appraisal was used to identify learning needs, and there was a plan to support staff to develop their practice. From August 2017 to July 2018, the trust’s appraisals data showed three out of five qualified nursing staff in community urgent and emergency care received an appraisal (60.0%) compared to a trust target of 85%. The target was therefore not met. However, by the date of inspection staff confirmed that only one appraisal was late being undertaken.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

**Multidisciplinary working**

The MIU staff worked with other organisations to deliver effective care and treatment. The MIU staff liaised with GPs, district nurses, school nurses and social workers where appropriate, to arrange ongoing care and appropriate follow-up for patient’s post-discharge. We reviewed patients’ notes and saw evidence of multidisciplinary team working.

Staff described working with the local acute trust to make referrals quickly and efficiently.

All patient transfers went through the trust’s ED. There were limited direct pathways to avoid delays, however a transfer of patient records via the electronic system reduced the need for duplication. The MIU could refer medical patients directly to the Medical Triage Unit (MTU) and patients would attend there directly. The MIU could also refer to all specialities (e.g. Plastics, Max-fax, Orthopaedic, Spinal, Paediatrics) with the exception of general surgery. The current pathway for all other expected patients regardless of referral source was to attend the ED to wait to be seen by the specialist.

Referral to the acute hospital physiotherapy service was used to support onward care.

The MIU staff were working with the adjacent GP practice to work effectively.

The MIU team had an established relationship with the local GP surgery to provide primary care support. This relationship allowed the flow of appropriate patients both from the GP surgery via agreed pathways to the MIU, and from the MIU to the GP surgery to provide same day primary care access where necessary. The management team had regular meetings with the GP surgery to ensure regular feedback and fine tuning of pathways.

The out of hours GP service had a base at the MIU and provided additional support, including advice, guidance and receiving referrals where appropriate.

The MIU staff worked proactively with the ambulance service. Ambulance staff were encouraged to call the MIU before arriving to prevent an inappropriate journey.
The MIUs had access to psychiatric, substance misuse or specific health services. The staff told us they could ‘signpost’ patients to the appropriate services or would inform the patient’s GP to enable community services to be accessed.

**Seven-day services**

The MIU was open seven days a week between 8am and 10pm. Patients could attend during open times without an appointment or any prior booking. Waiting times for the MIU were available to the public via the trust’s website.

An X-ray service was available two full days and three half days each week. Funding was agreed for a future change in provision. Opening times were displayed in the waiting room.

All X-rays were read by a radiographer and nursing staff at the time of X-ray. Staff could request the acute hospital emergency doctors review any X-ray for a further opinion. A further check was completed two days later by a trust radiographer. Should the report differ from the MIU staff X-ray interpretation, staff would then telephone the patient and a further visit would be arranged.

Call back clinics were used to review specific injuries only. Patients who had potential simple fractures could be treated and then return next day for an X-ray and fracture clinic referral.

**Health Promotion**

Patients had access to information to help them understand their care and treatment and promote good health. Staff could provide health promotion advice and support and could direct patients to where further information could be found for example smoking cessation and healthy eating. Leaflets were available for staff to take away with them.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

Staff consent to care and treatment was sought in line with legislation and guidance. Staff had a clear understanding of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and patient consent.

Consent to treatment was undertaken by the nurse directly responsible for the person’s treatment and each patient was asked for their consent before treatment was provided. Staff followed trust policies to ensure a consistent and monitored approach.

There was a consent policy for children and young people accessible to staff. Staff confirmed they used the Gillick competence to assess if a child could consent. Gillick competence is a term originating in England and is used in medical law to decide whether a child (under 16 years of age) can consent to his or her own medical treatment, without the need for parental permission or knowledge.

Staff were also aware of Fraser guidelines, to decide if a child could consent to contraceptive or sexual health advice and treatment.

The trust provided training to all clinical staff on the Mental Capacity Act to ensure they could undertake their duties in relation to capacity and consent. Training in Mental Capacity Act and Deprivation of Liberty Safeguards was covered within the trust’s safeguarding adults training module. As of July 2018, this module was completed by nine of the 10 eligible qualified nursing staff at the Honiton MIU (90.0%). Therefore, the trust’s 75% target was met.

*(Source: Routine Provider Information Request (RPIR) – Training tab)*
Is the service caring?

Compassionate care

Staff treated patients with kindness, dignity, and respect. Staff interacted with patients in a positive, professional, and informative manner. This was in line with National Institute for Health and Care Excellence (NICE) Quality Statement 15. Reception staff were polite and discreet.

The NHS Friends and Family Test is a patient survey tool to learn about patient experience and satisfaction. The MIU had not been consistently gathering this information. They recognised this and had re-implemented the survey from January 2019. The first full month’s validation was not expected until the beginning of March 2019.

The unit now has feedback cards that state that they are specifically for the Honiton Minor Injury Unit and staff are actively encouraged to hand out cards to patients on each shift.

Data and any narrative will be collated and submitted by a member of the admin staff with feedback going to the lead practitioner for learning to be shared with the team.

Other feedback available from a public website showed mostly positive and grateful responses by the public. The comments reflected patients considered they had received a good quality of care received in a timely way.

Emotional support

Staff showed an encouraging, supportive and sensitive attitude to patients and those close to them. We observed nurses introducing themselves when they met patients and their families. We also saw staff sitting and talking with patients to ensure they were comfortable and involved in the care provided.

Patients’ privacy and confidentiality was respected. The MIU had been reconfigured to create confidential space. This meant patients in distress or with sensitive information to discuss were afforded the appropriate environment.

Understanding and involvement of patients and those close to them

Staff understood the importance of involving patients in their care. Staff considered any communication difficulties and had access to support services and aids to ensure patients and carers understood the care and treatment provided.

Staff had established processes to support patients with mental illness. Staff told us that when they had concerns about patients’ mental health wellbeing they would liaise with the GP or acute hospital. They gave an example of a patient who visited often and was exhibiting signs of general physical and mental deterioration. Staff worked with the patient’s GP and family to ensure the patient was safe and appropriately cared for.

The spiritual and pastoral care service operated an on-call arrangement for advice to the MIU. This ensured an individual’s beliefs were respected and accommodated. They could also facilitate support from the appropriate community faith leader as required.

There was no direct referral facility for staff to counselling services. However, staff could refer to the patient’s GP who could identify the appropriate service available.

Is the service responsive?
Service delivery to meet the needs of local people

Services provided reflected the needs of the local population where possible, and were responsive to patients’ needs.

The MIU provided minor injury and illness care. Patients could be referred to a local GP. There were established pathways to enable patients access as needed.

The waiting room was adequately sized to accommodate the numbers of patients and their relatives or friends. The waiting room displayed current waiting times. The area was being refurbished and all information reorganised. A new board had been developed by a recent student nurse to ensure information was comprehensive and clear and did not require patients to search for what they needed.

The environment enabled a quiet space for those patients who found busy environments distressing. This space could also be used for those patients who were waiting for any mental health or psychiatric input. The waiting room had CCTV coverage to enable staff to observe patients in the waiting room.

Staff explained that when a contraception service in the community was no longer available, they requested the service be reinstated at the MIU to enable continuity for the public.

Meeting people’s individual needs

The minor injury unit took account of patients’ individual needs. Staff supported patients with complex physical and/or mental health needs to understand the care and treatment being provided.

All areas of the MIU were accessible for patients with limited mobility or who used mobility aids. Accessible toilets were available for disabled patients and visitors.

Translation services were available with the use of a language telephone service.

Information leaflets were available for patients for a variety of medical conditions; staff could not confirm if these were available in different languages.

For patients awaiting transfer to the acute hospital, staff remained with them and continued to observe and support them. They would wait inside the treatment area to ensure they felt safe and supported. Information about the transfer would be input onto the electronic system to avoid duplication of questions on transfer. When appropriate the existing care providers would be informed of the patient’s treatment. This would include the patient’s GP, mental health teams and learning disability support.

Access and flow

Patients accessed care and treatment in a timely way. The Department of Health’s standard for emergency departments is that 95% of patients should be assessed and treated within four hours of arrival in the ED. From November 2017 to October 2018 the trust’s community urgent and emergency care services consistently met the standard, and consistently outperformed the England average. The average time patients were waiting to be seen and treatment commenced was nine minutes over the previous year.

The service delivered was flexible to ensure the flow of patients through the department was maintained. The trust maintained an MIU dashboard report which provided information on attendance patterns, for example the hour of arrival and peak times of activity. This meant patient
activity could be monitored and changes considered to staffing levels to meet identified demand. However, the report for December 2018 showed there was some increase in activity around 7pm. By that time, there was no reception staff available and so the two trained nurses would have the reception, triage and treatment roles to undertake.

If the MIU was not busy, patients were triaged and treated immediately. If there were multiple patients in the waiting room, each patient was booked in and triaged as soon as possible. The order of treatment was prioritised to ensure the patients with the highest risk were seen first. There were CCTV cameras for staff in the unit to constantly monitor any new arrivals or signs of patients who may be deteriorating. The triage and treatment of patients was continually being reassessed to ensure patients were safe but also seen in a timely way. If delays occurred, staff explained the reasons for the delay to waiting patients.

We observed patients being treated promptly and teamwork between staff ensured patients were booked in, triaged, treated and discharged quickly and safely.

Patients who arrived by ambulance were brought into the department for triage. Should the patient need transfer to the acute hospital a call was made to the ambulance service to organise a patient transfer.

Patients returning the next day for a wound check or call back were seen in between other patients.

Four-hour target performance - Royal Devon and Exeter NHS Foundation Trust

(Source: NHS England - A&E Waiting times)

Learning from complaints and concerns

Complaints were handled in accordance with trust policy. Complaints were investigated by the lead nurse and with assistance from the emergency department lead.

The trust had a complaints policy to deal with complaints quickly and appropriately. Information was available to inform patients of how to complain and leaflets were available for patients to take with them which explained the process.

From June 2017 to May 2018 the trust received one complaint about the MIU, and the subject was clinical treatment. The trust took 44 working days to investigate and close the complaint. This was
in line with the trust's complaints policy, which stated complaints should be responded to within 45 working days.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

**Number of compliments made to the trust**

From June 2017 to May 2018 the trust received two compliments about community urgent and emergency care. Both concerned the walk-in centre at Royal Devon and Exeter Hospital (Wonford).

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

**Is the service well-led?**

**Leadership**

Staff felt local leadership represented and enabled them, and hospital and divisional lead staff were accessible. Staff told us they felt supported and heard. There was a collective culture of openness to drive quality and improvement. The unit was managed as part of the medicine division. This divisional role had links to the trust board and was a means to cascade information from unit to board and back. Chief executive visits had not yet taken place.

At a local level the unit was managed by the unit’s Lead Nurse Practitioner and was supported at a divisional level by the ED senior nurse. Staff spoke positively about the support they had received. Staff told us that they felt senior staff had the skills and capacity needed to run the unit successfully. They considered the unit to be well-led and senior staff were accessible and supportive to ensure patients’ safety.

**Vision and strategy**

Staff were aware of the vision and strategy for the minor injury unit as well as the wider trust strategy.

Staff considered their role was to provide a high-quality service which supported patients to stay closer to home. Their vision was to develop the service to be in line with local needs and to constantly review the service they provided to ensure it met with local and national demands. The strategy was not yet formalised and recorded and so achievement was not monitored to assess progress. This was planned for the future.

As part of the trust, the MIU worked towards the ongoing support of patients with mental health needs. The trust had a very strong mental health strategy driven by the trust’s Medical Director with support at board level.

**Culture**

There was a strong ethos of teamwork and staff felt very well supported. Staff told us they enjoyed their jobs and there was a culture of openness and honesty where they felt listened to and supported.

Staff felt able to raise any concerns and that learning from issues was a positive part of the culture. Staff worked collaboratively and responsibly to ensure patient care was maintained. Staff told us the patient was at the heart of all they did.

**Governance**
There was a structured and effective governance management framework to monitor and develop the minor injury service. Governance arrangements demonstrated the processes through which unit to board reporting and continuous learning was achieved. The arrangements included analysing and responding to patient, public and staff experience feedback, incidents and risks, key performance indicators, quality metrics and audit results.

The MIU was part of the medicine division and sat within the ED governance. The unit did not have its own specific governance process but had a standing agenda item on the monthly ED speciality governance group meeting. The ED speciality governance group reported directly to the monthly medicine directorate governance group meeting. We saw minutes of clinical assurance audit groups which evidenced this process. For example, we saw changes to patient group directions were agreed through this governance procedure.

The senior nurse, clinical lead and cluster manager aimed to meet monthly to monitor unit governance at a local level. However, whilst notes were taken at these meetings, the meetings were not formally recorded. The senior nurse and lead nurse practitioner also met on a regular basis, often weekly, at either the ED or MIU. Again, these were informal meetings and so no minutes from these meetings were available.

Due to staffing challenges and the size of the team, staff attendance at regular face to face unit meetings had proven challenging. To overcome this and keep the team updated, the lead nurse sent email updates (at least monthly) to the team informing them of staffing and clinical updates as well as information which had been received relative to the unit.

There was auditing of the reasons patients attended the units to identify any themes or trends or identify if the visits prevented attendance at the local ED.

Mortality reviews were not undertaken by the MIU staff and staff did not get learning from the trust mortality reviews.

Management of risk, issues and performance

A local risk register was not in a standard template, but risks were included as part of the divisional risk registers and were overseen as part of the emergency department governance. This meant any risks of concern could be flagged to the division and trust board and learning shared across the hospital.

We saw risks were assessed, rated and safety measures recorded. The risk registers for the hospital followed how risks were being reviewed and managed.

A health and safety inspection had been undertaken with recommendations being actioned.

The MIU had implemented its own health and safety risk assessor. Any issues raised then went to the ED governance process for review agreement.

The impact of seasonal change was considered and managed. During the summer months staffing was adjusted to meet the seasonal demand. During winter the risk of poor weather was considered. A back-up generator enabled the unit to remain open in the event of a power failure and this was tested weekly.

Information management

Service performance measures were used to ensure the service was as effective as possible. The gathering of data to evidence service use highlighted the number of MIU attendances had dropped around the time of the inpatient beds being closed. Staff considered this may have been due in part to a misunderstanding of the MIU facilities available. The trust identified 4,000 patients
who attended the ED but who could maybe have been treated at the MIU. The trust wrote to those patients to inform them of the MIU service available to them locally.

**Information technology systems linked to the acute trust to enable safe and effective information management.** Patient records were available at both sites to ensure safe and responsive record management. The trust website had waiting times available for both the acute hospital ED and the HonitonMIU.

**Engagement**

The NHS Friends and Family test had recently been reimplemented to assess patients’ overall experience. Staff aimed to distribute a minimum of two questionnaires each per shift to ensure a suitable level of response could be attained. Key findings were to be collated and forwarded to the senior MIU staff for review and action as needed.

Staff surveys were undertaken to establish the views of staff on the service provided and the experience of working for the trust. The results were not yet available for our review, however an action plan with strategic objectives was being written to take learning from the survey forward.

**Learning, continuous improvement and innovation**

**Changes and developments in the minor injury unit were driven by dedicated staff.** For example, the waiting room area was being reorganised. The planned changes were because of a recent student nurse’s input to address the signage and ensure comprehensive patient information was available. The MIU won the trust’s Extraordinary People, Extra Mile Team Award in October 2018.

The long-term strategy was for all nurse practitioners to undertake the non-medical prescribing module. The training was centrally organised by the trust and the unit submitted a candidate for each intake. This would provide a continued level of improvement and wider scope for the treatment provided.